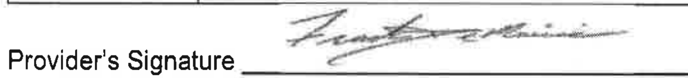
DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: The Vero at Newark DBA Juniper Village **DATE SURVEY COMPLETED:** December 18, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint Survey was conducted at this facility from December 16, 2024 through December 18, 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 one hundred thirty-four (134). The survey sample totaled fourteen (14) residents. Abbreviations/definitions used in this report are as follows: BOM – Business Office Manager; DOW – Director of Wellness; CFPM – Certified Food Protection Manager; Contract – A legally binding written agreement between the facility and the resident which enumerates all charges for services, materials, and equipment, as well as non-financial obligations of both parties, as specified in the State regulations; DHCFA (Delaware Health Care Facilities Association) - Program dedicated to enhance the quality of life of individuals in our facilities by promoting high standards of care. DHCFA supports its members in delivering accessible, efficient, quality long-term care and a continuum of related services to those they serve; EC – Executive Chef; EMAR – Electronic Medication Administration Record; FDOW – Former Director of Wellness;		

Provider's Signature  Title Executive Director, NHA Date 1/28/25

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	FSD – Food Service Director;		
	HR - Human Resources;		
	KS – Kitchen Staff;		
	LEA – Life Enrichment Associate;		
	LLAM – Limited Lay Administration of Medications;		
	LPN – Licensed Practical Nurse;		
	MC – Memory Care;		
	MCM – Memory Care Manager;		
	POM – Plant Operations Manager;		
	PS – Programs Supervisor;		
	RA – Resident Associate;		
	RDOW – Regional Director of Wellness;		
	Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse;		
	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	**Regulations for Assisted Living Facilities**	**3225.5.0**	

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: The Vero at Newark DBA Juniper Village **DATE SURVEY COMPLETED:** December 18, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.5.0 3225.5.2 S/S - E	**General Requirements** **All records maintained by the assisted living facility shall at all times be open to inspection and copying by the authorized representatives of the Department, as well as other agencies as required by state and federal laws and regulations. Such records shall be made available in accordance with 16 Del.C. Ch. 11, Subchapter I., Licensing by the State.** This requirement is not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for six (R2, R3, R5, R8, R9 and R14) out of ten resident charts sampled EMR entries, the facility lacked evidence of some resident information prior to the facility initiation of the new EMR system in May 2024. Findings include: 1. 5/11/23 – R2 was admitted to the facility. At the time of the survey, the EMR system in place began progress note entry on 5/25/24. The Surveyor was unable to access resident nursing progress notes for any incidents or resident concerns from 5/11/23-5/24/24. 2. 4/29/24 – R3 was admitted to the facility. At the time of the survey, the EMR system in place began progress note entry on 5/15/24. The Surveyor was unable to access resident nursing progress notes for any incidents or resident concerns from 4/29/23-5/14/24. 3. 8/24/23 – R5 was admitted to the facility. At the time of the survey, the EMR system in place contained no entries of resident nursing progress notes for any incidents or resident concerns from 8/24/23 to R5's discharge on 2/26/24.	Record Maintenance Available for inspection: 1. All residents have the potential to be impacted by this deficiency. Record retrieval for R2, R3, R5, R8, R9 and R14 is not able to be corrected. Due to change in management company and system change from Eldermark to Point Click Care, physical records prior to March 31st, 2024 were sent offsite to home office. Although they are retrievable it was made clear if not available at time of survey this would not be adequate. 2. We are aware this is a systemic issue reflective of all residents. An audit was not required for other residents. An audit is not relevant for widespread identification as we are aware hard copy records prior to March 31st, 2024 are offsite in storage due to the company management change. 3. We now are a subscriber to Point Click Care (PCC) which is tailored for paperless records and/or readily accessible access to surveyors and in our industry is considered a more appropriate regulatory compliant EMR. Such records are archived indefinitely and available for print copy.	

