DELAWARE HEALTH AND SOCIAL SERVICES

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

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 7, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced initial certification and complaint Survey was conducted at this facility from December 4, 2023 through December 7, 2023. The deficiencies contained in this report are based on interview, record review and review of other facility documentation, as indicated. The survey sample totaled thirteen reviewed residents. Abbreviations/definitions used in this state report are as follows: DON – Director of Nursing; ED – Executive Director; IRC – Incident Reporting Center; Hematoma – collection of blood outside of a blood vessel; LPN – Licensed Practical Nurse; RN – Registered Nurse; Tubersol – a skin test to help diagnose tuberculosis.	
3225.8.0	**Medication Management.**	
3225.8.3	**Medication stored by the assisted living facility shall be stored and controlled as follows:**	
3225.8.3.5	**All expired or discontinued medication, including those of deceased residents, shall be disposed of according to the assisted living facility's medication policies and procedures.** The requirement was not met as evidenced by: Based on observation and interview, it was determined that the facility failed dispose of ex-	3225.8.3.5 A. Resident R11 – Upon identification of expired eye drops, medications were discarded and re-ordered. The identified bottle of Tubersol was also discarded and reordered. No negative outcomes were identified by the deficient practice. B. All residents have the potential to be affected. C. A focused review of medications for all current

Provider's Signature Dil Bell Title Executive Director Date 12/22/23

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	pired medications. Findings include: A facility corporate policy (last revised 8/7/12) titled Dating and Discarding of Multidose Parenteral Vials included: "Nursing staff will date parenteral vials and discard opened vials as outlined to decrease the risk of contamination and bacterial or fungal growth from multidose vials. The pharmacy provider will affix a label on all multidose vials. This label is to be filled in by nursing after opening the vial. When nursing staff opens a multidose parenteral vial, they will initial, date the vials when first entered and designate expiration date." An undated facility policy and procedure titled Medication Destruction included: "Medication shall not be kept when expired, discontinued or for a Resident who no longer is living in the community. Medication that are expired or discontinued or for residents who no longer reside in the community cannot be administered." 1. Review of R11's clinical record revealed: 9/26/23 – R11 was admitted to the facility with dementia. 11/5/23 – A Physician's order included for R11 to be administered an eye drop four times per day. 12/4/23 11:05 AM – During a medication storage audit on the first-floor medication cart with E4 (LPN), two bottles of R11's eye drops were examined, and both were found to have an expiration date of 11/30/23. Review of R11's medication administration record revealed R11 had been administered the eyes drops on 12/1/23 four times, 12/2/23 four times, 12/3/23 four times and 12/4/23 four times and 12/5/23 three times.	residents was completed in order to identify any which had expired medications. No additional findings were identified. D. The RSD/designee will conduct medication cart audits weekly until compliance of 100% is achieved over 3 consecutive evaluations. Finally, the RSD/designee will conduct an audit 1 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 plan. E. Completion Date: 2/01/24

Provider's Signature Dial Bell Title Executive Director Date 12/22/23

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	12/5/23 11:19 AM – During an interview, E5 (LPN) confirmed R11 was still being administered the expired eye drops and that the eye drops remained stored in the medication cart. The facility failed to discard the two bottles of expired eye drops. 2. During a medication storage review, a vial of open Tubersol was noted in the medication refrigerator on the first-floor medication room. 12/4/23 2:17 PM – During an interview, E4 (LPN) confirmed the Tubersol vial had been opened had been accessed and was not dated when opened. E11 confirmed she would not be able to determine the 30-day expiration date after the vial had been accessed.	
3225.12.0 3225.12.1 3225.12.1.3	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** 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: Delaware Food Code 2-402.11 Hair Restraints Effectiveness:(A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE- SERVICE and SINGLE-USE ARTICLES. 12/05/23 – 12:20 PM - During the survey of the facility, the surveyor observed a E8 (cook) in the	**3225.12.1.3** Delaware Food Code 2-402.11 A. No residents were identified as being affected by the deficient practice. B. All residents have the potential to be affected. C. Culinary Services Director re-educated staff on the requirement for the use of hair and beard restraints. As a result of the root cause analysis systems were modified to include monitoring (pre-meal review/meeting) and reinforcement of requirements throughout the meal service process by the Culinary Services Director/designee. D. Culinary Services Director/designee will conduct daily audits until 100% compliance is reached over 4 consecutive evaluations. Then the Culinary Services Director/designee will conduct audits weekly until 100% compliance is reached over 3 consecutive evaluations. Then the Culinary Services Director/designee will conduct audits monthly until 100% compliance is reached over 2 consecutive evaluations. Finally, the Culinary Services Director/designee will conduct an audit one month later. If 100% compliance is achieved, the facility will conclude the deficiency has been corrected and the audit will occur at least annually as part of the Culinary Services QA monitoring plan. E. Completion Date: 1/15/24 Delaware Food Code 3-401.11 A. No residents were identified as being affected by

