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 - Millcroft Living Nursing Home

DATE SURVEY COMPLETED: October 2, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Annual and Complaint Survey was conducted at this facility from October 1, 2024 through October 2, 2024. 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 twenty-four (24). The survey sample totaled five (5) residents. Abbreviations/definitions used in this state report are as follows: DelVAX -A confidential online computer system used statewide by doctors, nurses, schools to keep track of their patient/student's immunizations; DRS – Director of Resident Services; ED - Executive Director; LPN – Licensed Practical Nurse; MT – Med Tech; 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; SLRE (Senior Living Resident Evaluation) – the Facility's resident evaluation tool in place of the SA to assess the resident's level of care and services that will be needed; TST - Tuberculin skin test; UAI (Uniform Assessment Instrument) - A document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical, and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both an initial and ongoing basis in accordance with these regulations.	
3225	**Assisted Living Facilities**	
3225.9.0	**Infection Control**	

Provider's Signature ______________________ Title ______________________ Date ______________

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3225.9.5 3225.9.5.1 S/S-D	**Requirements for tuberculosis and immunizations:** **The facility shall have on file the results of tuberculin testing performed on all newly placed residents.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for two (R3 and R4) out of three sampled residents for tuberculin testing at admission, the facility failed to have evidence of tuberculin testing. Findings include: 1. 8/31/24 – R3 was admitted to the facility. The facility failed to provide evidence of R3's tuberculin testing at admission. 2. 11/21/23 – R4 was admitted to the facility. The facility failed to provide evidence of R4's tuberculin testing at admission. 10/2/24 – Per interview with E3 (Clinical Specialist) at approximately 10:00 AM, E3 confirmed the tuberculin testing was not in evidence. 10/2/24 – Findings were reviewed with E1 (ED), E2 (DRS) and E3 at the exit conference beginning at approximately 12:00 PM.	Corrective Action: This issue represents past non-compliance. The facility must have on file the results of tuberculin testing that's performed on all new residents. Identification of Other Residents: All newly admitted residents have the potential to be affected by this issue. The corrective actions outlined below will ensure that all residents are protected moving forward. System Changes: For all new admissions to Assisted Living, results from tuberculin testing will be on file. Evaluation of Success: The Assisted Living Manager or designee will conduct audits of all newly admitted residents to ensure that medical evaluations have been completed by a physician within 30 days prior to admission. Audits will be conducted weekly for four weeks and then monthly for three months or until 100% compliance is achieved. The results of these audits will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and further action if necessary. Dates corrected: 11/07/24
3225.9.5.2 S/S – D	**Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public**	Corrective action. All employees are required to have a baseline two-step tuberculin skin test or a single interferon test as part of the pre-employment process. For E8, a TB test was conducted within the last year, with supportive documentation available. E7 also completed a second TB test, and supportive documentation has been verified. Identification of Other Residents: All newly admitted residents have the potential to be affected by this issue. The corrective actions outlined below will ensure that all residents are protected moving forward. System Changes: For all new employees, a base line two step tuberculin skin test or single interferon test for employment will be done.

Provider's Signature *Kristopher Brown* Title Executive Director Date 10/30/24

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	Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category. This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for two (E7 and E8) out of four sampled employee records, the facility failed to provide evidence of a TST prior to hire. Findings include: 1. 9/5/23 – E7 was hired at the facility. The first PPD was administered on 9/1/23. The facility failed to provide evidence of the second step TST. 2. 2/26/24 – E8 was hired at the facility. The TST in evidence was administered on 9/2/21, two years and five months prior to hire. The facility failed to provide evidence of a two-step TST within the year prior to hire. 10/2/24 – Per interview with E3 (Clinical Specialist) at approximately 10:00 AM, E3 confirmed the tuberculin testing was not in evidence. 10/2/24 – Findings were reviewed with E1 (ED), E2 (DRS) and E3 at the exit conference beginning at approximately 12:00 PM.	The Human Resource director or designee will conduct audits of all employees to ensure that a copy of a base line two step tuberculin skin test or single interferon test is in their file, and will be conducted weekly for four weeks and then monthly for three months or until 100% compliance is achieved. The results of these audits will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and further action if necessary Date corrected by: 11/07/24
3225.9.7 S/S -D	**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**	Corrective Action: The vaccination status for the three residents identified at time of survey (R2,R3, and R4) has been successfully updated in the electronic health record (PCC) Affected Residents: All residents may potentially be impacted by this identified deficiency. Corrective actions outlined below will ensure that all residents are adequately protected

