**DELAWARE HEALTH AND SOCIAL SERVICES**
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
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**STATE SURVEY REPORT**



**NAME OF FACILITY: Lodge Lane Assisted Living** **DATE SURVEY COMPLETED: January 12, 2023**

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLE-TION DATE |
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| | **REVISED REPORT**<br>**Deficiency 3225.9.5.1 Requirements for Tuberculosis and Immunizations and deficiency 3225.11.4 The resident assessment shall be completed in conjunction with the resident were removed from the deficiency report. The Facility disputed the deficiencies and submitted additional information on February 23, 2023.**<br><br>An unannounced Annual and Complaint Survey was conducted at this facility January 10, 2023, through January 12, 2023. 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 forty-nine (49). The survey sample totaled seven (7) residents.<br><br>Abbreviations/definitions used in this state report are as follows:<br><br>AIT – Administrator in Training;<br><br>Alzheimer's – a progressive brain disorder with memory loss, poor judgement, personality changes and disorientation OR loss of mental functions such as memory and reasoning that interferes with a person's daily functioning;<br><br>DelVAX - Delaware's state immunization registry serving as a database that contains the immunization records of Delaware residents;<br><br>Dementia - the loss of cognitive functioning — thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities; | | |

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| | CHF- (Congestive Heart Failure) - a chronic progressive condition that affects the pumping power of your heart muscle;<br><br>CVA – (Cerebrovascular accident) - a stroke is when blood flow to a part of your brain is stopped either by a blockage or the rupture of a blood vessel. | | |
| **3225.5.0**<br><br>**3225.5.12** | **General Requirements**<br><br>**An assisted living facility that provides direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.**<br><br>This requirement was not met as evidenced by:<br><br>Based on record review, interview and review of other facility documentation, it was determined that for five (E3, E8, E9, E10 and E11) out of five employees, the facility did not provide evidence of the annual training for dementia care. Findings include:<br><br>1/11/23 12:40 PM – During an interview, E1 (Administrator) confirmed that the annual trainings for these five employees were not found. E1 stated the education position had | 1.Dementia training will be provided to E3, E8, E9, E10 and E11 by February 28, 2023.<br>2. All staff have the potential to be affected. HR will audit all staff.. Staff without dementia training will be provided training by February 28. 2023.<br><br>3. RCA: This training was being performed at New Employee Orientation and mandatory review days (MRD). These orientation days and MRD have been scheduled and cancelled due to outbreaks, and staffing opportunities.<br><br>New employees will now be assigned Dementia training on-line by the Human Resources (HR) department at time of hire and are to be completed prior to their first assignment day. The new employee is compensated for the time they are completing the dementia training webinars. The Nursing Scheduler confirms in the Nursing Education electronic system that the education has been completed prior to their first orientation day taking care of residents.<br><br>Dementia training will be provided by a certified dementia trainer to all staff members required to obtain continuing education for renewal of their licenses or certifications, at yearly critical skills/mandatory review day sessions. | 04/10/2023 |

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| | changed numerous times and that files of education were difficult to locate. E1 was unsure if the trainings were completed or not.<br><br>1/12/23 - Findings were reviewed with E1, E2 (Administrator Director-AIT) and E3 (DON) at the exit conference, beginning at approximately 3:05 PM. | Nursing Home Administrator educated the HR department on the new process on 2/2/2023 and the process has al-ready been implemented.<br><br>4. HR (or designee) will conduct audits of new hire training weekly x 3 or until 100% compliance is achieved. Audits will con-tinue monthly x 2 or until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.<br><br>WD (or designee) will conduct audits of an-nual critical skills/mandatory review day sessions to ensure all indicated staff receive their required training yearly. Findings of the audits will be reported to the QAPI committee yearly to ensure compliance is obtained and maintained. | |
| **3225.9.0**<br><br>**3225.9.6** | **Infection Control**<br><br>**The assisted living facility shall have on file evidence of annual vaccination against in-fluenza for all residents, as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Con-trol, unless medically contraindicated. All residents who refuse to be vaccinated against influenza 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.**<br><br>This requirement was not met as evidenced by: | 1. R4 came to facility after vaccination clinic was offered. On 2/21/2023, the NHA verified in DelVax R4 had not received their influenza vaccine.R4's representative was notified by the Well-ness Director (WD) on 2/21/2023 the resident should receive a flu vaccine , and that LLAL had no record of R4 receiving an influenza vaccination this flu season, and asked representative to have R4 vaccinated. R4s representative is check-ing to be sure no vaccination received this flu season. If not done, will take resident for vaccination.<br><br>2. Potentially all residents may be affect-ed. WD will review the list of active res- | 04/10/2023 |