Provider's Signature [signature] Title Executive Director, NHA Date 1/28/25

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	4. 7/6/23 – R8 was admitted to the facility. At the time of the survey, the EMR system in place began progress note entry on 5/9/24. The Surveyor was unable to access resident nursing progress notes for any incidents or resident concerns from 7/6/23-5/8/24. 5. 4/4/23 - R9 was admitted to the facility. At the time of the survey, the EMR system in place began progress note entry on 6/2/24. The Surveyor was unable to access resident nursing progress notes for any incidents or resident concerns from 4/4/23-6/1/24. 6. 10/25/23 - - R14 was admitted to the facility. At the time of the survey, the EMR system in place began progress note entry on 5/15/24. The Surveyor was unable to access resident nursing progress notes for any incidents or resident concerns from 10/25/23-5/14/24. 12/17/24 – Per interview with E1 (ED) at approximately 11:30 AM, E1 confirmed the EMR system change and that records recorded in the old EMR system were supposed to transfer over to the current system but did not. The old EMR system notes were not printed to hard copy prior to change. The old EMR system is not able to currently be accessed. 12/17/24 – Per interview with E5 (RDOW) at approximately 1:30 PM, E5 stated the old system can be accessed but would take many difficult steps to do so. E5 stated she could go into the system to pull something specific that the Surveyor needed. Since there was no one specific date needed, the Surveyor did not request any be done. 12/18/24 – Findings were reviewed with E1, E2 DOW, E5, E7 (EC/FSD), E8 (AL Director of	To ensure deficient practice does not reoccur should any future change in electronic medical record system take place we will maintain both hard copy and electronic copy and server access. This was an unfortunate oversight in our transition to new systems and is very unlikely to reoccur. We are aware that adequate record maintenance and accessibility does not include Iron Mountain Storage and other offsite record maintenance. 4. To monitor deficient practice will not reoccur and quality assurance directives to put in place: Monthly review of move outs at QAA will specifically include acknowledgement by inspection DOW, ED or designee that physical medical record of thinned chart is in the appropriate storage location which is the DOW office. Audit in QAA will be maintained for 3 months or until 100% compliance is achieved and reported to QAA committee.	**6/1/24** **QAA (2/1/25)**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Sales/Marketing), E9 (Sales Advisor), E14 (Catalyst), E15 (Medical Concierge) and E16 (BOM/HR Partner) the exit conference, beginning at approximately 2:40 PM.	**3225.7.0** Specialized Care for Memory Impairment:	
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, provided, in addition to that care and treatment required by the rules and regulations herein.**	1. All residents in Wellspring (Memory Care) have the potential to be impacted by this deficiency. To correct deficiency of impacted residents the updated Specialized Care for Memory Impairment Disclosure will be shared with all residents/families who moved in after March 31st, 2025 when this practice was suspended.	
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:**	2. We are aware this is also a systemic issue reflective of all residents who moved into Wellspring after March 31st, 2024. An audit was not required for other residents. An audit is not relevant for widespread identification as we are aware the Specialized Care for Memory Impairment Disclosure Statement was not inclusive of the move in agreements after March 31, 2024 due to change in management entity which included a change in move in paperwork.	
3225.7.3.5	**Staffing Plan & Training Policies: staffing plan, orientation, and regular in-service education for specialized care;**		
3225.7.3.6	**Physical Environment: the physical environment and design features, including security systems, appropriate to support the functioning of adults with memory impairment;**		
3225.7.3.7	**Resident Activities: the frequency and types of resident activities;**		
3225.7.3.9 S/S - E	**Psychosocial Services: the process for addressing the mental health, behavior management, and social functioning needs of the resident;** This requirement was not met as evidenced by:	3. To ensure deficient practice does not reoccur all move in packets have been updated to include the Specialized Care for Memory Impairment Disclosure	