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	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, interview and review of State DelVAX website, it was determined that for three (R2, R3 and R4) out of five sampled residents for pneumococcal vaccines, the facility failed to provide evidence of the residents' pneumococcal vaccine status. Findings include: "Pneumococcal Vaccine Timing for Adults- Adults >/= 65 years old Complete pneumococcal vaccine schedules... PCV13 only at any age- Option A: >/= 1 year, give PVC20, Option B: >/= 1 year, give PPSV23." U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. 1. 11/1/21 – R2, now aged 101, was admitted to the facility. The facility failed to provide evidence of R4's pneumonia vaccine or a declination of such. 10/2/24 – A search on the DelVAX website contained no information of R2's pneumonia vaccines. 2. 8/31/24 – R3, now aged 72, was admitted to the facility. The facility failed to provide evidence of R4's pneumonia vaccine or a declination of such.	System Changes: Immunization documentation for all current residents will be updated with the latest information obtained from family members and the DelVax website. A vaccine clinic will be scheduled to offer the Pneumococcal vaccine to all eligible residents. Nurses will receive training on the requirement that all patients aged 65 and older must be assessed for their pneumococcal vaccination status during routine healthcare visits and at the time of admission by the Assisted Living manager or designee. If a resident is unvaccinated or due for a booster, the Power of Attorney (POA) or family member will be given the required information and a consent form. If the consent is secured, the appropriate pneumococcal vaccine will be ordered and administered by the nurse in accordance with CDC guidelines. Success Evaluation: An audit will be conducted to verify that updated vaccination information for all current residents is documented in the electronic health record (PCC). Audits will occur weekly for four weeks, followed by monthly audits for three months or until 100% compliance is achieved. The audit results will be reported to the QAPI Committee by the Executive Director or their designee. Date corrected by: 11/07/24

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	10/2/24 - A search on the DelVAX website contained no information of R3's pneumonia vaccines. 3. 11/21/23 – R4, now aged 92, was admitted to the facility. The facility failed to provide evidence of R4's pneumonia vaccine or a declination of such. 10/2/24 – A search on the DelVAX website revealed R4 received the PVC13 pneumococcal vaccine on 8/29/15 at age 83 and the PPV23 on 10/30/19 at age 87. While the DelVax website confirmed that R4's PCV13 and PPV23 vaccinations were received, the facility failed to provide evidence of such in R4's medical record. The facility failed to provide evidence of any documentation of R4 completing the pneumococcal vaccine schedule by receiving a PVC20 vaccine or a declination of such. 10/2/24 – Per interview with E3 (Clinical Specialist) at approximately 10:00 AM, E3 confirmed the pneumonia vaccine information was not in evidence. E3 confirmed they have access to the DelVAX website. 10/2/24 – Findings were reviewed with E1 (ED), E2 (DRS) and E3 at the exit conference beginning at approximately 12:00 PM.	
3225.10.0	**Contracts**	
3225.10.10 S/S – B	**No contract shall be signed before a full assessment of the resident has been completed and a service agreement has been executed. If a deposit is required prior to move-in, the deposit shall be fully refundable if the parties**	

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	cannot agree on the services and fees upon completion of the assessment. This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for three (R3, R4 and R5) out of three residents sampled for contracts, the facility failed to obtain the required assessments prior to the resident signing the contract. 1. 8/31/24 - R3 was admitted to the facility. The UAI was completed on 8/31/24. The contract was signed on 8/30/24, prior to the assessment being completed. 2. 11/21/23 – R4 was admitted to the facility. The UAI was completed on 11/21/23. The contract was signed on 11/19/23, prior to the assessment being completed. 3. 7/10/24 – R5 was admitted to the facility. The UAI and SA were both completed on 7/10/24. The contract was signed on 6/27/24, prior to the assessments being completed. 10/2/24 – Per interview with E3 (Clinical Specialist) at approximately 11:55 AM, E3 confirmed the contract signing dates were prior to the full assessments being completed. 10/2/24 – Findings were reviewed with E1 (ED), E2 (DRS) and E3 at the exit conference beginning at approximately 12:00 PM.	Corrective Action: This issue represents past non-compliance. Contracts must be signed only after the completion of the admission UAI-based (Uniform Assessment Instrument) and Service Agreement. The contracts for three residents (R3, R4, and R5) have already been signed and cannot be retroactively corrected. Identification of Other Residents: All newly admitted residents have the potential to be affected by this issue. The corrective actions outlined below will ensure protection for all residents moving forward. System Changes:The UAI will be completed, and Service Plan Agreement will be executed prior to date of admission.The contract will only be signed after both the UAI and Service Plan Agreement have been completed and signed by the resident or their Power of Attorney (POA). Evaluation of Success:The Assisted Living Manager or designee will audit the records of all newly admitted residents to ensure that the UAI and Service Agreement are completed and signed before the contract is signed.Audits will be conducted weekly for four weeks, then monthly for three months or until 100% compliance is achieved.The results of these audits will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the Assisted Living Manager or designee for review and further action if necessary Date corrected by:11/07/24
3225.11.0	**Resident Assessment**	
3225.11.2 S/S - D	**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**	