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| | Based on medical record review, interview and review of facility provided documentation, it was determined that for one (R4) out of seven residents sampled for an annual vaccination against influenza, the vaccine was not given or there was no record of the vaccine being offered to the resident and declined. Findings include:<br><br>10/26/22 - R4 was admitted with a diagnosis of Alzheimer's. There was no indication that the 2022 influenza vaccine was administered or declined by the resident.<br><br>1/10/23 at 2:00 PM, per interview with E3 (DON), E3 confirmed there was no record of the 2022 influenza vaccine being administered or of the resident's declination of such.<br><br>1/12/23 - Findings were reviewed with E1 (Administrator), E2 (Administrator Director-AIT) and E3 at the exit conference, beginning at approximately 3:05 PM. | idents on premise for influenza vaccination or declination. by March 15, 2023. For any residents not vaccinated, or who have not signed a declination, WD or designee will contact resident/representative to have resident vaccinated or sign declination form. If no response received, request will be sent to resident/representative via a certified letter by March 31, 2023.<br>3. RCA: Residents and/or their designated representatives are offered opportunities to participate in the LLAL Annual Flu Vaccination Program. The cur-rent process did not have a mechanism to handle residents/representatives who failed to respond to the request. Also, there was no process in place to verify vaccination upon admission after the clinic was offered, and so no notification was given to residents/representatives to obtain flu vaccination this season.<br><br>Residents/representatives will be notified in advance of the Annual LLAL Flu Clinic for consent to administer the influenza vaccination, or to sign a declination form if they chose not to receive the vaccine. Residents/representative who do not respond will receive a 2nd notification. A certified letter will be sent to all those who fail to respond to the 2nd communication, which will ensure the resident/family received the document and did not wish to respond to the request.<br><br>For residents admitted after the date of the LLAL Flu Clinic, the Wellness Director or designee will confirm vaccination status on admission. If resident is not vaccinated, resident/representative will be asked to have resident vaccinated or have them immediately sign a declination form. Influenza vaccination/declination confirmation will be | |

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| | | added to the Sales & Marketing and Wellness Director's Admission check-list.<br><br>WD will request access to DHIN/DelVax by February 28, 2023, as another avenue to check for vaccination status in Delaware. Until access is obtained, WD will contact NH Administrator or Administrative Director to verify vaccinations via DHIN/DelVax. The Administrative Director will educate the WD and Sales & Marketing Director in this process.<br><br>4. The WD (or designee) will conduct audits of new residents weekly x 3 or until 100% compliance is achieved. Audits will continue monthly x 2 or until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |
| **3225.11.0**<br><br>**3225.11.2** | **Resident Assessment**<br><br>**A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse (RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive** | 1. While R3 is no longer a resident of the facility. R3s initial UAI was performed on 11/6/2020 and admission took place on 11/6/2020. It was signed by the resident representative on 11/13/2020.<br><br>2. As there was no deficient practice, not other residents were affected.<br><br>3. RCA: The resident identified had the documentation noted in their paper medical record. It is unclear how the documentation was missed by both the Surveyor and the WD at the time of the Survey. | 04/10/2023 |

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| | **technology, that component of the assessment must be performed by personnel qualified in that specialty area.**<br><br>This requirement was not met as evidenced by:<br><br>Based on record review, interview and review of other facility documentation, it was determined that for one (R3) out of seven sampled residents, the facility failed to provide evidence that the initial UAI assessment was completed within 30 days prior to admission. Findings include:<br><br>11/13/20 - R3 was admitted with a diagnosis of CVA. The initial UAI assessment was not in evidence as being completed.<br><br>1/11/23 1:40 PM - During an interview, E3 (DON) confirmed that R3's initial UAI assessment was not located.<br><br>1/12/23 - Findings were reviewed with E1 (Administrator), E2 (AIT) and E3 at the exit conference, beginning at approximately 3:00 PM. | Lodge Lane will be moving to an electronic medical record by the end of calendar year 2023. Once that occurs, the documentation will be more readily recognizable to the surveyors and staff.<br><br>The Sales and Marketing Director will confirm the initial UAI has been complete prior to admission, and verified with the Admission Checklist.<br><br>The WD will perform the initial assessment within 30 days of admission, complete and sign the initial UAI, and have the resident/representative sign the UAI acknowledging their review and understanding of the document. Upon completion, a staff nurse will review the UAI for completion and signatures before placing the document in the resident's record.<br><br>The Administrative Director will educate the Sales and Marketing Director and Wellness Director in this process.<br><br>4. WD (or designee) will conduct audits of newly admitted resident UAIs weekly x 3 or until 100% compliance is achieved. Audits will continue monthly x 2 or until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |
| **3225.11.5** | **The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.**<br><br>This requirement was not met as evidenced by: | 1. R2 was reviewed on 7/1/2022 for evaluation for memory care. R2's representative planned to move R2 to Florida in-stead. R2 was unable to move and re-turned to the facility. R2 was reviewed again upon her return on 7/13/2022 and resident was moved into memory care on 7/15/2022 as soon as we could make a space available for the resident. | 04/10/2023 |

