

STATE SURVEY REPORT

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NAME OF FACILITY: Somerford Place

NAME OF	-ACILITY. Someriord Place	DATE SURVEY COMPLETED.	tuduot not none
SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	A		
	An unannounced Annual and Complaint	I	
	Survey was conducted at this facility from		
	August 19, 2025, through August 20, 2025		
	The deficiencies contained in this report are	1 h	
	based on interview, record review and re		
	view of other facility documentation as indi	- I I	
	cated. The facility census on the first day of	 	
	the survey was thirty-four (34). The survey	'	
	sample totaled eight (8) residents.		
	Abbreviations/definitions used in this state		
	report are as follows:		
			1
	AA – Administrative Associate;		
	BOM – Business Office Manager;		
	CD – Culinary Director;		
	CG – Caregiver;		35.
	DHW – Director of Health and Welliness;		
	DOSM – Director of Sales and Marketing; ED - Executive Director;		
	EMR – Electronic Medical Record;	ľ	
	ER – Emergency Room;		
	FD – Facilities Director;		
	LPN Licensed Practical Nurse;		
	MT – Medication Tech;		
	NP – Nurse Practitioner;		
	RN – Registered Nurse;		
*0	SA (Service Agreement)— allows both par	_	
	ties involved (the resident and the assisted		
	living facility) to understand the types of		
	care and services the assisted living pro		
	vides. These include: lodging, board, house	1	
	keeping, personal care, and supervision ser	l .	
	vices.		
3225	Assisted Living Facilities		
	lefestion Control		
3225.9.0	Infection Control		
	1) - 0	0 1	10/92

Office of Long-Term Care Residents Protection

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

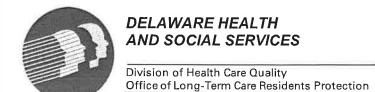
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NAME OF FACILITY: Somerford Place