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	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 technology, that component of the assessment must be performed by personnel qualified in that specialty area. This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for three (R3, R4 and R5) out of five sampled residents the facility failed to complete the initial UAI assessments prior to admission or a review of such 30 days after admission. 1. 8/31/24 - R3 was admitted to the facility. The Surveyor found conflicting dates on the UAI assessment and was unable to determine if an initial UAI or a 30-day after admission was completed timely. The assessment dated 8/31/24, the day of admission was signed by the resident on 8/30/24 and the 30 day after admission assessment date was also dated as 8/31/24 but signed by E2 (DRS) on 9/30/24. 2. 11/21/23 - R4 was admitted to the facility. The initial UAI assessment was completed on 11/21/23, the day of admission. The facility failed to provide evidence of a 30-day after admission assessment. 3. 7/10/24 - R5 was admitted to the facility. The initial UAI assessment was completed on 7/10/24, the day of admission.	Corrective Action: This deficiency reflects past non-compliance. A resident seeking admission must have an initial UAI- based (Uniform Assessment Instrument) resident assessment completed by a registered nurse (RN) on behalf of the assisted living facility no more than 30 days prior to admission. The assessments for four residents (R3, R4, and R5) have already been completed and cannot be retroactively corrected. Identification of Other Residents: All newly admitted residents have the potential to be affected by this issue. The corrective actions outlined below will ensure that all residents are protected moving forward. System Changes: For all new admissions to Assisted Living, both the UAI and the service plan agreement must be completed prior to date of admission. An initial UAI-based resident assessment will be conducted by a registered nurse (RN) on behalf of the assisted living facility no more than 30 days prior to admission, and the assessment must be signed by the resident or their Power of Attorney (POA). Evaluation of Success:The Assisted Living Manager or designee will conduct audits of all newly admitted residents to ensure that the UAI resident assessments are completed by an RN no more than 30 days prior to admission and signed by the resident or POA. Audits will be conducted weekly for four weeks and then monthly for three months or until 100% compliance is achieved.The results of these audits will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and further action if necessary. Date corrected by: 11/07/24

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	10/2/24 – Per interview with E3 (Clinical Specialist) at approximately 10:00 AM, E3 confirmed the assessments were not completed timely or in evidence. 10/2/24 – Findings were reviewed with E1 (ED), E2 (DRS) and E3 at the exit conference beginning at approximately 12:00 PM.	
3225.11.3 S/S - D	**Within 30 days prior to admission, a prospective resident shall have a medical evaluation completed by a physician.** This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for three (R3, R4 and R5) out of three sampled residents for medical evaluation, the facility failed to provide evidence of a medical assessment being completed prior to admission. Findings include: 1. 8/31/24 - R3 was admitted to the facility. The facility failed to provide evidence of a medical evaluation completed within 30-days prior to admission. 2. 11/21/23 - R4 was admitted to the facility. The facility failed to provide evidence of a medical evaluation completed within 30-days prior to admission. 3. 7/10/24 - R5 was admitted to the facility. The medical evaluation in evidence was dated 7/11/24, one day after admission. The facility failed to provide evidence of a medical evaluation completed within 30-days prior to admission.	Corrective Action: This issue represents past non-compliance. A prospective resident must have a medical evaluation completed by a physician within 30 days prior to admission. The medical evaluation for R3,R4,and R5 has already been completed and cannot be retroactively corrected. Identification of Other Residents: All newly admitted residents have the potential to be affected by this issue. The corrective actions outlined below will ensure that all residents are protected moving forward. System Changes: For all new admissions to Assisted Living a medical evaluation must be completed by a physician within 30 days prior to admission. Evaluation of Success: The Assisted Living Manager or designee will conduct audits of all newly admitted residents to ensure that medical evaluations have been completed by a physician within 30 days prior to admission. Audits will be conducted weekly for four weeks and then monthly for three months or until 100% compliance is achieved. The results of these audits will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and further action if necessary. Date corrected by:11/07/24

