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: AL- Somerford Place

DATE SURVEY COMPLETED: December 12, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Follow-Up Survey was conducted at this facility from December 10, 2024, through December 12, 2024. The deficiencies contained in this report are based on interview, record review and review of other facility information as indicated. The facility census on the first day of the survey was thirty-two (32). The survey sample totaled fifteen (15) residents. Abbreviations/definitions used in this State Report are as follows: BOM – Business Office Manager; CS – Clinical Specialist; DHW – Director of Health and Wellness; ED – Executive Director; RDHW – Regional Director of Health and Wellness; UAI – Uniform Assessment Instrument/used to collect information regarding the assisted living applicant/resident's physical condition, medical status, and psychosocial needs. The information is to be used to: (1) determine if an applicant meets eligibility for entrance or retention in an assisted living facility; (2) if admitted, determine the appropriate level of care for the resident and develop a service agreement; and (3) update service needs and the service agreement.		
3225.7.0	**Specialized Care for Memory Impairment**		
3225.7.1	**Any assisted living facility which offers to provide specialized care for residents with memory impairment shall be required to disclose its policies and procedures which describe the form of care or treatment pro-**		

Provider's Signature _____ Title ED Date 5/16/25

NAME OF FACILITY: AL- Somerford Place

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	vided, in addition to that care and treatment required by the rules and regulations herein. **3225.7.2 Said disclosure shall be made to the Department and to any person seeking specialized care for memory impairment in an assisted living facility.** **3225.7.3 The information disclosed shall explain the additional care that is provided in each of the following areas:** **3225.7.3.5 S/S D Staffing Plan & Training Policies: staffing plan, orientation, and regular in-service education for specialized care.** **This requirement was not met as evidenced by:** Based on interview and review of the facility's memory care information, the facility failed to correct the deficient practice cited on the 8/20/24 Annual Survey to disclose to persons seeking specialized care the facility's staffing plan and training policies. Findings include: 12/10/24 – In response to the Surveyor's request for the facility's correction to the deficient practice cited during the 8/20/24 survey under this requirement, the E1 (ED) provided the following (undated) letter: "Thank you for Choosing Somerford Place for your loved ones Memory Care needs. Here at Somerford Place we provide the State required 12 hours of Dementia specific training and in addition we offer our own	1.No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be affected by this deficient practice. 3. The root cause of the identified issue was inadequate and inconsistent dementia care training for both direct and non-direct care staff, along with insufficient annual refresher training. As part of their orientation, new direct care team members will receive 12 hours of dementia care services training and new non-direct care team members will receive 6 hours of dementia care services training. As part of their annual training, direct care team members will receive 4 hours of dementia care services training and non-direct care team members will receive 2 hours of dementia care services training. Current direct care team members will complete 12 hours of dementia care services training and current non-direct care team members will complete 6 hours of dementia care services training by 2/14/25 then they will complete the annual dementia care services training as listed above. 4. Executive Director (ED) or designee will audit team member training records weekly x 4 weeks until 100%, then biweekly x 4 weeks until 100%, then monthly x 1 month until 100% to ensure compliance with this regulation.	2/14/25

Provider's Signature _____ Title ED Date 5/16/25

NAME OF FACILITY: AL- Somerford Place

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	Bridge to Rediscovery monthly training to our dedicated staff. We understand the challenges of caring for residents with various forms of dementia so we ensure ample staffing is provided to meet the needs of every resident. In addition, our Director of Health and Wellness is available to the staff twenty-four hours per day, seven days per week for any resident related questions or concerns." 12/12/24 at 12:40 PM - During an interview, Surveyor reviewed the requirement with E1 and confirmed that this letter does not meet the requirement 3225.7.3.5. The letter lacked information about the facility's staffing plan, employee orientation and the frequency of the Dementia training. 12/12/24 at 1:55 PM – Finding was reviewed during the exit conference with E1, E2 (DRC), E3 (RDHW), E4 (CS) and E5 (BOM).		
3225.11.4 **S/S E**	**The resident assessment shall be completed in conjunction with the resident.** **This requirement was not met as evidenced by:** Based on interview and review of clinical records, it was determined that for five (R1, R8, R9, R14 and R15) out of eight residents reviewed for UAIs, the facility failed to provide evidence that each resident had a current Uniform Assessment Instrument (UAI) signed by the resident/residents' representative confirming their agreement with the assessment in response to the deficient		