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| | Based on record review, interview and review of other facility documentation, it was determined that for two (R2 and R3) out of seven sampled residents, the facility failed to provide evidence that the 30-day or significant change in condition UAI's were completed. Findings include:<br><br>1. 11/13/20 - R3 was admitted with a diagnosis of CVA. The 30-day UAI assessment was not in evidence as being completed.<br><br>2. 6/13/22 - R2 was admitted with a diagnosis of dementia. The initial UAI was completed 5/19/22 and the 30-day UAI assessment was completed 7/13/22. Per the nurses' notes, the resident was relocated to the Memory Care Unit on 7/15/22 and demonstrated some behavior changes which included yelling and aggression on 7/16/22. The clinical record indicated bruising on R2's left thigh on 7/28/22 possibly due to fall and on 8/1/22 at 7:00 AM, R2 was found packing her belongings and her wet clothing was found in the apartment and in the shower. On 8/2/22 at 4:00 AM, R2 was dressed and "going out for an appointment" in which staff found it difficult to redirect the resident. The clinical record noted that on 10/4/22 at 2:00 PM, staff found R2 "rubbing and touching another resident and wanting him to go to her room" and on redirect, R2 became angry. On 10/8/22 at 3:00 PM, it was noted in the record that the R2 was upset, throwing items and threatening to punch the nurse. A significant change in condition UAI was not in evidence after R2 was relocated to the Memory Care Unit and R2's behavior changed, which required increased attention by staff. | R3s 30-day UAI was completed but not signed. As the resident is deceased, no correction is possible.<br><br>2. Unable to create or correct historical UAIs.<br><br>3. RCA: Behaviors exhibited once R2 moved to Memory Care are consistent with expected behaviors for R2s dementia and so were not considered a change in status. WD had a lack of knowledge that another UAI was required for resident R2 as these were normal behaviors for her dementia. The State regulations do not specify what constitutes a significant change. No changes to her plan of care were initiated due to the behaviors exhibited and nothing on the UAI would have changed.<br><br>R3s 30-day UAI was completed but not signed by the resident/representative. There were several Wellness Directors and Unit Clerks responsible for medical records over the last several years We cannot determine how the signature was missed.<br><br>WD will complete the 30-day or change UAIs, sign and date any changes, review with the resident/representative and ensure they sign as well. Upon completion, a staff nurse will review the UAI for completion and signatures before placing the UAI in the resident's chart.<br><br>Administrative Director will educate the WD in this process.<br><br>4. Wellness Director (or designee) will conduct audits of completions weekly 3 or until 100% compliance is achieved. Audits will continue monthly x 2 or until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee | |

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| | 1/11/23 1:40 PM - During an interview, E3 (DON) confirmed that a R3's 30-day UAI assessment or R2's significant change in condition UAI was not in evidence after R2 was relocated to the Memory Care Unit and R2's behavior changed.<br><br>1/12/23 - Findings were reviewed with E1 (Administrator), E2 (AIT) and E3 at the exit conference, beginning at approximately 3:00 PM. | monthly x 3 months to ensure compliance is obtained and maintained. | |
| **3225.13.0**<br><br>**3225.13.1** | **Service Agreements**<br><br>**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.**<br><br>This requirement was not met as evidenced by:<br><br>Based on record review, interview and review of other facility documentation, it was determined that for one (R5) out of seven sampled residents, the facility failed to provide evidence that the service agreement was signed by either the resident or family member. Findings include:<br><br>8/25/22 - R5 was admitted with a diagnosis of CHF. The service agreement dated 8/25/22 was not signed by either the resident or by a family member. | 1. R5 is no longer a resident of the facility. We are unable to correct.<br><br>2. Unable to create or correct historical Service Agreements.<br><br>3. RCA: The resident was quickly being discharged from another facility and was assessed via Zoom. There is no area on the Service Agreement form to note that it was re-viewed with the family via Zoom. WD failed to follow-up with having the resident/representative to obtain signature on admission.<br><br>The Sales and Marketing Director will confirm the service agreement has been complete and signed, verified against the Admission Checklist.<br><br>The WD (or designee) will ensure the Service Agreement is dated and signed at the time of assessment, or if done utilizing technology such as zoom no later than the day of admission. A note will be added to the document attesting to the consent of the resident and/or family member.. Upon admission, a staff nurse will re-view document for completion and signatures before filing the document in the resident's chart. | 04/10/2023 |

