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: Brandywine Assisted Living Seaside Pointe **DATE SURVEY COMPLETED:** January 30, 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, Complaint and Emergency Preparedness survey was conducted at this facility from January 24, 2025, through January 30, 2025. 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 one hundred and eleven (111). The survey sample totaled eight (8) residents. Abbreviations/definitions used in this state report are as follows: ED – Executive Director WD – Wellness Director CD – Culinary Director DEMA – Delaware Emergency Management Agency	A. No residents were harmed by this deficient practice. B. All residents are at risk from this deficient practice. C. RCA: Due to the staffing changes in the culinary department, the food temperature taken at each meal was inconsistent at best. The Culinary Director educated the cooks present that day on taking food temps and logging them accordingly. Food temps were initiated that day. The additional cooks were in-service prior to starting their next shift. Additional in- servicing to be provided by the Culinary Director during the week of 3/3/25. D. The Culinary Director/designee will audit the food temps each meal daily until 100% compliance is achieved, weekly X 4 weeks until 100% compliance is achieved and monthly X 2 months until 100% compliance is achieved.	3/21/2025
3225.0	**Regulations for Assisted Living Facilities.**		
3225.12.0	**Services**		
3225.12.1	**The assisted living facility shall ensure that:**		
3225.12.1.3	**Food service complies with the Delaware Food Code**		
S/S – E	**Delaware Food Code**		
	3-501 Temperature and Time Control		
	3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be		

Provider's Signature Theresa Coe Title NHA Date 3-5-25

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	maintained: (1) At 57°C (135°F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54°C (130°F) or above. **This requirement is not met as evidenced by:** 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: 1/28/25 - During the survey of the facility at approximately 1:00 PM, records of temperature monitoring were not consistently being maintained to verify that safe food temperatures were being maintained in order to prevent food borne illness of highly suspectable residents. It was discovered that the facility was missing 239 mealtime temperature logs out of 267 reviewed. The facility failed to provide records for all of November and December 2024, in addition to, dinner temperatures in the month of January 2025. Discussed findings with E1 (ED) at 2:15 PM and E18 (CD) at 2:45 PM. 1/30/25 11:07 AM – Findings were reviewed with E1 (ED) and E2 (WD) at the exit conference.	A. No residents were harmed by this deficient practice. B. All residents are at risk from this deficient practice. C. RCA: While scanning the Emergency Disaster Plan to send over to the surveyor, the elopement plan was inadvertently omitted. The surveyor reached out to the ED on 1/31/25 at 12:18pm requesting a copy of the elopement policy. The ED provided this policy to the surveyor on 1/31/25 at 12:51pm. The elopement policy was in the Emergency Preparedness Binder and continues to be located there. D. The ED/designee will audit the Emergency Preparedness Binder to ensure all emergency preparedness policies are present, daily until 100% compliance is achieved, weekly X 4 weeks until 100% compliance is achieved and monthly X 2 months until 100% compliance is achieved.	3/21/2025
3225.18.0 **3225.18.3** **S/S – E**	**Emergency Preparedness** **Each facility shall develop and maintain all-hazard emergency plans for evacuation and sheltering in place. The plan must be submitted to the Division and DEMA in a**		

Provider's Signature Theresa O'Connell COAC Title NHA Date 3-5-25

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	digital format and it must conform to the template prescribed by the Division. The all-hazard emergency plan must include plans to address staffing shortages and facility demands. **This requirement is not met as evidenced by:** Based on observations and interviews it was determined that the facility failed to include all-hazards in their emergency plans. Findings include: 1/31/25 – Documents received by email at approximately 12:52 PM revealed that facility failed to include elopement/ missing residents as part of their all-hazard emergency plan.		3/21/2025

Provider's Signature Theresa O'Connell CHE Title LNHA Date 3-5-25