Provider's Signature _____ Title ED Date 5/16/25

NAME OF FACILITY: AL- Somerford Place

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	practice cited during the 8/20/24 Annual Survey. Findings include: Cross refer to 3225.13.0, examples 1, 2, 3, 4, 5 1. R1's clinical record revealed: 9/8/22 – R1 was admitted to the facility. Review of R1's most recently completed UAI, dated 3/13/24, revealed that the facility failed to identify and correct the deficient practice cited during the 8/20/24 Annual Survey and obtain R1's resident representative's signature on the UAI. In addition, R1's 3/13/24 UAI documented the wrong "Date of Admission: 07/19/2019" to the facility. During the Follow-Up Survey, R1's clinical record lacked a UAI signed by R1's resident representative confirming their agreement with the assessment. 2. R8's clinical record revealed: Review of R8's most recently completed UAI, dated 10/27/22, preceded her admission to this facility, a locked dementia facility. The 10/27/22 UAI was documented during R8's time in another assisted living facility. The locked dementia facility continued to use R8's 10/27/22 UAI, which was also not signed by R8's resident representative. 2/14/23 – R8 was admitted to the locked dementia facility.	1.There were no residents negatively impacted by this deficient practice. Resident 1's POA was contacted via phone on 11/25/24 and 1/16/25. Per POA, signature will be provided on next visit to the community. Resident 8's POA was contacted via phone 12/11/24 and 1/16/25. Per POA, signature will be provided on next visit to the community. Resident 9's POA's was contacted via phone on 1/16/25. Per POA, signature will be provided on next visit to the community. Resident 14's POA's was contacted via email on 1/16/25 with documents provided via email per POA request. Awaiting signature. Resident 15's POA was contacted via phone on 1/16/25 and requested documents be sent via email for signing, which was completed. 2. All residents have the potential to be negatively impacted by this deficient practice. 3. Somerford House and Somerford Place were separated into two databases in PointClickCare (PCC). At that time, all residents of Somerford Place were moved into the newly created database and all census information, including their move in date to Somerford Place, was updated. All residents will have a current Uniform Assessment Instru-	2/14/25

Provider's Signature [signature] Title ED Date 3/16/25

NAME OF FACILITY: AL- Somerford Place

DATE SURVEY COMPLETED: December 12, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Despite being cited for not having a signed UAIs during the 8/20/24 Annual Survey, the facility failed to identify and correct the deficient practice and obtain R8's resident representative's signature on a UAI assessment from August 20, 2024 through December 12, 2024, over three months. During the Follow-Up Survey, R8's clinical record lacked a UAI signed by R8's resident representative confirming their agreement with the assessment. 3. R9's clinical record revealed: 2/1/24 – R9 was admitted to the facility. Review of R9's most recently completed UAI, dated 11/9/24, revealed that the facility failed to identify and correct the deficient practice cited after the 8/20/24 Annual Survey and obtain R9's resident representative's signature on the UAI. In addition, R9's 11/9/24 UAI documented the wrong "Date of Admission: 11/12/2020" to the facility. During the Follow-Up Survey, R9's clinical record lacked a UAI signed by R9's resident's representative confirming their agreement with the assessment. 4. R14's clinical record revealed: 4/16/24 – R14 was admitted to the facility. Review of R14's most recent UAI, dated 10/29/24, revealed that the facility failed to identify and correct the deficient practice cited after the 8/20/24 Annual Survey and	ment (UAI) which is signed by the resident/residents' representative. The Registered Nurses (RNs) were in-serviced by the Regional Director of Health and Wellness (RDHW) on the requirements of this regulation. 4. The Director of Health and Wellness (DHW) or designee will audit 3 residents UAIs weekly x 4 weeks until 100%, then biweekly x 4 weeks until 100%, then monthly x 1 month until 100% to ensure compliance with this regulation.	

