


**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: The Lodge at Historic Lewes Senior Living DATE SURVEY COMPLETED: December 19, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
<p>3225.0</p> <p>3225.12.0</p>	<p>An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from December 16, 2024, through December 19, 2024. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was seventy (70). The survey sample totaled eleven (11) residents.</p> <p>Abbreviations/definitions used in this state report are as follows:</p> <p>DON – Director of Nursing; ED – Executive Director; IRC – Incident Reporting Center; LPN – Licensed Practical Nurse; RN – Registered Nurse; UAI – Uniform Assessment Instrument. Autonomic nervous system disruptions – A dysfunction of the nerves that regulate non-voluntary, such as heart rate, blood pressure and sweating. Dementia – The loss of cognitive functioning – thinking, remembering and reasoning – to such an extent that it interferes with a person’s daily life, and activities; Lewy body dementia – A progressive brain disorder that affects thinking, movement, behavior, and mood; Memantine – A medicine used for dementia; Parkinson’s – A brain disorder that causes gradual, worsening problems with movement, balance, and coordination.</p> <p>Regulations for Assisted Living Facilities.</p> <p>Services</p> 	<p>3225.12.1.3</p> <p>A. No residents were identified as being affected by the deficient practice.</p>	

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<p>3225.12.1</p> <p>3225.12.1.3</p> <p>S/S – F</p>	<p>The assisted living facility shall ensure that:</p> <p>Food service complies with the Delaware Food Code</p> <p>Delaware Food Code</p> <p>Based on observations, interview, and review of other facility documentation it was determined that the facility failed to comply with the Delaware Food Code. Findings include:</p> <p>Delaware Food Code 3-401.11 Raw Animal Foods: (A) Except as specified under (B) and in (C) and (D) of this section, raw animal FOODS such as EGGS, FISH, MEAT, POULTRY, and FOODS containing these raw animal FOODS, shall be cooked to heat all parts of the FOOD to a temperature and for a time that complies with one of the following methods based on the FOOD that is being cooked.</p> <p>12/17/24 – 11:30 AM - During the survey of the facility, the surveyor interviewed E3 (Director of Culinary Services), upon review of requested temperature logs of meals it was discovered that the facility is missing mealtime temperature logs 330 out of 459 reviewed.</p> <p>12/17/24 1:50 PM - Discussed findings with E3 and E1 (Executive Director).</p>	<p>B. All residents have the potential to be affected.</p> <p>C. Culinary Services Director re-educated staff via in-service (Attachment 1) on the requirement to monitor/record the food temperature at each meal to ensure meals are cooked to the proper temperature based on the food type. (Daily monitoring system by culinary mgt. team)</p> <p>D. The Culinary Services Director/designee will conduct food temperature log audits (Attachment 2) to ensure food temperatures are being recorded properly and consistently. These audits will be completed daily until 100% compliance is achieved over five consecutive evaluations. The audits will then be completed once weekly until 100% compliance is achieved over three consecutive evaluations. Finally, the Culinary Services Director/designee will conduct an audit one month later. If 100% compliance is achieved the community will conclude the deficiency has been corrected and the audit will occur semi-annually as part of the QA monitoring process.</p>	
<p>3225.13.0</p> <p>3225.13.5</p> <p>S/S – D</p>	<p>Service Agreements</p> <p>The service agreement shall be developed and followed for each resident consistent</p>	<p>E. Completion Date: 02/17/05</p>	

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	<p>with that person's unique physical and psychosocial needs with recognition of his/her capabilities and preferences.</p> <p>This requirement is not met as evidenced by the following:</p> <p>Based on record review and interview, it was determined that for two (R1 and R2) out of 11 residents reviewed, the facility failed to develop a service agreement that is consistent to the resident's unique physical and psychosocial needs.</p> <p>1. A review of R1's record revealed the following:</p> <p>10/12/23 – R1 was admitted to the facility.</p> <p>1/3/24 – A new diagnosis of senile dementia was added to R1's electronic chart.</p> <p>6/28/24 – A level of care program assessment documents R1's orientation and behavior as mild confusion, but generally cooperative.</p> <p>6/28/24 – A significant change resident service agreement for R1 lacked any evidence of cognitive function including any goal or actions related to memory or orientation.</p> <p>11/28/24 – A new medication order for Memantine 5 mg tablet, take 1 tablet by mouth twice a day for dementia.</p> <p>The service agreement lacks any information regarding R1's cognitive capacity or interventions to monitor a decline.</p> <p>2. A review of R2's record revealed the following:</p>	<p><u>3225.13.5</u></p> <p>A. Residents R1 and R2 - No negative outcome was identified by the deficient practice. A comprehensive review of R1 and R2's service agreement was conducted. The agreements were updated to include documentation of cognitive function, goals, and actions related to memory and orientation.</p> <p>B. All residents have the potential to be affected.</p> <p>C. All service agreements will be reviewed and updated to incorporate interventions for monitoring cognitive decline and supporting cognitive capacity for each resident, if appropriate. Nursing staff responsible for assessments will be in-serviced (Attachment 3) with a focus on the following areas: 1. Assessing and documenting cognitive functions and reflecting this information in the service plan, and 2. Implementing targeted interventions to address residents' psychosocial and physical needs when appropriate. Additionally, all significant changes in resident conditions will be reflected in revised service agreements. Finally, the facility will collaborate with the Information Technology Support team to enhance documentation</p>	