Provider's Signature [signature] Title Executive Director, NHA Date 1/28/25

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Based on interviews, review of marketing brochure "Celebrate your life in the third act", review of the "resident and services agreement", and review of the "addendum to residence and service agreement for memory care services", it was determined that the facility's memory care information disclosed to persons seeking specialized care for memory impairment in an assisted living facility failed to provide some elements of information. Findings include: The facility failed to provide the staffing plan & training policies including the staffing plan, orientation, and regular in-service education for specialized care; the physical environment of the memory care unit, the frequency and types of resident activities and the processes for addressing the mental health, behavior management, and social functioning needs of the resident. 12/18/24 - Per interview with E9 (Sales Advisor) at approximately 2:00 PM, E9 confirmed the information contained in the facility's materials may not contain all of the regulatory required information. E9 stated when prospective residents/families arrive for a tour, the Memory Care unit and services are discussed. 12/18/24 - Per interview with E8 (AL Director of Sales/Marketing) at approximately 2:05 PM, E8 confirmed the information contained in the facility's materials may not contain all regulatory required information. E8 stated prospective residents are given the resident services agreement and addendum agreement for Memory Care to review prior to being admitted. 12/18/24 – Per interview with E1 (ED) at approximately 2:15 PM, E1 stated the information may be lacking in the agreements and	Statement per our initial licensure standards. **The move in checklist** was updated to include this requirement for inspection/audit purposes. The 3 staff associates in sales and medical concierge were re-inserviced by Director of Wellness on re-implementation of this standard. **(see attachment 1A and 1B)** 4. To monitor deficient practice will not reoccur and quality assurance directives to put in place: Sales Manager, ED or designee will audit new move ins to ensure compliance with this practice. Audit in QAA will be maintained monthly * 3 months or until 100% compliance is achieved and reported to QAA committee.	**2/1/25**

DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: The Vero at Newark DBA Juniper Village **DATE SURVEY COMPLETED:** December 18, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	that the Company may have to include more information in the marketing materials to meet the regulatory requirements. 12/18/24 – Findings were reviewed with E1, E2 (DOW), E5 (RDOW), E7 (EC/FSD), E8, E9, E14 (Catalyst), E15 (Medical Concierge) and E16 (BOM/HR Partner) at the exit conference, beginning at approximately 2:40 PM.	**3225.8.0** Medication Management:	
3225.8.0 3225.8.8 3225.8.8.2 S/S - D	**Medication Management** **Concurrently with all UAI-based assessments, the assisted living facility shall arrange for an on-site medication review by a registered nurse, for residents who need assistance with self-administration or staff administration of medication, to ensure that:** **Each resident receives the medications that have been specifically prescribed in the manner that has been ordered;** This requirement was not met as evidenced by: Based on record review, interview, review of other facility documentation and the State Agency Reporting System, it was determined that for one (R3) out of fourteen residents sampled, the facility failed to administer the proper medications as ordered by the Physician. 4/29/24 – R3 was admitted to the facility. On 5/4/24 F1 (R3's daughter) brought to the attention of the nurse that her mother should only be receiving medications once per day, not twice per day. Per documentation review, research conducted by E25 (FDOW) revealed that the medications were listed on the EMAR twice. E25 notified the pharmacy and interviewed nurses and found that no nurse claim-	1. All residents have the potential to be impacted by this deficiency. The correction was already made at time of survey as this is a past non compliance notation. E26 was immediately removed from medication administration duties. E25 later provided observation of E26 passing medications and retrained E26 on the five rights for medication administration. 2. No other residents were identified as being impacted by this deficiency. A revised medication error report on the LLAM Annual Report was resubmitted to DHCFA on 12/17/24 to report E26's medication error. 3. Systemic Changes were already in place as this is a past non compliance. Surveyor reviewed facility documentation, training to staff, employee files and LLAM reports and found the facility to be in compliance. 4. No further QAA monitoring is required as facility maintains in compliance since date of deficiency correction 5/8/24	**This is a PAST NON-COMPLIANCE. Completion date 5/8/2** **This is a PAST NON-COMPLIANCE. Completion date 5/8/2**