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	assisted living kitchen area cooking without a hair net nor beard net on. 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. 12/05/23 – 10:00 AM - During the survey of the facility, the surveyor interviewed E7 (Director of Culinary Services), upon interview it was disclosed that the facility had not been keeping record of food temperatures for each mealtime. Discussed findings with E7 (Director of Culinary Services) at 1:35 PM and E1 (Executive Director) at 1:40 PM.	the deficient practice. B. All residents have the potential to be affected. C. A Food Temperature Log has been implemented to monitor/record food at each meal is cooked to proper temperatures based on the food type. Culinary Services Director educated identified staff re: the documentation requirement. D. The Culinary Services Director/designee will conduct record audits daily until compliance of 100% is achieved over 5 consecutive evaluations. Then the Culinary Services Director/designee will conduct audits once per week until compliance is achieved over 2 consecutive evaluations. Finally, the Culinary Services Director/designee will conduct an audit 1 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 plan. E. Completion Date: 2/01/24
3225.19.0 3225.19.1	**Records and Reports.** **The assisted living facility shall be responsible for maintaining appropriate records for each resident. These records shall document the implementation of the service agreement for each resident.** **The requirement was not met as evidenced by:** Based on record review and interview, it was determined for one (R2) out of thirteen residents reviewed for accuracy of documentation, the facility failed to ensure that the resident's status was accurately reported in the medical record and incident report. Findings include: 11/9/23 8:34 PM – A Daily Note (nursing) revealed, "Resident alert and oriented x3, able to make needs known, fell in front of her door at 4:45 pm. Hematoma on the back of her head,	3225.19.1 A. Resident R2 - No negative outcome was identified by the deficient practice. B. A focused review of incident reports, along with associated accuracy of documentation, for the past 30 days was completed in order to identify any potential discrepancies/inaccuracies with corrective action taken if necessary. There were no findings based on the review. C. A root cause analysis was completed by nursing including policies and procedures related to incident reports. No required changes/modifications were identified. D. The DON/designee will conduct incident report

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	resident denies pain. Neuro check in progress, family and primary care notified. On call nursing supervisor and DON notified also. Resident is in her room resting, nursing will continue with monitoring." 11/10/23 untimed – An incident report finalized by E2 (DON) revealed that the resident fell on 11/9/23 and was not injured. 12/5/23 11:14 AM – During an interview, R2 reported that she had a fall on 11/9/23. 12/4/23 approximately 12:50 PM – During an interview, E2 stated there was a "miscommunication" after R2 fell. E6 (LPN) notified E5 (on call RN supervisor) of the fall. E6 thought E5 was going to call R2's doctor and family and E5 thought E6 was going to make the calls, but neither made the calls. 12/7/23 8:48 AM – In an interview, E1 (ED) acknowledged that there was an error in the incident report because R2 was injured after falling. E1 acknowledged the "miscommunication" between E5 and E6 and stated that documentation needs to be based on first-hand knowledge. **Reportable incidents include:** **Significant injuries.**	audits 3 times per week until compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits once per week until compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits monthly until compliance is achieved over 3 consecutive evaluations. Finally, the DON/designee will conduct an audit 1 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 plan. E. Completion Date: 2/01/24
3225.19.7 3225.19.7.7 3225.19.7.7.2	**Injury from a fall which results in transfer to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours.** The requirement was not met as evidenced by: Based on record review and interview, it was determined for one out of three residents reviewed for falls, the facility failed to ensure that	**3225.19.7.7.2** A. R2 returned to the community with no new orders. B. A review of incident reports for the past 30 days

Provider's Signature [signature] Title [illegible] Date 12/22/23

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	a reportable fall was reported to the State Agency. 11/9/23 8:34 PM – A Daily Note (nursing) revealed, "Resident alert and oriented x3, able to make needs known, fell in front of her door at 4:45 pm. Hematoma on the back of her head, resident denies pain...." 11/10/23 untimed – An incident report finalized by E2 (DON) revealed that the resident fell on 11/9/23 and sustained a "small hematoma" to her head. This report further reflected that "Neuro checks in place, resident denies pain." 12/5/23 11:14 AM – During an interview, R2 reported that she had a fall on 11/9/23, but that she did not go for testing until approximately two weeks later. 12/7/23 8:30 AM – Review of IRC revealed the 11/9/23 fall was not reported by the facility. 12/7/23 8:48 AM – During an interview, E1 stated it was felt the incident was not reportable because R2 was not sent to the hospital when she first fell on 11/9/23. R2 was ultimately sent to the hospital for diagnostic testing on 11/27/23 after the facility received an order from R2's provider for her to be transferred. This was done in accordance with the family's request. E2 stated he and E2 stated they felt that because the transfer was family initiated, the fall was not deemed to be "reportable." 12/7/23 9:57 AM – In an interview, E2 stated she did not report the fall because the resident did not have symptoms at the time she was transferred to the hospital, the amount of time that had lapsed between the fall on 11/9/23 and the transfer on 11/27/23, and because the transfer was initiated by the family.	was completed in order to identify any incidents that were not reported in accordance with applicable regulations and corrective action taken if necessary. There were no findings based on the review. C. The ED reviewed state reportable incident requirements with the RSD in order to ensure understanding of such requirements. The reporting process responsibility has been expanded to additional members of the nursing management team with oversight by the DON/designee. Incident occurrences and investigations will be reviewed at the community's morning meeting to evaluate compliance with proper reporting procedures. The DON/designee will maintain an incident report log which documents compliance with State reporting requirements. D. The DON/designee will conduct audits 3 times per week until compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits once per week until compliance is achieved over 3 consecutive evaluations. Then the DON/designee will conduct audits monthly until compliance is achieved over 3 consecutive evaluations. Finally, the DON/designee will conduct an audit 1 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 plan. E. Completion Date: 2/01/24

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	12/7/23 12:37 PM – FIndings were reviewed with E1 (ED) and E2 (DON) during the exit conference.	

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