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| | 1/12/23 10:20 AM – Per interview with E3 (DON) regarding signatures on the UAI and service agreements, E3 stated the residents/families are involved in the assessment and both should be signed by the resident or by family. E3 confirmed R5's signature on the service agreement was not in evidence.<br><br>1/12/23 - Findings were reviewed with E1 (Administrator), E2 (AIT) and E3 at the exit conference, beginning at approximately 3:00 PM. | Administrative Director will educate the WD and Sales and Marketing Director in this process.<br><br>4. WD (or designee) will conduct audits of resident / family signatures weekly x 3 or until 100% compliance is achieved. Audits will continue monthly x 2 or until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. | |
| **12.1.3** | **Food service complies with the Delaware Food Code**<br><br>**6-202.11 Light Bulbs, Protective Shielding.**<br><br>(A) Except as specified in ¶ (B) of this section, light bulbs shall be shielded, coated, or otherwise shatter-resistant in areas where there is exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; or unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. (B) Shielded, coated, or otherwise shatter-resistant bulbs need not be used in areas used only for storing FOOD in unopened packages, if:<br><br>(1) The integrity of the packages cannot be affected by broken glass falling onto them; and<br><br>(2) The packages are capable of being cleaned of debris from broken bulbs before the packages are opened.<br><br>Based on observation and interview, it was determined that the facility failed to ensure | 1. Maintenance staff placed a cover on the light in the Lodge Lane kitchen's janitor's closet on 1/10/2023 by the end of the day.<br><br>Lodge Lane does not have a loading dock. The light fixture at the Kutz Rehabilitation and Nursing loading dock was corrected on 2/24/23.<br><br>2. Maintenance staff conducted an audit of all other lighting fixtures at Lodge Lane on 1/10/2023 and at the Kutz Rehabilitation and Nursing loading dock on 2/24/2023 and found no other deficiencies to correct.<br><br>3. RCA: The kitchen staff rarely enter the kitchen's janitor's closet,. No food items are stored in the closet. Staff were not checking to see if the light had a covering. In addition, Kutz Senior Living Campus has had several Maintenance Di-rectors over the past twenty-four months, the last of which was newly hired as of 12/26/2022, | 04/10/2023 |

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| | adequate services to comply with the Delaware Food Code. Findings include:<br><br>During the kitchen inspection on 1/10/23 from approximately 9:00 AM to 10:15 AM, it was revealed that the florescent lights at the dry storage and loading dock did not have a covering.<br><br>Finding was reviewed and confirmed by E12 (Dining Director) on 1/10/23 at approximately 10:30 AM.<br><br>1/12/23 - Findings were reviewed with E1 (Administrator), E2 (AIT), E3 (DON), E5 (Dining Manager) and E12 at the exit conference, beginning at approximately 3:00 PM. | as well as the addition of several maintenance staff. Therefore, it is unclear if the team routinely reviewed the light coverings at the loading dock.<br><br>For any lights in areas of food and dining, the Dining Director (or designee) will conduct a weekly audit of all light fixtures for working condition and proper covering. Deficiencies will be entered in-to the TELS Work Order system for re-pair.<br><br>The Maintenance Director (or designee) will conduct a weekly audit of all light fixtures at the Kutz Loading Dock for condition and coverings. Any deficiencies will be repaired by the maintenance staff.<br><br>Administrative Director will educate the Dining Director, and Maintenance Director in this process.<br><br>4. Dining Director and Maintenance Director (or designee) will conduct audits of lights in food and dining areas and Kutz Loading dock respectively weekly x3 or until 100% compliance is achieved, then monthly x 2 or until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee quarterly x2 to ensure compliance is obtained and maintained. | |

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