Provider's Signature [signature] Title Executive Director, NHA Date 1/28/25

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	ed to have entered the medication in the EMAR and that the pharmacy only entered the medication once per day in the morning. E25 was unable to determine how the medications were listed a second time in the previously used EMAR system that did not confirm who entered medications. This double medication entry resulted in R3 receiving three medications (Donepezil, Lisinopril and Atorvastatin) twice per day for four days when the Physician order was for one time per day. The Physician was notified and E25 instituted retraining for all nurses and a new procedure with the facility pharmacy on data entry confirmation. E25 reviewed all of the residents' medications to ensure accuracy. R3 was closely monitored over the next 48 hours to observe for any untoward side effects of receiving double doses of the medications. The facility no longer utilizes the EMAR system that was in place during this error. 5/7/24 - At approximately 9:20 AM, E25 was notified by E26 (MA) that R3 received another resident's medication. E26 indicated she became distracted by another resident and inadvertently administered (Amlodipine, Lasix, Ferrous Sulfate, Metamucil, Vitamin C, Vitamin D, Eliquis and Magnesium Oxide) to R3. After R3 took the medication, R3 stated she usually does not take that much medication. E26 then notified the nurse on duty, E10 (LPN) of her error. The Physician and family were notified of the medication error and R3 was monitored hourly for untoward results from these medications. E26 was immediately removed from medication administration duties. E25 later provided observation of E26 passing medications and retrained E26 on the five rights for medication administration.		

Provider's Signature ____ Title Executive Director, NHA Date 1/28/25

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	12/17/24 – Per interview with E10 at approximately 10:00 AM, E10 confirmed the findings of both medication errors. E10 stated that E26 has had no medication errors since this incident. 12/17/24 – Per interview with E1 (ED) at approximately 2:00 PM, E1 completed a revised medication error report on the LLAM Annual Report and resubmitted that to DHCFA on 12/17/24 to report E26's medication error. E1 stated he was not aware of the error at the time of occurrence. 12/17/24 - Surveyor reviewed facility documentation, training to staff, employee files and LLAM reports and found the facility to be in compliance. 12/18/24 – Findings were reviewed with E1, E2 (DOW), E5 (RDOW), E7 (EC/FSD), E8, E9, E14 (Catalyst), E15 (Medical Concierge) and E16 (BOM/HR Partner) at the exit conference, beginning at approximately 2:40 PM. **This is a PAST NON-COMPLIANCE. Completion date 5/8/24**		
3225.10.0 3225.10.10 S/S - D	**Contracts** **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 cannot agree on the services and fees upon completion of the assessment.** This requirement was not met as evidenced by:	**3225.10** Contracts: 1. All residents have the potential to be impacted by this deficiency. In this circumstance a contract (move in agreement) was signed "pending" the level of care assessment. The original UAI was in fact conducted, however they took financial occupancy (not having physically moved in) as there was a delay in physical move in. It is understood, however, that based on the language of the regulation a deficiency was noted as the UAI was redone the day of actual move in. R3 could not be corrected due to past timeline of deficiency, however, is up	