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	10/2/24 – Per interview with E3 (Clinical Specialist) at approximately 10:00 AM, E3 confirmed the medical evaluations were not completed timely or in evidence. 10/2/24 – Findings were reviewed with E1 (ED), E2 (DRS) and E3 at the exit conference beginning at approximately 12:00 PM.	
3225.12.0 3225.12.1 3225.12.1.3 S/S -E	**Services** **The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **Delaware Food Code** 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: **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 maintained: (1) At 57oC (135oF) 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 54oC (130oF) or above; P or (2) At 5ºC (41ºF) or less. P (B) EGGS that have not been treated to destroy all viable Salmonellae shall be stored in refrigerated EQUIPMENT that maintains an ambient air temperature of 7°C (45°F) or less.**	Corrective Action: The Assisted Living Manager and Director of Food and Beverage have implemented corrective actions. All employees involved in food handling have been educated on proper procedures for compliance with the Delaware Food Code. This education included maintaining temperature logs for the refrigerator in the Assisted Living (AL) kitchen, ensuring all food items are properly dated, and discarding expired food items. Identification of Other Residents: All residents have the potential to be affected by improper food handling. To prevent this, the Director of Food and Beverage or designee will provide ongoing education to both current and newly hired staff, ensuring compliance with all food safety and storage requirements. System Changes: The root cause of the issue was identified as a failure by the dietary staff to store food in a sanitary manner. In response, the facility's process for kitchen sanitation has been updated. Weekly sanitation rounds will now be conducted by the dietician and the Director of Food and Beverage to ensure the Assisted Living kitchen and refrigerators are properly maintained. All concerns raised have been addressed. Evaluation of Success: Audits will be conducted to ensure compliance with temperature-log maintenance and food safety practices in the Assisted Living kitchen and refrigerators. These audits will take place weekly for four weeks, followed by monthly audits for three months or until 100% compliance is achieved. The audit results will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and any necessary follow-up actions.

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	10/1/24 – During the survey of the facility at approximately 12:45 PM, 50% of food temperature logs were found to be not maintained for the month of September. 10/1/24 – During an interview with E5 (Director of Dietary Services) at approximately 12:45 PM, E5 confirmed the food temperatures log findings. 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. 10/1/24 – During the survey of the facility at approximately 11:30 AM, the walk-in refrigerator was observed with repackaged lettuce without a date marking. 10/1/24 – During the survey of the facility at approximately 11:30 AM, the walk-in freezer was observed with a bag of frozen chicken tenders and a bag of succotash without a date marking. 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in ¶ 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature	Date corrected by:11/07/24

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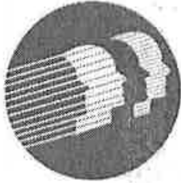
	and time combination specified in ¶ 3-501.17(A), except time that the product is frozen. 10/1/24 – During the survey of the facility at approximately 10:30 AM, cottage cheese noted with the expiration date of 9/15/24 was found in the Assisted Living service area refrigerator. 10/1/24 – During the survey of the facility at approximately 10:45 AM, cottage cheese with the expiration date of 9/28/24 was found inside a kitchen refrigerator. 10/1/24 – During the survey of the facility at approximately 11:30 AM, corn beef dated 9/17/24 and shrimp alfredo dated 9/22/24 located in the walk-in refrigerator was not discarded after day 7. 10/1/24 – During an interview with E9 (Head Chef) at approximately 11:30 AM, E9 confirmed the service area and walk-in refrigerator findings. **3-305.11 Food Storage.** **(A) Except as specified in ¶¶ (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location.** 10/1/24 - During the survey of the facility at approximately 11:30 AM, the walk-in refrigerator located in the main kitchen was observed with debris on the floor underneath the shelving. 10/1/24 – Findings were reviewed with E1 (ED) and E5 (Director of Dietary Services) at approximately 2:00 PM.	
3225.13.0	**Service Agreements**	