Provider's Signature _____ Title ED Date 5/16/25

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	obtain R14's resident representative's signature on the UAI. In addition, R14's 10/29/24 UAI documented the wrong "Date of Admission: 10/31/2023" to the facility. During the Follow-Up Survey, R14's clinical record lacked a UAI signed by R14's resident's representative confirming their agreement with the assessment. 5. R15's clinical record revealed: 9/13/23 – R15 was admitted to the facility. Review of R15's most recent UAI, dated 1/15/24, revealed that the facility failed to identify and correct the deficient practice cited after the 8/20/24 Annual Survey and obtain R15's resident representative's signature on the UAI. In addition, R15's 1/15/24 UAI documented the wrong "Date of Admission: 08/18/2023" to the facility. During the Follow-Up Survey, R15's clinical record lacked a UAI signed by R15's resident's representative confirming their agreement with the assessment. 12/12/24 at 1:55 PM – Findings were reviewed during the exit conference with E1, E2 (DRC), E3 (RDHW), E4 (CS) and E5 (BOM). Based on interview and review of clinical records and facility documentation, it was determined that for five (R1, R8, R9, R14 and R15) out of eight residents reviewed for Service Agreements, the facility failed to provide evidence that each resident had a current Service Agreement signed by both the		

Provider's Signature _____ Title ED Date 5/16/25

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	facility and resident representative in response to the deficient practice cited during the 8/20/24 Annual Survey. Findings include: Cross refer to 3225.11.4, examples 1, 2, 3, 4, 5 1. R1's clinical record revealed: 9/8/22 – R1 was admitted to the facility. Review of R1's Service Agreement, last revised on 11/25/24, revealed that the facility failed to identify and correct the deficient practice cited during the 8/20/24 Annual Survey to ensure both facility and R1's resident representative signed the Service Agreement. In addition, R1's 11/25/24 Service Agreement documented the wrong "Move in Date: 07/19/2019" to the facility. As of 12/12/24 Follow-Up Survey, R1's clinical record lacked a signed Service Agreement by both a facility and R1's resident representative. 2. R8's clinical record revealed: Review of R8's Service Agreement, last revised on 11/6/24, revealed that the facility failed to identify and correct the deficient practice cited during the 8/20/24 Annual Survey to ensure both facility and R8's resident representative signed the Service Agreement. In addition, R8's 11/6/24 Service Agreement documented the wrong "Move in Date: 09/28/2022" to the facility.		

Provider's Signature _____ Title ED Date 5/16/25

NAME OF FACILITY: AL- Somerford Place

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	As of the 12/12/24 Follow-Up Survey, R8's clinical record lacked a signed Service Agreement by both a facility representative and R8's resident representative. 2/14/23 – R8 was admitted to the locked dementia facility. Despite being cited for not having a signed UAIs during the 8/20/24 Annual Survey, the facility failed to identify and correct the deficient practice and obtain R8's resident representative's signature on a UAI assessment from August 20, 2024 through December 12, 2024, over three months. During the Follow-Up Survey, R8's clinical record lacked a UAI signed by R8's resident representative confirming their agreement with the assessment. 3. R9's clinical record revealed: 2/1/24 – R9 was admitted to the facility. Review of R9's Service Agreement, last revised on 7/25/24, revealed that the facility failed to identify and correct the deficient practice cited after the 8/20/24 Annual Survey and obtain R9's resident representative's signature on the Service Agreement. In addition, R9's 7/25/24 Service Agreement documented the wrong "Move in Date: 11/12/2020" to the facility. As of 12/12/24 Follow-Up Survey, R1's clinical record lacked a signed Service Agreement by both a facility and R1's resident representative.		

Provider's Signature _____ Title ED Date 5/16/25

NAME OF FACILITY: AL- Somerford Place

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	4. R14's clinical record revealed: 4/16/24 – R14 was admitted to the facility. Review of R14's Service Agreement, last revised on 10/21/24, revealed that the facility failed to identify and correct the deficient practice cited after the 8/20/24 Annual Survey and obtain R14's resident representative's signature on the Service Agreement. In addition, R14's 10/21/24 Service Agreement documented the wrong "Move in Date: 10/31/2023" to the facility. During the Follow-Up Survey, R14's clinical record lacked a Service Agreement signed by both a facility representative and R14's resident's representative. 5. R15's clinical record revealed: 9/13/23 – R15 was admitted to the facility. Review of R15's Service Agreement, last revised on 7/16/24, revealed that the facility failed to identify and correct the deficient practice cited after the 8/20/24 Annual Survey and obtain R15's resident representative's signature on the Service Agreement. In addition, R15's 7/16/24 Service Agreement documented the wrong "Move in Date: 08/18/2023" to the facility. During the Follow-Up Survey, R15's clinical record lacked a Service Agreement signed by both a facility representative and R15's resident's representative.		

