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 Lorelton

DATE SURVEY COMPLETED: February 4, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual and Complaint Survey was conducted at this facility from February 3, 2025, through February 4, 2025. The deficiencies contained in this report are based on interview, record review and review of other facility and partnering services documentation as indicated. The facility census on the first day of the survey was eighty-one (81). The survey sample totaled eight (8) residents and a subsample survey of an additional three (3) residents. Abbreviations/definitions used in this state report are as follows: DelVAX -A confidential online computer system used statewide by doctors, nurses, schools to keep track of their patient/student's immunizations; DM – Dietary Manager; DON – Director of Nursing; ED - Executive Director; LPN – Licensed Practice Nurse; RN – Registered Nurse.		
3225			
3225.9.0	**Assisted Living Facilities**		
3225.9.7	**Infection Control**		
S/S - D	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically**	1. For all affected residents identified during the survey, the DON or representative will offer pneumococcal pneumonia(PNA) vaccine to resident or resident representative if documentation has not been found. If it is declined, they will be educated and documentation of such education and signature of resident/representative will be placed in the chart. 2. An audit of ALL charts will take place to assure all residents have documentation of the PNA Vaccine. If anyone is found without documentation, they will be offered the PNA vaccine and appropriate documentation filed.	4/4/25

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contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.

This requirement was not met as evidenced by:

Based on interview, record review and review of other facility documentation, it was determined that for three (R6, R7 and R8) out of eight residents sampled for pneumococcal pneumonia vaccines, the facility failed to provide evidence of the vaccination or a declination of such. Findings include:

1. 10/14/24 - R6 was admitted to the facility. The facility was unable to provide any documentation of R6 having a pneumococcal vaccination or a declination of such.

2. 2/23/24 – R7 was admitted to the facility. The facility was unable to provide any documentation of R7 having a pneumococcal vaccination or a declination of such.

3. 7/16/23 – R8 was admitted to the facility. The facility was unable to provide any documentation of R8 having a pneumococcal vaccination or a declination of such.

2/4/25 – Per interview with E2 (DON) at approximately 3:20 PM, E2 confirmed she has access to the DelVAX

3. Admission Paperwork has a field for the physician to fill out the date of PNA, pre-admission. This will be reviewed by the Interdisciplinary team(IDT) in the daily stand up meeting, as received, to ensure PNA is documented or needs attention
4. Ed or ED representative will perform an audit of all admissions will take place x30 days, in stand up meeting, to determine PNA status. Documentation will reveal 100% compliance or continue until achieved x30 days.

4/4/25

1. All food that was open and not dated was discarded on 2/2/24. All dietary staff Re-oriented

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3225.12.0
3225.12.1
3225.12.1.3
S/S -F

site to identify residents' vaccines and the dates administered. E2 confirmed the immunizations or declinations were not located for these residents.

2/4/25 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 3:25 PM.

Services

The assisted living facility shall ensure that:

Food service complies with the Delaware Food Code

3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.

(B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if

and in serviced about safe food handling, storage, and dating.
https://www.youtube.com/watch?v=8sjclAPj8NU

2. Proper safe food handling will take place moving forward. Any staff or resident could have been exposed to a food born illness due to lack of dating and documentation
3. The dining staff had become complacent with food labeling. ALL dining staff will be immediately in-serviced on safe food handling and dating. This is signed off and a post test will be documented as well. To avoid complacency, each member of the department will watch video on their anniversary 1 year.
4. The Dietary Manager, or representative on off days, will audit all food storage for proper dating, storage, and general food safety x2 weeks until 100% compliance is achieved x14days.
Then, after 1 week has passed, the same 2 week audit will resume until 100% compliance is achieved x14days.

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the manufacturer determined the use-by date based on FOOD safety.

Based on observation and interview, it was determined that the facility failed to ensure food was stored and served in a manner that prevents food borne illness to the residents. Findings include:

2/3/25 - During the kitchen tour at approximately 10:38 AM, the surveyor found an undated opened bottle of original syrup, an expired undated maple syrup and undated multiple aliquoted cups of maple syrup in the dry storage room. The findings were confirmed with E3 (DM) on site.

3225.16.0
3225.16.2
S/S – D

2/3/25 – During the tour at approximately 10:45 AM, the surveyor found an undated opened jar of soup cream in a standalone refrigerator in the kitchen. In the walk-in refrigerator, there were undated opened items: sausages, roasted lunch ribs, a jar of mayonnaise, two jars of salad dressing, a bottle of sauce, a metal can of mustard, a plastic bag of baked sweet potatoes, a half glass jar of cherry and bologna lunch meat.