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3225.13.1 S/S -B	**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.** These requirements were not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for four (R1, R2, R3 and R5) out of five sampled residents, the facility failed to provide evidence of the resident's signature on the SA/SLRE or that a copy was provided to the resident. 1. 11/21/21 – R1 was admitted to the facility. The facility's Senior Living Resident Evaluation (SLRE) was completed on 7/30/24. The facility failed to provide evidence of R1's signature indicating participation in the development of the services to be provided, or that a copy was given to R1. 2. 11/1/21 – R2 was admitted to the facility. The facility's SLRE was completed on 5/27/24. The facility failed to provide evidence of R2's signature indicating participation in the development of the services to be provided, or that a copy was given to R2. 3. 8/31/24 - R3 was admitted to the facility. The SA was completed on 9/1/24 and the SLRE assessments were completed on 8/3/24 and 9/30/24. The facility failed to provide evidence	Corrective Action: This issue is identified as past non-compliance. A service agreement based on the needs identified in the UAI (Uniform Assessment Instrument) must be completed prior to or no later than the day of admission for each resident seeking entrance. The resident or family must participate in the development of the service agreement and the resident/resident representative must be provided a copy. The service agreements for Four residents (R1, R2, R3, and R5 have already been completed and cannot be retroactively corrected. Identification of Other Residents: All newly admitted residents have the potential to be affected by this issue. Corrective actions outlined below will ensure the protection of all residents going forward. System Changes: For all new admissions to Assisted Living a service agreement based on the needs identified in the UAI will be completed prior to or no later than the day of admission. The resident's attending physician(s) will be documented in the service agreement, including their name, address, and telephone number. Documentation will support resident/resident representative participation in the development process of the service agreement and include evidence that a signed copy was provided to the resident/resident representative. Evaluation of Success: The Assisted Living Manager or designee will audit all newly admitted residents to ensure that a service agreement based on the UAI is completed and that the residents' personal attending physician(s) are properly identified by name, address, and telephone number. Documentation will support resident/resident representative participation in the development process of the service agreement and include evidence that a signed copy was provided to the resident/resident representative. Audits will be conducted weekly for four weeks, then monthly for three months or until 100% compliance is achieved. The results of these audits will be presented to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and any necessary actions.

Provider's Signature *Kristopher Brown* Title Executive Director Date 10/30/24

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	of R3's signature indicating participation in the development of the services to be provided, or that a copy was given to R3. 4. 7/10/24 - R5 was admitted to the facility. The SA was completed on 7/10/24. The facility failed to provide evidence of R5's signature indicating participation in the development of the services to be provided, or that a copy was given to R5. 10/2/24 – Per interview with E3 (Clinical Specialist) at approximately 10:00 AM, E3 confirmed the service agreements or the SLREs were not signed by the resident/POC. E3 confirmed that copies were not given to residents. 10/2/24 – Findings were reviewed with E1 (ED), E2 (DRS) and E3 at the exit conference beginning at approximately 12:00 PM.	Date corrected by:11/07/24
3225.13.3 S/S - B	**The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.** Based on record review, interview and review of other facility documentation, it was determined that for four (R1, R2, R3 and R5) out of five sampled residents, the facility failed to include the resident's personal Physician's information other than the Physician's name. Findings include: 1. 11/21/21 – R1 was admitted to the facility. The facility's Senior Living Resident Evaluation (SLRE) was completed on 7/30/24. The SLRE did not contain R1's personal Physician's information other than the Physician's name. 2. 11/1/21 – R2 was admitted to the facility. The facility's SLRE was completed on 5/27/24.	Corrective Action: This issue is identified as past non-compliance. A service agreement based on the needs identified in the UAI (Uniform Assessment Instrument) must be completed prior to or no later than the day of admission for each resident seeking entrance. The resident or family must participate in the development of the service agreement and the resident/resident representative must be provided a copy. The service agreements for Four residents (R1, R2, R3, and R5 have been updated with the residents' personal physician information. Identification of Other Residents: All newly admitted residents have the potential to be affected by this issue. Corrective actions outlined below will ensure the protection of all residents going forward.