Provider's Signature _____ Title ED Date 5/16/25

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	12/12/24 at 1:55 PM – Findings were reviewed during the exit conference with E1, E2 (DRC), E3 (RDHW), E4 (CS) and E5 (BOM).		2/14/25
3225.13.0	**Service Agreements**		
3225.13.1	**A service agreement based on the needs identified in the UAI shall be completed prior to or no later than the day of admission. The resident shall participate in the development of the agreement. The resident and the facility shall sign the agreement and each shall receive a copy of the signed agreement. All persons who sign the agreement must be able to comprehend and perform their obligations under the agreement.**		
S/S E	**This requirement was not met as evidenced by:** Based on interview and review of clinical records and facility documentation, it was determined that for five (R1, R8, R9, R14 and R15) out of eight residents reviewed for Service Agreements, the facility failed to provide evidence that each resident had a current Service Agreement signed by both the facility and resident representative in response to the deficient practice cited during the 8/20/24 Annual Survey. Findings include: Cross refer to 3225.11.4, examples 1, 2, 3, 4, 5 1. R1's clinical record revealed: 9/8/22 – R1 was admitted to the facility.	1.There were no residents negatively impacted by this deficient practice. Resident 1's POA was contacted via phone on 11/25/24 and 1/16/25. Per POA, signature will be provided on next visit to the community. Resident 8's POA was contacted via phone 12/11/24 and 1/16/25. Per POA, signature will be provided on next visit to the commu-nity. Resident 9's POA's was contacted via phone on 1/16/25. Per POA, signature will be provided on next visit to the community. Resident 14's POA's was contacted via email on 1/16/25 with documents provided via email per POA request. Awaiting signature. Resident 15's POA signed the service plan on 1/9/25. 2. All residents have the potential to be negatively impacted by this deficient practice. 3. Somerford House and Somerford Place were separated into two databases in PointClickCare (PCC). At that time, all residents of Somerford Place were moved into the newly created database and all census information, including their move in date to Somerford Place, was updated. All residents will have a current Service Plan signed by the resi-	

Provider's Signature _____ Title ED Date 3/16/25

NAME OF FACILITY: AL- Somerford Place

DATE SURVEY COMPLETED: December 12, 2024

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	Review of R1's Service Agreement, last revised on 11/25/24, revealed that the facility failed to identify and correct the deficient practice cited during the 8/20/24 Annual Survey to ensure both facility and R1's resident representative signed the Service Agreement. In addition, R1's 11/25/24 Service Agreement documented the wrong "Move in Date: 07/19/2019" to the facility. As of 12/12/24 Follow-Up Survey, R1's clinical record lacked a signed Service Agreement by both a facility and R1's resident representative. 2. R8's clinical record revealed: Review of R8's Service Agreement, last revised on 11/6/24, revealed that the facility failed to identify and correct the deficient practice cited during the 8/20/24 Annual Survey to ensure both facility and R8's resident representative signed the Service Agreement. In addition, R8's 11/6/24 Service Agreement documented the wrong "Move in Date: 09/28/2022" to the facility. As of the 12/12/24 Follow-Up Survey, R8's clinical record lacked a signed Service Agreement by both a facility representative and R8's resident representative. 2/14/23 – R8 was admitted to the locked dementia facility. Despite being cited for not having a signed UAIs during the 8/20/24 Annual Survey, the facility failed to identify and correct the defi-	dent/residents' representative. The Registered Nurses (RNs) were in-serviced by the Regional Director of Health and Wellness (RDHW) on the requirements of this regulation. 4. The Director of Health and Wellness (DHW) or designee will audit 3 residents Service Plans weekly x 4 weeks until 100%, then biweekly x 4 weeks until 100%, then monthly x 1 month until 100%, to ensure compliance with this regulation.	