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Based on record review, interview and review of other facility documentation, it was determined that for one (R3) out of fourteen residents sampled, the facility lacked failed to complete the full assessment and service agreement prior to the resident signing the contract. Findings include: 4/29/24 – R3 was admitted to the facility. The UAI was completed on 4/26/24 and the Service Agreement was executed on 4/26/24. The contract was signed on 4/13/24, prior to the assessments being completed. 12/17/24 – Per interview with E16 (BOM) at approximately 11:00 AM, E16 confirmed the contract signing date. 12/18/24 – Findings were reviewed with E1 (ED), E2 DOW, E5 (RDOW), E7 (EC/FSD), E8 (AL Director of Sales/Marketing), E9 (Sales Advisor), E14 (Catalyst), E15 (Medical Concierge) and E16 the exit conference, beginning at approximately 2:40 PM.	to date on recurring and current service plan(s). 2. No other residents were identified as being impacted by this deficiency. This was an unusual situation based on an unforeseen delay in physical move in. Future occurrences if applicable will require a new UAI 24 hours prior to completion of move in agreement as one's condition may change and engaging in a contract for someone not appropriate level of care at minimum is wasteful of family and resident time and/or may not meet the code.	
3225.11.0 3225.11.3 S/S - D	**Resident Assessment** **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 one (R7) out of fourteen residents sampled, the facility lacked evidence of a Physician's evaluation within 30 days prior to admission. Findings include:	3. Systemic Changes are in place. **The move in checklist** was updated to include this requirement for inspection/audit purposes. The 3 staff associates in sales and medical concierge were reinserviced by Director of Wellness regarding enforcement of this standard. **(see attachment 1A and 2B)** 4. To monitor deficient practice will not reoccur and quality assurance directives to put in place: Sales Manager, ED or designee will audit new move ins to ensure compliance with this practice. Audit in QAA will be maintained monthly * 3 months or until 100% compliance is	2/1/25

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	11/13/24 – R7 was admitted to the facility. The medical evaluation was signed by the Physician on 10/9/24. However, the actual visit between R7 and the Physician was performed on 9/20/24, over 30 days prior to admission. 12/18/24 – Per interview with E2 (DOW) and E5 (RDOW) at approximately 2:00 PM, it was confirmed that the actual documented visit to the Physician was over 30 days prior to admission. 12/18/24 – Findings were reviewed with E1 (ED), E2, E5, E7 (EC/FSD), E8 (AL Director of Sales/Marketing), E9 (Sales Advisor), E14 (Catalyst), E15 (Medical Concierge) and E16 (BOM/HR) the exit conference, beginning at approximately 2:40 PM.	achieved and reported to QAA committee. **3225.12.0** Food Protection Manager: 1. All residents have the potential to be impacted by this deficiency. Updated SafeServe certification was not in place for Executive Chef and/or enough Cooks to adequately meet regulation. Executive Chef is being scheduled for re-certication 2. No other residents were identified as being impacted by this deficiency. Audit supports we do not have SafeSeve or other acceptable credentialing to meet this requirement among current staff due to turn over. 3. Systemic Changes are in place. **New hire orientation requirements** for cooks/chefs will include obtaining certification within 90 days from hire (based on availability of training) 4. To monitor deficient practice will not reoccur and quality assurance directives to put in place: Executive Chef will provide Audit in QAA ensuring at least one cook/chef has active certification (reviewing	
3225.12.0 **3225.12.1** **3225.12.1.3** **S/S - F**	**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: **2-101.11 Assignment. (A) Except as specified in ¶ (B) of this section, the PERMIT HOLDER shall be the PERSON IN CHARGE or shall designate a PERSON IN CHARGE and shall ensure that a PERSON IN CHARGE is present at the FOOD ESTABLISHMENT during all hours of operation.** **2-102.12 Certified Food Protection Manager (A) At least one employee, the PERSON IN**		**2/1/25**