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	The SLRE did not contain R2's personal Physician's information other than the Physician's name. 3. 8/31/24 - R3 was admitted to the facility. The SA was completed on 9/1/24 and the SLRE assessments were completed on 8/3/24 and 9/30/24. The SA or SLRE assessments did not contain R3's personal Physician's information other than the Physician's name. 4. 7/10/24 - R5 was admitted to the facility. The SA was completed on 7/10/24. The SA did not contain R5's personal Physician's information other than the Physician's name. 10/2/24 – Per interview with E3 at approximately 11:55 AM, E3 confirmed the service agreement or SLRE being utilized by the facility do not include the Physician's information other than the name. 10/2/24 – Findings were reviewed with E1 (ED), E2 (DRS) and E3 at the exit conference beginning at approximately 12:00 PM.	System Changes: For all new admissions to Assisted Living a service agreement based on the needs identified in the UAI will be completed prior to or no later than the day of admission. The resident's attending physician(s) will be documented in the service agreement, including their name, address, and telephone number. Documentation will support resident/resident representative participation in the development process of the service agreement and include evidence that a signed copy was provided to the resident/resident representative. Evaluation of Success: The Assisted Living Manager or designee will audit all newly admitted residents to ensure that a service agreement based on the UAI is completed and that the residents' personal attending physician(s) are properly identified by name, address, and telephone number. Documentation will support resident/resident representative participation in the development process of the service agreement and include evidence that a signed copy was provided to the resident/resident representative. Audits will be conducted weekly for four weeks, then monthly for three months or until 100% compliance is achieved. The results of these audits will be presented to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and any necessary actions. Date corrected by:11/07/24
3225.14.0	**Resident Rights**	
3225.14.1 S/S -E	**Assisted living facilities are required by 16 Del.C. Ch. 11, Subchapter II, to comply with the provisions of the Rights of Patients covered therein.**	
Del.C. Ch 11, Subchapter II - § 1121. Resident's rights.	**Del.C. Ch 11, Subchapter II - § 1121. Resident's rights.** **§ 1123. Notice to patient.** **(b) Copies of § 1121 of this title shall be furnished to the resident upon admittance to the facility; all residents currently residing in the facility; and the authorized representative un-**	

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	der § 1122 of this title. The long-term care facility shall retain in its files a statement signed by each person listed in this subsection that the person has received a copy of § 1122 of this title. This requirement was not met as evidenced by: Based on record review and interview, it was determined for five (R1, R2, R3, R4 and R5) out of five residents reviewed for updated resident rights notification, the facility failed to ensure that the resident or resident representative was notified and signed off on the updated resident rights. Findings include: The Resident Rights form (updated September 2023) required each resident or resident representative to sign and date acknowledging the receipt of a copy of the Resident Rights. 1. 11/1/21 – R1 was admitted to the facility. The facility was unable to provide any documentation of R1 or R1's resident representative being notified and signing off on the updated Resident Rights form. 2. 10/28/21 – R2 was admitted to the facility. The facility was unable to provide any documentation of R2 or R2's resident representative being notified and signing off on the updated Resident Rights form. 3. 8/31/24 – R3 was admitted to the facility. The facility was unable to provide any documentation of R3 or R3's resident representative being notified and signing off on the updated Resident Rights form. 4. 11/21/23 – R4 was admitted to the facility. The facility was unable to provide any documentation of R4 or R4's resident representative	Corrective Action: The Resident Rights form, updated in September 2023, requires each resident or their representative to sign and date the form, acknowledging receipt of a copy of the Resident Rights. Identification of Other Residents: The updated Resident Rights were incorporated into the facility's Resident Agreement in May 2024. Therefore, all residents admitted after this date have received the most current version of the Resident Rights. However, it was identified that residents admitted before this update have not yet received the new Resident Rights information. System Changes: To ensure all residents are informed, the facility will distribute the updated Resident Rights form to all current residents or their representatives who were admitted prior to the May 2024 update. Each resident or representative will be required to sign and date the form to acknowledge receipt. Evaluation of Success: Audits will be conducted weekly for four weeks to ensure that all residents or their representatives have received and acknowledged the updated Resident Rights. Following the initial four weeks, audits will continue monthly for three months or until 100% compliance is achieved. The results of these audits will be presented to the QAPI (Quality Assurance and Performance Improvement) Committee by the Executive Director (ED) or their designee for review and action if needed Date corrected by:11/07/24

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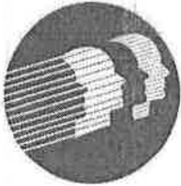

DELAWARE HEALTH AND SOCIAL SERVICES

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 - Millcroft Living Nursing Home

DATE SURVEY COMPLETED: October 2, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	being notified and signing off on the updated Resident Rights form. 5. 7/10/24 – R5 was admitted to the facility. The facility was unable to provide any documentation of R5 or R5's resident representative being notified and signing off on the updated Resident Rights form. 10/1/24 – Per interview with E1 (ED) and E3 (Clinical Specialist) at approximately 11:15 AM, both E1 and E3 confirmed the updated resident rights had not been provided to these or other residents. 10/2/24 – Findings were reviewed with E1, E2 (DRS) and E3 at the exit conference beginning at approximately 12:00 PM.	

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