Provider's Signature _____ Title ED Date 5/16/25

NAME OF FACILITY: AL- Somerford Place

DATE SURVEY COMPLETED: December 12, 2024

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	cient practice and obtain R8's resident representative's signature on a UAI assessment from August 20, 2024 through December 12, 2024, over three months. During the Follow-Up Survey, R8's clinical record lacked a UAI signed by R8's resident representative confirming their agreement with the assessment. 3. R9's clinical record revealed: 2/1/24 – R9 was admitted to the facility. Review of R9's Service Agreement, last revised on 7/25/24, revealed that the facility failed to identify and correct the deficient practice cited after the 8/20/24 Annual Survey and obtain R9's resident representative's signature on the Service Agreement. In addition, R9's 7/25/24 Service Agreement documented the wrong "Move in Date: 11/12/2020" to the facility. As of 12/12/24 Follow-Up Survey, R1's clinical record lacked a signed Service Agreement by both a facility and R1's resident representative. 4. R14's clinical record revealed: 4/16/24 – R14 was admitted to the facility. Review of R14's Service Agreement, last revised on 10/21/24, revealed that the facility failed to identify and correct the deficient practice cited after the 8/20/24 Annual Survey and obtain R14's resident representative's signature on the Service Agreement. In		

Provider's Signature _____ Title ED Date 5/16/25

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	addition, R14's 10/21/24 Service Agreement documented the wrong "Move in Date: 10/31/2023" to the facility. During the Follow-Up Survey, R14's clinical record lacked a Service Agreement signed by both a facility representative and R14's resident's representative. 5. R15's clinical record revealed: 9/13/23 – R15 was admitted to the facility. Review of R15's Service Agreement, last revised on 7/16/24, revealed that the facility failed to identify and correct the deficient practice cited after the 8/20/24 Annual Survey and obtain R15's resident representative's signature on the Service Agreement. In addition, R15's 7/16/24 Service Agreement documented the wrong "Move in Date: 08/18/2023" to the facility. During the Follow-Up Survey, R15's clinical record lacked a Service Agreement signed by both a facility representative and R15's resident's representative. 12/12/24 at 1:55 PM – Findings were reviewed during the exit conference with E1, E2 (DRC), E3 (RDHW), E4 (CS) and E5 (BOM).		
3225.18.0	**Emergency Preparedness**		
3225.18.1	**Nursing facilities shall comply with the rules and regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction.**		

Provider's Signature _____ Title ED Date 5/16/25

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3225.18.3 **S/S E**	**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 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 was not met as evidenced by:** cc Findings include: Review of the facility's 12/10/24, last revised, EOM, under Appendix 2 – Emergency Preparedness Committee, revealed only one primary physician's practice with contact information. Review of the facility's 12/12/24 Resident Listing Report documented each residents' current primary physician. There were seven additional physicians listed on this report which were not included in the facility's 12/10/24 EOM. The facility failed to include the seven additional physicians' names and contact information in the EOM. 12/12/24 at 12:45 PM – During an interview with E1, the Surveyor reviewed and confirmed the finding. 12/12/24 at 1:55 PM – Finding was reviewed during the exit conference with E1, E2 (DRC), E3 (RDHW), E4 (CS) and E5 (BOM).	1.There were no residents negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. 3. The root cause was an oversight in the initial update process of the Emergency Operations Manual (EOM) and a lack of routine verification to ensure that all required information, including each resident's primary physician name and contact details, was consistently included. The Regional Clinical Specialist added the seven additional physicians' names and contact information in the Emergency Operations Manual (EOM) on 12/12/24 during the inspection and notified the surveyor prior to the exit interview. To ensure ongoing compliance, the DHW or designee will provide in-service training to business office personnel on the updated process for verifying and maintaining required information in the Emergency Operations Manual (EOM), including each resident's primary physician name and contact details. This training was completed on 2/14/2025. The DHW will conduct monthly audits of the EOM to ensure accuracy and address any discrepancies promptly. 4. ED or designee will audit the EOM weekly x 4 weeks until 100%, then biweekly x 4 weeks until 100%, then monthly x 1 month until 100%, to ensure compliance with this regulation.	12/12/24

