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: Somerford Place

DATE SURVEY COMPLETED: August 20, 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 August 19, 2025, through August 20, 2025. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. 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: AA – Administrative Associate; BOM – Business Office Manager; CD – Culinary Director; CG – Caregiver; DHW – Director of Health and Welllness; DOSM – Director of Sales and Marketing; ED - Executive Director; EMR – Electronic Medical Record; ER – Emergency Room; FD – Facilities Director; LPN – Licensed Practical Nurse; MT – Medication Tech; NP – Nurse Practitioner; RN – Registered Nurse; SA (Service Agreement)– allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living provides. These include: lodging, board, housekeeping, personal care, and supervision services.		
3225 **3225.9.0**	**Assisted Living Facilities** **Infection Control**		

Provider's Signature Reyna Somma Title ED Date 9/9/25

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3225.9.7	**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 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 record review and interview, it was determined that for one (R2) out of eight residents reviewed for pneumococcal vaccines, the facility failed to provide evidence of the residents' pneumococcal vaccine. Findings include: 4/2/25 - R2 was admitted to the facility. 8/20/25 - The facility was unable to provide any documentation of R2 having received any pneumococcal vaccination or that the vaccination was offered and declined. 8/20/24 – Per interview with E2 (DHW) at approximately 10:30 AM, E2 confirmed the above resident's pneumococcal vaccine information was not in evidence. 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	3225.9.0 1.There were no residents negatively impacted by deficient practice. This 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 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 no later than 11/30/25. 2. All residents have the potential to be affected by this deficient practice. 3.All nursing staff will be going through mandated training provided by DHW or designess to make sure that all required forms are documented in the residents file. 4. The DHW or designee will perform random checks on charts monthly to make sure all mandated medical forms are documented and in the chart. Until 100% compliance is achieved.	10/03/2025

Provider's Signature Lorraine Bowen Title ED Date 9/9/25

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	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.** This requirement was not met as evidenced by: 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 resident's personal attending Physician was identified on the SA. Findings include: 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. 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. 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. 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.	3225.13.0 1.There were no residents negatively impacted by deficient practice. The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number. 2. All new residents have the potential to affected by this deficient practice. 3. Upon admission all residents will have. Each resident medical record will be updated to reflect the resident attending physician on SA . 4.Staff will be in-serviced to ensure that 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 100% compliance is achieved.	10/03/2025

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	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.	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 each nursing station. 2. All residents have the potential to affected by this deficient practice.	10/03/2025
3225.18.0 **3225.18.4**	**Emergency Preparedness** **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:		

Provider's Signature S. Romano Title ED Date 9/9/25

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	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: 4/12/21 - E7 (LPN) was hired. The facility failed to have Emergency Preparedness training in evidence. 8/20/25 – Per interview with E2 (DHW) at approximately 1:00 PM, E2 confirmed the training was not in evidence. 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.	3.All staff will be going through mandated training on the Emergency and Evacuation Plans provided by ED or designee. 4.The BOM will insures an updated Emergency and Evacuation Plans. Is placed in all employee's Relias training. Audits will be performed x 2 monthly until all staff training is completed. Then yearly, until 100% compliance is achieved.	
3225.19.0 **3225.19.6** **3225.19.7** **3225.19.7.7** **3225..19.7.7.2**	**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:** **Significant injuries** **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.** This requirement was not met as evidenced by:	3225.19.0 1.There were no residents negatively impacted by deficient practice. 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: Significant injuries 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.	10/03/25

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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 [signature] Title ED Date 9/9/25