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<p>3225.19.0</p> <p>3225.19.1</p> <p>S/S - A</p>	<p>2/9/24 – R2 was admitted to the facility.</p> <p>2/9/24 – An admission resident service agreement for R2 lacked any evidence of cognitive function including any goal or actions related to memory or orientation.</p> <p>3/9/24 – A level of care program assessment documents R2's orientation and behavior as mild confusion, but generally cooperative.</p> <p>6/24/24 – A doctor's note shows R2 with a diagnosis of Lewy Body Dementia progressing as an autonomic disruption (nerves that regulate the nonvoluntary nervous system).</p> <p>7/15/24 – A doctor's note shows R2 with mild cognitive difficulties.</p> <p>The service agreement lacks any information regarding R2's cognitive capacity or interventions to monitor a decline.</p> <p>12/19/24 9:51AM – During an interview with E1 (Executive Director) and E2 (DON), E2 confirmed that the service agreements for R1 and R2 do not include information specific to the resident's cognitive decline or mental capacity. The facility monitors a resident's activities of daily living, assistance with care and any behavioral activity.</p> <p>12/19/24 2:31 PM – Findings were reviewed with E1 and E2 during exit conference.</p> <p>Records and Reports</p> <p>The assisted living facility shall be responsible for maintaining appropriate records for each resident. These records shall document the implementation of the</p>	<p>templates, ensuring sufficient space for required information.</p> <p>D. The DON/designee will conduct audits (Attachment 4) of 10% of all current resident service agreements to ensure there is sufficient assessment and documentation of cognitive functions and interventions to address psychosocial and physical needs. These audits will be conducted weekly until 100% compliance is achieved over four consecutive evaluations. Audits will continue monthly until 100% compliance for two consecutive evaluations, then quarterly until 100% compliance is achieved. If 100% compliance is achieved the community will conclude the deficiency has been corrected and the audit will occur semi-annually as part of the QA monitoring process.</p> <p>E. Completion Date: 02/17/2025</p> <p>3225.19.1</p> <p>A. Resident R4 no longer resides at the community.</p>	

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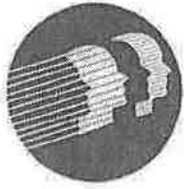
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	<p>service agreement for each resident.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review and interview it was determined that for one (R4) out of eleven residents sampled, the facility failed to maintain accurate records for the resident. Findings include:</p> <p>10/24/23 – A medical evaluation for R4 documented Parkinson’s as the primary diagnosis.</p> <p>11/8/23 – R4 was admitted to the facility with diagnoses including, but not limited to Parkinson’s disease.</p> <p>12/8/23 – A 30-day uniform assessment instrument (UAI) was completed and lacked documentation regarding R4’s Parkinson’s diagnosis.</p> <p>3/20/24 – A service agreement for R4 documented that R4 was moved to the memory care unit for more specified care.</p> <p>3/20/24 – A significant change UAI was completed and lacked documentation regarding R4’s Parkinson’s diagnosis.</p> <p>12/19/24 – An interview with E1 (ED) and E2 (DON) confirmed that R4’s UAI lacked documentation regarding R4’s diagnosis.</p> <p>12/19/24 2:31 PM – Findings were reviewed with E1 and E2 during exit conference.</p>	<p>B. All residents have the potential to be affected.</p> <p>C. A comprehensive review of all current residents’ medical records, specifically UAI assessment documents, will be conducted to identify and correct any omissions in diagnoses and care documentation. Nursing Designee responsible for maintaining records will be in-serviced (Attachment 5) on the necessity to conduct cross-verification of diagnoses between medical evaluations, Uniform Assessment Instruments (UAI), and service agreements.</p> <p>D. The DON/designee will conduct audits (Attachment 6) of medical evaluations, UAIs, and service agreements on 10% of resident charts to verify diagnoses are consistent across all three documents. These audits will be conducted weekly until 100% compliance is achieved over four consecutive evaluations. Audits will continue monthly until 100% compliance for two consecutive evaluations, then quarterly until 100% compliance is achieved. If 100% compliance is achieved the community will conclude the deficiency has been corrected and the audit will occur semi-annually as part of the QA monitoring process.</p>	

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