Provider's Signature _____ Title ED Date 5/16/25

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3225.18.4 S/S E	**The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at each nursing station.** **This requirement was not met as evidenced by:** Based on interview and review of facility documentation, it was determined that for five (E2, E6, E8, E9 and E10) out of five employees reviewed for emergency preparedness training, the facility failed to have evidence of employee training based on their Emergency Operations Manual, last revised on 12/10/24. Findings include: In response to the Surveyor's request for evidence of emergency preparedness training after the 8/20/24 Annual Survey, the facility provided the following Relias web training certificates for E2, E8 and E10 entitled, "Workplace Emergencies and Natural Disasters: An Overview" out of the five employees sampled. The Course Description documented, "...This course is a basic overview of natural disasters and workplace emergencies. It is designed to supplement your awareness of natural disasters and workplace emergencies and to complement your use of workplace specific emergency plans established by your employer...". The facility lacked evidence that each of the five employees received training based on the facility's Emergency Operations Manual. No further information was provided to the Surveyors.	1.No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. 3. The root cause was a failure in the facility's tracking and documentation system for emergency preparedness training. All team members will be trained on the facility's emergency and evacuation plans by 2/14/25. To address the tracking and documentation failure, the ED or designee will educate all department managers on the updated system for recording emergency preparedness training. This education will include proper documentation procedures and timelines. All department managers will, in turn, ensure their team members complete and sign training records. Training on the new system will be completed by 2/14/25. 4. Executive Director (ED) or designee will audit team member training records weekly x 4 weeks until 100%, then biweekly x 4 weeks until 100%, then monthly x 1 month until 100%, to ensure compliance with this regulation.	2/14/25

Provider's Signature _____ Title ED Date 5/16/25

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Delaware Code Title 24 § 6001 Definitions S/S D	12/12/24 at 12:45 PM – During an interview with E1 (ED), the Surveyor reviewed and confirmed the finding. 12/12/24 at 1:55 PM – Finding was reviewed during the exit conference with E1, E2 (DRC), E3 (RDHW), E4 (CS) and E5 (BOM). **(2) "Health-care provider" means any person authorized to deliver clinical health-care services by telemedicine and participate in telehealth pursuant to this chapter and regulations promulgated by the respective professional boards listed in § 6002 of this title.** **(6) "Telemedicine" means a form, or subset, of telehealth, which includes the delivery of clinical health-care services by means of real time 2-way audio (including audio-only conversations, if the patient is not able to access the appropriate broadband service or other technology necessary to establish an audio and visual connection), visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery, which facilitates the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's health care.** **§ 6002 Authorization to practice by telehealth and telemedicine**		

Provider's Signature _____ Title ED Date 5/16/25

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DATE SURVEY COMPLETED: December 12, 2024

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	(a) Health-care providers licensed by the following professional licensing boards existing under this title are authorized to deliver health-care services by telehealth and telemedicine subject to the provisions of this chapter: **(5) The Delaware Board of Nursing created pursuant to Chapter 19 of this title.** **§ 6003 Scope of Practice; provider-patient relationship required.** **(a) Except for the instances listed in this chapter, health-care providers may not deliver health-care services by telehealth and telemedicine in the absence of a health-care provider-patient relationship. A health-care provider-patient relationship may be established either in-person or through telehealth and telemedicine but must include all the following:** **(3) Receipt of appropriate consent from a patient after disclosure regarding the delivery model and treatment method or limitations, including informed consent regarding the use of telemedicine technologies as required by paragraph (a)(5) of this section.** **§ 6004 Practice requirements.** **(a) A health-care provider using telemedicine and telehealth technologies to deliver health-care services to a patient must, prior to diagnosis and treatment, do at least 1 of the following:**	1.No residents were negatively impacted by this deficient practice. 2. All residents have the potential to be impacted by this deficient practice. 3. The root cause was a lack of established protocols for securing telemedicine communication systems and obtaining necessary consents from resident representatives prior to implementing post-fall assessments via telemedicine. A secured company cell phone was purchased for the community so if a resident falls when an RN is not present in the community and a Post-Fall Assessment needs to be completed via telemedicine, the team member in the community will use the secured company cell phone to call the RNs secured company cell phone to complete the assessment. Additionally, a Consent for Treatment via Telehealth form was created by our corporate lawyer. The responsible parties for all residents were contacted to sign the Consent for Treatment via Telehealth form. It was explained to them that a resident cannot have a	2/14/25