Provider's Signature [signature] Title Executive Director, NHA Date 1/28/25

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	CHARGE at the time of inspection, shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM. 12/16/24 – During the survey of the facility, documentation reviewed showed that E7 (EC/FSD) had a CFPM certificate that expired in July of 2024. No other employees held the Certified Food Protection Manager certification. 12/16/24 - During an interview with E7 at approximately 11:00 AM, E7 confirmed that there was not a CFPM in charge. **3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by: (1) Except as specified in (1)(d) below, separating raw animal FOODS during storage, preparation, holding, and display from: (a) Raw READY-TO-EAT FOOD including other raw animal FOOD such as FISH for sushi or MOLLUSCAN SHELLFISH, or other raw READY-TO-EAT FOOD such as fruits and vegetables.** 12/16/24 – During the initial tour of the kitchen at approximately 9:30 AM, inside the walk-in refrigerator, revealed raw bacon was stored on a tray above a tray of gelatin dessert. 12/16/24 - During an interview with E7 at approximately 9:30 AM, E7 confirmed the storage positioning of the raw bacon was above the gelatin dessert. **3-304.14 Wiping Cloths, Use Limitation. (B) Cloths in-use for wiping counters and other**	changes in shift or schedule) to ensure a SafeServe credentialed associate is in place throughout dining hours. This will be maintained for 3 months or until 100% compliance is achieved and reported to QAA committee. 3-304.14 Wiping Cloth Limitation: 1. All residents have the potential to be impacted by this deficiency. Deficiency was corrected at time of survey and associate re-inserviced. 2. No other residents were identified as being impacted by this deficiency. Executive Chef continues to observe for repeat deficiencies. **(In-Service Attachment 3.0)** 3. Systemic Changes are in place. **Sanitation Procedures** and observation for this deficiency is added to the **Sanitation/Food & Beverage Checklist (5)** to ensure compliance.	

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

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

STATE SURVEY REPORT

NAME OF FACILITY: The Vero at Newark DBA Juniper Village **DATE SURVEY COMPLETED:** December 18, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	EQUIPMENT surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under § 4-501.114. 12/16/24 – During the initial tour of the kitchen at approximately 9:30 AM, a soiled wiping cloth was observed lying on a food prep surface and not stored in a chemical sanitizer. 12/16/24 – During interview with E7 at approximately 9:30 AM, E7 confirmed the findings. This surveyor asked where the sanitizing buckets for cloth storage were and E7 reported that they had not been prepped yet. E7 immediately prepped, tested, and positioned the sanitizing solution for use. **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: (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor.** 12/16/24 – During the initial tour of the kitchen at approximately 9:30 AM, the walk-in refrigerator revealed uncovered desserts on a shelf and sodas stored in a bin on the floor. 12/16/24 – During an interview with E7 at approximately 9:30 AM, E7 confirmed the findings. **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**	4. To monitor deficient practice will not reoccur and quality assurance directives to put in place: Executive Chef will provide Audit in QAA ensuring a 10% sample of **Sanitation/Food & Beverage Checklist (5)** from prior month **monthly.** This will be maintained monthly *3 months or until 100% compliance is achieved and reported to QAA committee. **3-305.11** Food storage: 1. All residents have the potential to be impacted by this deficiency. Deficiency was corrected at time of survey and associate re-inserviced. 2. No other residents were identified as being impacted by this deficiency. Executive Chef continues to observe for repeat deficiencies. **(In-Service Attachment 3.0)** 3. Systemic Changes are in place. **Sanitation Procedures** and observation for this deficiency is added to the **Sanitation/Food & Beverage Checklist (5)** to ensure compliance (covered/dated). 4. To monitor deficient practice will not reoccur	**2/1/25**

Provider's Signature [signature] Title Executive Director, NHA Date 1/28/25

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	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. 12/16/24 -Review of food temperature log documentation revealed 177 out of 228 or 78% of food temperatures were not logged between October 1 and December 15, 2024. **3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (D) A date marking system that meets the criteria stated in ¶¶ (A) and (B) of this section may include: (2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (A) of this section; (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (B) of this section;** 12/16/24 - During the initial tour of the kitchen at approximately 9:30 AM, dry storage was observed with food items that were not dated when opened to include: pasta, biscuit gravy mix, and corn flakes. The walk-in refrigerator was observed with prepped items that were dated but not discarded timely to include: egg salad dated 12/6/24, biscuit gravy dated 12/5/24, chili dated 11/18/24, corn beef hash dated 12/7/24, and ham slices dated 11/29/24. 12/16/24 - During an interview with E7 at approximately 9:30 AM, E7 confirmed the findings.	and quality assurance directives to put in place: Executive Chef will provide Audit in QAA ensuring a 10% sample of **Sanitation/Food & Beverage Checklist (5)** from prior month **monthly.** This will be maintained monthly * 3 months or until 100% compliance is achieved and reported to QAA committee. **3-501.16** Time/Temperature: 1. All residents have the potential to be impacted by this deficiency. Deficiency was corrected at time of survey and associates re-in-serviced. 2. No other residents were identified as being impacted by this deficiency. Executive Chef continues to observe for repeat deficiencies. **(In-Service Attachment 3.0)** 3. Systemic Changes are in place. **Temperature Control Logs** are already a standard per policy and procedure quality assurance and continued monitoring will be needed. 4. To monitor deficient practice will not reoccur	2/1/25 2/1/25