2/3/25 - The findings were confirmed with E3 (DM) on site.

2/3/25 – The findings were reviewed at the environmental exit conference with E1 (ED) at approximately 12:01 PM.

Staffing

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A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.

Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2023 ... Post Fall Assessment & Documentation

This requirement was not met as evidenced by:

Based on record review, interview and review of other facility and State documentation, it was determined that for two (R5 and R6) out of eight sampled residents, an LPN, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice, completed a resident's post fall assessment. Findings include:
1. 12/18/24 - R5 was admitted to the facility. Per incident report documentation on 12/26/24 at 10:24 PM, E6 (LPN) wrote: [sic] "Resident was found on the ground lying down near his bedroom inside of his room. Med tech alerted nurse. Nurse came inside of the room and got resident up off the ground with help from med techs. Daughter POA was called. Observation note documented. Incident report documented. Vital signs 98 pulse ox, 97.2 F, 16 respiration, 90/50 blood pressure,60 heart rate, no pain".

The facility failed to provide an assessment by a registered nurse after R5 experienced a fall. The post-fall assessment was completed by E6, not an RN

4/4/2025

1. Two of eight residents reviewed had a fall, with no adverse effects. They were assessed by the charge nurse (LPN). In Delaware, that is not in the scope of practice for an LPN. All Charge nurses oriented to this on 3/3/2025 and have expressed understanding that an LPN can not assess a resident for injury, post fall. The assessment must be completed by a Registered Nurse, P.A., N.P., or Physician.
2. Any resident who may have a fall, off of normal hours, could be affected by this deficient practice.
3. Following the survey, ED met with Seniority Healthcare to discuss the possibility of virtual assessments following falls where it is not clear if there is injury when an RN is not present. The Group agreed to have the on-call physician or NP perform the virtual assessment to determine if further care is needed when an RN is not available. If no one is available to assess, a call to the ED will be required.
   All nursing staff reminded of this policy by DON verbally and in writing, with signature confirmation.
4. DON and ED will audit every fall from 3/3/25 through 4/2/25 to ensure this practice is taking place. Nursing staff to email/text ED and DON if fall occurs off hours for this time period.
   Both will be on call if any questions arise.
   Success will be determined by 100% compliance over 30 days.

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as required by the Delaware State regulation of the Board of Nursing Scope of Practice.

2. 10/14/24 - R6 was admitted to the facility. Per incident report documentation on 1/6/25 at 7:05 AM, E6 (LPN) wrote: [sic] Resident fell found on bedroom floor near bedroom door. Near her wheelchair. Resident had explained that she was trying to go to the bathroom. However, she had a fall, stated she did not hit her head. In pain all over her body. Rated her pain as 10 out of 10. Pain medication was administered. Vital signs as follows Pulse OX 98, Heart rate 66, 16 respiration, Blood pressure 122/79, Temp 97.4."

On 12/23/24 incident report documentation at 6:49 PM, E6 wrote: [sic] "Resident had a witness fall. The person who witness the fall was her husband. Resident slipped out of the couch then made an attempt to get up

3225.17.0 and came forward, falling on the ground. Resident said she hit her head.

3225.17.2.2 Cas the husband said she barely even hit her head near his wheelchair. I

3225.17.2.3 called the daughter POA no answer. I left a voice message to call back. Ob-

S/S – C servation note completed, incident report, and alert HCP".

The facility failed to provide an assessment by a registered nurse after R6 experienced several falls. The post-fall assessments were completed by E6, not an RN as required by the Delaware State regulation of the Board of Nursing Scope of Practice.