Provider's Signature _____ Title ED Date 5/16/25

NAME OF FACILITY: AL- Somerford Place

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	(2) Require another Delaware-licensed health-care provider be present at the originating site with the patient at the time of the diagnosis. **This requirement was not met as evidenced by:** Based on interview and review of clinical records and facility documentation, it was determined that for two (R8 and R9) out of three residents reviewed for falls, the facility failed to have a SECURED communication system in place for facility staff to conduct post-fall assessments utilizing "telemedicine" and failed to have the appropriate "telemedicine" consents from the residents' representatives for the use of this technology. Findings include: The facility's policy and procedure entitled, Cellular Phones and Mobile Devices, effective date of 8/1/18, stated, "This purpose of this policy is to provide guidelines for the use of personal and Company-provided cellular phones and other mobile and electronic devices during working hours in order to maintain a safe and productive working environment... 4. Conversations that occur on Cell Phones are not confidential and can be monitored or intercepted by outsiders. Team members should exercise caution when discussing confidential, sensitive information when using either a personal or Company Cell Phone, or other device, for business reasons and team members and should refrain from discussing the protected health information of residents while using such devices. B. Personal Devices: 1. While	Post-Fall Assessment completed via telemedicine until they signed and returned the form to the community. The Registered Nurses (RNs) were in-serviced by the RDHW on the requirements of this regulation as well as ensuring the team member is using the secured company cell phone and we have a Consent for Treatment via Telehealth form signed by the resident's responsible party prior to completing a Post-Fall Assessment. 4. The DHW or RN designee will audit that a signed Consent for Treatment via Telehealth is obtained from the resident's responsible party, and ensure the use of the secured company cell phone, prior to completing a Post-Fall Assessment via telemedicine, weekly x 4 weeks until 100%, then biweekly x 4 weeks until 100%, then monthly x 1 month until 100%, to ensure compliance with this regulation.	

Provider's Signature _____ Title ED Date 5/16/25

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	at work, Team Members are expected to exercise the same discretion in utilizing Personal Devices as is utilized with respect to Company Cell Phones and Mobile Devices. Personal Devices should be turned off during working time and stored in the team member's bag... Team members may not maintain Personal Devices on their person during working time...". 1. R8's clinical record revealed: 11/30/24 (Saturday) at 10:15 AM – The facility's incident report documented that "this nurse [E6] was notified by the caregiver that resident was on the floor. Resident was found on the floor by her bed on her back. Resident denied hitting her head. Resident unable to give description. Immediate Action Taken: This nurse notified the DRC, an assessment was done by the DRC, resident was assisted off the floor into her wheelchair. Resident denied any pain or discomfort at this time. NO bruising or injuries observed at this time... Vital signs were obtained. Resident was able to move all extremities within her normal limit." 12/11/24 at 9:42 AM – During an interview, E6 (LPN) reviewed R8's 11/30/24 (Saturday) fall incident with the Surveyor. E6 stated that she went to the resident's room and called the DRC (E2) as the DRC only works Monday through Friday. When E6 was asked how she contacted E2 (DRC) to conduct R8's post-fall assessment, E6 stated that she used her personal cell phone to call E2 first. Then she stated that she hung up and used her personal cell phone to conduct a video call		

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	with E2 so E2 could perform a post-fall assessment of R8. 12/11/24 at 11:00 AM – During a combined interview with E2 (DRC) and E6 (LPN), the Surveyor asked E2 what device was used to conduct post-fall assessment of residents in the facility. E2 stated that she was provided with and used a facility corporate cell phone to receive phone and video calls from the nurses. Surveyor confirmed with E2 that the nurses are using their own personal cell phones to conduct phone and video calls after residents' falls. 2. R9's clinical record revealed: 12/7/24 at 7:20 AM – The facility's incident report documented that "... this nurse [E7, LPN] was called by the caregiver that resident was found lying on the floor in her room. Resident said she fell while trying to get up from her bed... This nurse called the DRC [E4, CS] and an assessment was conducted...". 12/12/24 at 9:06 AM – During an interview, E7 (LPN) confirmed that she called E4 and was told to do a video call so E4 could conduct a post-fall assessment on 12/7/24 (Saturday) at 7:22 AM. E7 confirmed with the Surveyor that she used her own personal cell phone for the two calls, including the resident's post-fall assessment. 12/11/24 at approximately 12:02 PM – During an interview, when asked if the facility had resident representatives' consents for the post-fall video assessments, E4 (RDHW)		

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NAME OF FACILITY: AL- Somerford Place

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	confirmed that they do not and that they sent a request to the facility's Legal department. 12/12/24 at 1:55 PM – Findings were reviewed during the exit conference with E1, E2 (DRC), E3 (RDHW), E4 (CS) and E5 (BOM).		

Provider's Signature _____ Title ED Date 5/16/25