Provider's Signature [signature] Title Executive Director, NHA Date 1/28/25

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	4-601.11 Equipment, Food-Contact Surfaces, Nonfood- Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) Nonfood-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 12/16/24 - Direct observation of the kitchenette in the memory care unit at approximately 10:45 AM revealed residue in the sink and inside the refrigerator at the base. 12/16/24 – During an interview with E23 (RA) at approximately 10:45 AM, E23 confirmed the findings. 12/16/24 - Through interviews with E7 and E24 (LEA), confirmation of whose responsibility it was to clean the sink and refrigerator was unable to be attained. During an interview with E7 at approximately 10:46 AM, E7 reported that the cleaning of this area would be addressed with the food service department and added to their responsibilities. 12/16/24- Findings were reviewed with E1 (ED) and E7 at the environmental exit conference beginning at approximately 2:30 PM.	Executive Chef will provide Audit in QAA ensuring all **Temperature Logs showing temp and signature** from prior month **monthly.** This will be maintained for 3 months or until 100% compliance is achieved and reported to QAA committee. **<u>4-601.11</u>** <u>Equipment/Food Service</u>: 1. All residents have the potential to be impacted by this deficiency. Deficiency was corrected at time of survey and associate(s) re-inserviced. 2. No other residents were identified as being impacted by this deficiency. Executive Chef continues to observe for repeat deficiencies. **(In-Service Attachment 3.0)** 3. Systemic Changes are in place. **Sanitation Procedures** and observation for this deficiency is added to the **Sanitation/Food & Beverage Checklist (5)** to ensure compliance (covered/dated). 4. To monitor deficient practice will not reoccur	
3225.13.0	**13.0 Service Agreements**		
3225.13.3 S/S - E	**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:	and quality assurance directives to put in place	**2/1/25**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Based on record review, interview and review of other facility documentation, it was determined that for eight (R2, R3, R6, R7, R8, R9, R11 and R14) out of ten resident sampled Service Agreements, the facility lacked evidence of the residents' personal attending Physician's address and phone number. Findings include: 1. 5/11/23 – R2 was admitted to the facility. The Service Agreement completed on 11/3/24 did not contain the R2's personal attending Physician's address and phone number. 2. 4/29/24 – R3 was admitted to the facility. The Service Agreement completed on 4/26/24 did not contain the R3's personal attending Physician's address and phone number. 3. 10/31/24 - R6 was admitted to the facility. The Service Agreement completed on 10/31/24 did not contain the R6's personal attending Physician's address and phone number. 4. 11/13/24 – R7 was admitted to the facility. The Service Agreement completed on 10/23/24 did not contain the R7's personal attending Physician's address and phone number. 5. 7/6/23 – R8 was admitted to the facility. The Service Agreement completed on 8/6/24 did not contain the R8's personal attending Physician's address and phone number. 6. 4/4/23 – R9 was admitted to the facility. The Service Agreements completed on 4/4/24 and 5/14/24 did not contain the R9's personal attending Physician's address and phone number.	Executive Chef will provide Audit in QAA ensuring a 10% sample of **Sanitation/Food & Beverage Checklist** from prior month **monthly.** This will be maintained monthly * 3 months or until 100% compliance is achieved and reported to QAA committee. **3225.13.0** Service Agreements: 1. All residents have the potential to be impacted by this deficiency. In review our current Point Click Care did not have an option to include the physician demographics. A work order has been requested for PCC to integrate population fields to include this requirement. All impacted residents (R2, R3, R6, R7, R8, R9, R11 and R14) have been corrected by manually including the physician information required. 2. It was found that all residents were in fact affected by the same deficiency. All charts have been updated to include the physician information required. Director of Wellness Re-Inserviced Medical Concierge on requirement. 3. Systemic Changes are in place. A "work ticket" has been requested of Point	