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	2/4/25 – Per interview with E2 (DON) at approximately 2:00 PM, E2 stated she was unaware the LPN was not allowed to conduct post fall assessments per the Delaware Scope of Practice. 2/4/25 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 3:25 PM. **Environment and Physical Plant** **Be clean** **Have a hazard-free environment complies with the Delaware Food Code** **5-501.115 Maintaining Refuse Areas and Enclosures** **A storage area and enclosure for REFUSE, recyclables, or returnables shall**		
3225.19.0 **3225.19.6**	**be maintained free of unnecessary items, as specified under § 6-501.114, and clean.** Based on observation and interview, it was determined that the facility failed to provide safe sanitary environment to guard off vermin. Findings include: 2/3/2025 – A tour at approximately 10:59 AM was conducted with E3 (DM) to the trash collecting dock. This dock connects to a large room where a walk-in freezer and an ice cream freezer were housed. There were streaks of water and mud inside the large room close to the garage door that leads to the docking platform. There were two mattresses, a chair, two metal barrels for cooking oil waste	1. The loading dock(outside)is where the dumpster resides and is picked up. It is separated from the building by an automatic garage door that seals to the ground. Items on the dock include recycled waste vegetable oil container that is on pallets to keep them off of the ground. At the time of the survey, there was a single bed (mattress and box-spring) and a chair that were left by a family. They would not fit in the dumpster so they were neatly placed on a pallet behind the dumpster waiting for our scrap guy to pick up. No residents were impacted by this. The area on the inside of the garage door houses a tote for broken down cardboard for recycle and the walk in freezer. There was	4/4/2025

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and a large dumpster. The metal barrels and the mattresses were placed on several wooden pallets. Some mud and small pieces of trash were scattered around the wooden pallets. The findings were confirmed with E3 on site.

2/3/25 – The findings were reviewed at the environmental exit conference with E1 (ED) at approximately 12:01 PM.

Records and Reports

Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.

Reportable incidents include:

Death of a resident in a facility or within 5 days of transfer to an acute care facility.

This requirement was not met as evidenced by:

Based on record review, interview and review of other facility and State Agency Incident Reporting System documentation, it was determined that for one (R11) out of eleven sampled residents for reportable incidents, the facility failed to report a resident's death to the State within the required eight hours after the event. Findings include:

apparently "water and mud" on the floor. It rained that day and many employees enter and exit from the man door on the dock that has a remote activated lock on it. The "mud" or stains on the floor are permanent stains as it was originally a locker room floor constructed in 1932. We have chosen to preserve the floor as we are listed on the National Historic Registry. The stains on the floor of the "Employees Only" marked area have never negatively impacted residents.

2. As the area is marked, "Employees Only", the potential for the permanently stained floor to impact residents is nil.
3. The cause of the water on the floor is likely foot traffic, coming in the building, following in 19805climate weather. A floor mat will be placed inside the man door for employees to wipe their feet.
4. To ensure that the loading dock is free from "water and mud", a sign off sheet will be introduced by ED for Maintenance and Dietary departments to sign off on at least daily. They will be signing off on the monitoring and remediation of mud, water, or anything else that may contribute to the facility being "unclean". Succes will be measured by a loading dock that is free from "mud and water" and a full, signed off sheet for 30 days, with 100% success, as determined by the ED.

1. Recording incidents in a timely fashion is critical to LTC. TL failed to report the passing of a resident in the allotted time frame. No residents were impacted or harmed due to this oversight.

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1/13/23 – R11 was admitted to the facility. R11 was a DNR, was under Hospice care and per medical record review, R11 expired on 8/23/24. Per the State Agency Incident Reporting System, the facility reported R11's death on 9/16/24, more than three weeks later.

2/4/25 – Per interview with E2 (DON) at approximately 3:20 PM, E2 confirmed this was an oversite in reporting. E2 stated she reported the death when she discovered it had not been reported to the State, therefore the delay. E2 stated she is contacted for all incidents and now verifies that it was reported if applicable.

2/4/25 – Surveyor reviewed the State Agency Incident Reporting System and found the submission, albeit after the 8-hour requirement.

2/4/25 - Findings were reviewed with E1 (ED) and E2 at the exit conference, beginning at approximately 3:25 PM.

2. During stand up each day, we review all incidents, both reportable and internal reports to determine RCA with the IDT and to make sure appropriate documentation has been made. This one made it past the goalie and the omission of report was self reported to the division by the DON when it was discovered and ultimately reported outside of the allowable timeframe. No residents were harmed nor impacted by the delay in reporting. Also, no incident reports have been missed since 8/23/24.
3. The stand up meeting will still be used to discuss incident reports. However, they will be documented and compared to the prior shift report to ensure all incidents are reviewed, assigned, and followed up on.
4. ED or ED representative will conduct a 30 day audit will track and match all reportable events to reported documentation, both initial and 5 day follow up. The audit will continue until 30 days have passed without missed or late documentation, resulting in 100% compliance

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