Provider's Signature Soamer

NAME OF FAC	ILITY: Somerford Place	DATE SURVEY COMPLETED: August 20, 2025	
SECTION ST.	ATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.9.7	The assisted living facility shall have on file	≘ 3225.9.0	
3223.3.7			
	evidence of vaccination against pneumo	1 1 There were no recidents negatively im-	
	coccal pneumonia for all residents olde	I proted by deficient practice. This facility	
	than 65 years, or those who received the	shall have on file evidence of vaccination	
	pneumococcal vaccine before they became	Logorat prelimococcal prelimonia for all	
	65 years and 5 years have elapsed, and a	residents older than 65 years or those	
	recommended by the Immunization Prac	- who received the preumococcel veccine	
	tice Advisory Committee of the Centers fo	before they became 65 years and 5 years	
	Disease Control, unless medically contrain	have elanced and as recommended by the	
	dicated. All residents who refuse to be vac	Immunization Practice Advisory Com-	
	cinated against pneumococcal pneumoni	I mittee of the Centers for Disease Confrol	10/03/2025
	must be fully informed by the facility of the	I linless medically contraindicated. All res-	10/03/2023
	health risks involved. The reason for the re	Indents who retuse to be vaccinated against	
	fusal shall be documented in the resident	pneumococcal pneumonia must be fully	
	medical record.	informed by the facility of the health risks	
	This requirement was not met as evidence	involved. The reason for the refusal shall	
	by:	be documented in the resident's medical	
		record no later than 11/30/25.	
	Based on record review and interview,		
	was determined that for one (R2) out o		
	eight residents reviewed for pneumococc		1 6
	vaccines, the facility failed to provide ev		
	dence of the residents' pneumococcal vac)-	
	cine. Findings include:		
	4/2/25 - R2 was admitted to the facility.	3.All nursing staff will be going through	
	8/20/25 - The facility was unable to provide	mandated training provided by DHW or	
	any documentation of R2 having received	1 designess to make sure that an required	
	any pneumococcal vaccination or that the	Tomis are documented in the residents	
	vaccination was offered and declined.	file.	
	 8/20/24	t	
	approximately 10:30 AM, E2 confirmed the	4. The DHW or designee will perform rail-	
	above resident's pneumococcal vaccine in	I dom checks off chans monuniv to make sufe	
	formation was not in evidence.	and in the chart. Until 100% compliance is	
		achieved	
l	8/20/25 - Findings were reviewed with E	1	
	(ED), E2, E3 (BOM), E4 (Regional DHW), E		
	(CD), E6 (FD), E15 (DOSM) and E16 (AA) a	t	
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STATEMENT OF DEFICIENCIES ADMINISTRATOR'S PLAN FOR Complete			
SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES WITH	Date
		ANTICIPATED DATES TO BE CORRECTED	
	the exit conference beginning at approximately 1:30 PM.		
3225.13.0	Service Agreements		
3225.13.3	The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.	3225.13.0	
	This requirement was not met as evidenced by:	1. There were no residents negatively impacted by deficient practice. The resi-	10/03/2025
	Based on record review, interview and review of other facility documentation, it was determined that for eight (R1, R2, R3, R4, R5, R6, R7 and R8) out of eight sampled residents for the SA completion, the facility failed to provide evidence that the residence	dent's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.	
	dent's personal attending Physician was identified on the SA. Findings include:	2. All new residents have the potential to affected by this deficient practice.	
	1. 9/28/22 – R1 was admitted to the facility. The SA completed on 1/17/25 did not contain the resident's personal attending Physician's address or phone number.	3. Upon admission all residents will have. Each resident medical record will be updated to reflect the resident attend-	
	2. 4/2/25 – R2 was admitted to the facility. The SA completed on 1/9/25 did not contain the resident's personal attending Physician's address or phone number.	ing physician on SA. 4.Staff will be in-serviced to ensure that	
	3. 8/18/23 – R3 was admitted to the facility. The SA completed on 4/2/25 did not contain the resident's personal attending Physician's address or phone number.	there is a attending physician documented in the all residents files by the DHW or designee. The ED/ designee will audit new resident medical records weekly x4 week monthly x2 months until	
	4. 4/16/24 – R4 was admitted to the facility. The SA completed on 3/11/25 did not contain the resident's personal attending Physician's address or phone number.	100% compliance is achieved.	
Provider's Signa	ture Som T	itle Date 9	19/25



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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
3225.18.0	5. 8/16/22 – R5 was admitted to the facility. The SA completed on 1/22/25 did not contain the resident's personal attending Physician's address or phone number. 6. 4/2/24 – R6 was admitted to the facility. The SA completed on 5/13/25 did not contain the resident's personal attending Physician's address or phone number. 7. 10/31/24 – R7 was admitted to the facility. The SA completed on 6/18/25 did not contain the resident's personal attending Physician's address or phone number. 8. 7/14/25 – R8 was admitted to the facility. The SA completed on 7/2/25 did not contain the resident's personal attending Physician's address or phone number. 8/20/25 – Per interview with E2 (DHW) at approximately 1:00 PM, E2 confirmed the SAs being utilized did not contain the resident's personal attending Physician's address or phone number. 8/20/25 - Findings were reviewed with E1 (ED), E2, E3 (BOM), E4 (Regional DHW), E5 (CD), E6 (FD), E15 (DOSM) and E16 (AA) at the exit conference beginning at approximately 1:30 PM. Emergency Preparedness	3225.18.0 1.There were no residents negatively impacted by deficient practice. The staff on all shifts shall be trained on emergency and evacuation plans. Evacuation routes shall be posted in a conspicuous place at	10/03/2025
3225.18.4	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.	fected by this deficient practice.	