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	7. 6/6/24 – R11 was admitted to the facility. The Service Agreement completed on 6/6/24 did not contain the R11's personal attending Physician's address and phone number. 8. 10/25/23 – R14 was admitted to the facility. The Service Agreement completed on 8/20/24 did not contain the R14's personal attending Physician's address and phone number. 12/18/24 – Per interview with E5 (RDOW) at approximately 2:00 PM, it was confirmed that the Service Agreement form the facility is utilizing does not contain the residents' personal attending Physician's address or phone number. E5 indicated that the current EMR system may be able to be updated to include this information, the facility will obtain the Physician's ink stamp containing the required information and manually add to all the Service Agreements. 12/18/24 – Findings were reviewed with E1 (ED), E2 (DOW), E5, E7 (EC/FSD), E8 (AL Director of Sales/Marketing), E9 (Sales Advisor), E14 (Catalyst), E15 (Medical Concierge) and E16 (BOM/HR) the exit conference, beginning at approximately 2:40 PM.	Click Care (PCC) In the interim we are manually including the information on new move ins. 4. To monitor deficient practice will not reoccur and quality assurance directives to put in place: Medical Concierge or designee will provide Audit in QAA ensuring all **Move In Charts** from prior month **monthly** have the appropriate physician information recorded. This will be maintained monthly * 3 months or until 100% compliance met.	**2/1/25**
3225.14.0 3225.14.1 S/S - E	**Resident Rights** **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.** **§ 1121. Resident's rights. (b) It is the public policy of this State that the interests of the resident must be protected by a declaration of a resident's rights, and by requiring that all facilities treat their residents in accordance with such rights, which must include the following: (1) Each resident shall have the right**	**3225.14.0** Resident Rights: 1. All residents have the potential to be impacted by this deficiency. Gloves were worn by one associate in memory care during the dining process and re-educated by Executive Chef and Executive Director. 2. It was found that all residents were in fact affected by the same deficiency who were served for that meal. No reoccurrence was observed throughout the remaining survey or subsequent observation after by Executive Director or Department Manager. **(In-Service Attachment 3.0)**	

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality. Based on observations and interview it was determined that one staff member utilized gloves while serving residents in the dining room infringing on their right to dignity in their home environment. 12/16/24 – During an observation of lunch service in the memory care unit at approximately 12:30 PM, E24 (LEA) was observed wearing gloves in the dining area while serving resident drink items to multiple residents. 12/16/24 - During an interview with E24 at approximately 12:40 PM, E24 confirmed the findings. 12/16/24- Findings were reviewed with E1 (ED) and E7 (EC/FSD) at the environmental exit conference beginning at approximately 2:30 PM.	**Sanitation Procedures** and observation for this deficiency is added to the **Sanitation/Food & Beverage Checklist (5)** to ensure compliance (covered/dated). 3. Systemic Changes are in place. Facility will continue in training re-enforcement of basic resident rights expectations and through meal serving. An associate from food and beverage is being assigned in memory care to ensure consistency of standard in assisted living. 4. To monitor deficient practice will not reoccur and quality assurance directives to put in place: Executive Chef will provide Audit in QAA ensuring a 10% sample of **Sanitation/Food & Beverage Checklist** from prior month **monthly.** This will be maintained monthly * for 3 months or until 100% compliance is achieved and reported to QAA committee.	2/1/25

Provider's Signature [signature]   Title Executive Director, NHA   Date 1/28/25