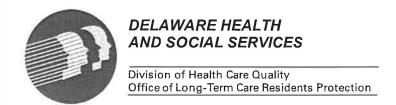


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STATEMENT OF DEFICIENCIES		ADMINISTRATOR'S PLAN FOR	Completion
SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Date
	<u></u>		
	Based on interview and review of other facility documentation, it was determined that one (E7) out of five employees' training record review, the facility failed to provide evidence of the Emergency Preparedness education. Findings include:	3.All staff will be going through mandated training on the Emergency and Evacuation Plans provided by ED or designee.	
	4/12/21 - E7 (LPN) was hired. The facility failed to have Emergency Preparedness training in evidence.	4. The BOM will insures an updated Emergency and Evacuation Plans. Is	
	8/20/25 — Per interview with E2 (DHW) at approximately 1:00 PM, E2 confirmed the training was not in evidence.	Audits will be performed x 2 monthly until all staff training is completed. Then	
	8/20/25 - Findings were reviewed with E1 (ED), E2, E3 (BOM), E4 (Regional DHW), E5 (CD), E6 (FD), E15 (DOSM) and E16 (AA) at the exit conference beginning at approximately 1:30 PM.	achieved.	
3225.19.0 3225.19.6	Records and Reports	3225.19.0	
	Reportable incidents shall be reported im- mediately, which shall be within 8 hours of the occurrence of the incident, to the Divi-		10/03/25
3225.19.7	sion. The method of reporting shall be as directed by the Division.	1. There were no residents negatively impacted by deficient practice. Reportable	
3225.19.7.7	Reportable incidents include:	incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division.	
322519.7.7.2	Significant injuries	The method of reporting shall be as di-	
	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.	to an acute care facility for treatment or evaluation or which requires periodic reassessment of the resident's clinical status	
	This requirement was not met as evidenced by:	by facility professional staff for up to 48 hours.	r / a =



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DATE SURVEY COMPLETED: August 20, 2025

NAME OF FACILITY: Somerford Place		DATE SURVEY COMPLETED: August 20, 2025	
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	Based on record review, interview, other facility documentation and State Agency Incident Reporting System reports, it was determined that for one (R1) out of eight residents reviewed, the facility failed to report the incident to the State agency within the 8-hour time frame. Findings include: 9/28/22 — R1 was admitted to the facility with diagnoses, including but not limited to dementia with agitation. 7/11/25 — Per EMR entry by E17 (LPN) at 6:18 PM, E17 noted R1 "fell forward to floor which resulted in a hematoma on the forehead." R1 was transported to the ER for evaluation. 7/12/25 — Per EMR entry by E18 (LPN) at 1:38 PM, E18 noted that R1 was returned to the facility with a "hematoma of the face and probable fracture of the left hand." E18 noted R1's "third and fourth digits were taped together he had a splint on his right hand." 7/15/25 - The facility reported this fall with injury to the State Agency Incident Reporting System at approximately 12:36 PM, three days after the incident, not within the required eight hours after the incident. 8/20/25 — Per interview with E2 (DHW) at approximately 1:00 PM, E2 confirmed the fall with injury report was filed late. 8/20/25 - Findings were reviewed with E1 (ED), E2, E3 (BOM), E4 (Regional DHW), E5 (CD), E6 (FD), E15 (DOSM) and E16 (AA) at the exit conference beginning at approximately 1:30 PM.	2. All new residents have the potential to affected by this deficient practice. 3. The DHW received re-education by ED regarding the regulatory requirement to report all qualifying incidents to the Division within 8 hours of the incident's occurrence, as outlined in state regulation 3225.19.0. A centralized Incident Reporting Log was implemented and is, maintained by the DHW, to track all incidents, time of occurrence, time of notification, determination of reportability, and time of submission to the Division. In the absence of the DHW, a designated RN or the Executive Director will notify the Regional DHW to ensure timely reporting. 4. The Executive Director or designee will review the incident log and the State Agency Incident Reporting System weekly x4, then monthly x4 then yearly until 100% compliance is achieved.	

Provider's Signature

Title ____

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Date 9/9/25