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: Meadowcrest at Middletown Senior Living **DATE SURVEY COMPLETED: March 30, 2026**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual and Complaint Survey was conducted at this facility from March 26, 2026, through March 30, 2026. The deficiencies contained in this report are based on interview, record review, review of other facility documentation and State Agency Incident reports. The facility census on the first day of the survey was sixty-seven (67). The survey sample totaled nine (9) residents plus six (6) additional subsampled residents. Abbreviations/definitions used in this state report are as follows: ARSD – Assistant Resident Services Director; C – Consultant; CSD – Culinary Services Director; ED - Executive Director; EMR – Electronic Medical Record; FO - Facilities Operation; HD – Housekeeping Director; RSD – Resident Services Director; 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,		
3225.0	**Assisted Living Facilities**		
3225.1.0	**Purpose** **The Department of Health and Social Services is issuing these regulations to promote and ensure the health, safety, and well-being of all residents of assisted living facili-**		

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	tles. These regulations are also meant to ensure that service providers will be accountable to their residents and the Department, and to differentiate assisted living care from skilled nursing care. The essential nature of assisted living is to offer living arrangements to medically stable persons who do not require skilled nursing services and supervision. The regulations establish the minimal acceptable level of services for residents of assisted living facilities.		
3225.8.0 **3225.8.6** **S/S – D**	**Medication Management** **Within 30 days after a resident's admission and concurrent with all UAI-based assessments, the assisted living facility shall arrange for an on-site review by an RN of the resident's medication regime if he or she self-administers medication. The purpose of the on-site review is to assess the resident's cognitive and physical ability to self-administer medication or the need for assistance with or staff administration of medication.** This requirement was not met as evidenced by: Based on interview, record review and other facility documentation, it was determined that for one (R3) out of four residents sampled for self-administration of medication assessments, the facility failed to have evidence on file of an evaluation completed concurrently with all UAI-based assessments. Findings include: 9/13/21 – R3 was admitted to the facility. The last self-administration of medication assessment in evidence for R3 was completed on	• A licensed RN completed a current self-administration medication assessment for R3 on 3/30/3026 • A full audit of all residents who are self-administers was completed on 6/15/2026 • The EMR assessment workflow was updated to generate a required RN medication self-administration assessment task whenever a UAI is initiated. The RSD and ARSD trained on the new workflow by Executive Director • RSD and/or ARSD will audit 10% of all UAI assessments monthly for six months to ensure the RN education assessment is present. Results will be reviewed in monthly QA meetings	7/01/26

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	10/4/24. The facility lacked evidence of an assessment completed with the 4/15/25 or 9/19/25 UAI-based assessments. 3/30/26 2:30 PM – Per interview with E3 (RSD), E3 confirmed the two assessments were not in evidence. 3/30/26 - Findings were reviewed with E1 (ED), E2 (C), E3, E4 (ARSD), E6 (CSD) and E7 (FO) at the exit conference, beginning at approximately 2:40 PM.		
3225.9.0 **3225.9.5** **3225.9.6** **S/S – D**	**Infection Control** **Requirements for tuberculosis and immunizations:** **The assisted living facility shall have on file evidence of annual vaccination against influenza for all residents, as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against 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.** This requirement was not met as evidenced by: Based on interview, record review and other facility documentation, it was determined that for one (R9) out of nine residents sampled for Influenza vaccine, the facility failed	• R9 physician was contacted; vaccination status was verified. A signed declination was obtained on 6/15/26 and filed in the EMR. • A full audit of all resident influenza vaccine records for 2025-2026 was completed. Missing documentation was corrected by obtaining physician records or declinations. • A new annual immunization checklist was added to the admission packet. EMR alerts now require completion of influenza field before admission can be finalized. • RSD and/or ARSD will run a monthly immunization compliance report for six months. Any missing documentation must be corrected within 72 hours.	7/01/26

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	to have evidence on file of an annual vaccination against influenza or a declination of such. Findings include: 10/15/25 – R9 was admitted to the facility. There was no evidence of a 2025 Influenza vaccination being administered or of a declination of such. 3/30/26 2:30 PM – Per interview with E3 (RSD), E3 confirmed the influenza data was not in evidence. 3/30/26 - Findings were reviewed with E1 (ED), E2 (C), E3, E4 (ARSD), E6 (CSD) and E7 (FO) at the exit conference, beginning at approximately 2:40 PM.		
3225.12.0	**Services**		
3225.12.1	**The assisted living facility shall ensure that:**		
3225.12.1.3 **S/S – F**	**Food service complies with the Delaware Food Code** **Delaware Food Code** This requirement was not met as evidenced by: Based on observations and interview it was determined that the facility failed to comply with the Delaware Food Code. Findings include: **6-501.12 Cleaning, Frequency and Restrictions.** **(A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.**	• All sinks were cleaned immediately on 3/30/26. All sanitizer buckets were placed and rested at correct ppm levels. CSD re-tested and documented compliance. • A full kitchen sanitation audit was completed_3/30/2026, including all sinks, pre areas, and sanitizer stations. Any out-of-compliance areas were corrected the same day • A daily kitchen sanitation checklist was implemented 3/30/2026. Staff retrained by Culinary Director on proper sanitizer concentration testing and documentation. New color-coded sanitizer buckets were purchased to prevent misuse • CSD will perform daily sanitizer ppm checks and weekly sink inspections.	7/01/26

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	3/30/26 10:00 AM – During the survey of the facility, an observation of three hand washing sinks revealed the presence of residue. This was evident in two sinks in the kitchen area and one sink in the service area. 3/30/26 10:00 AM – During an interview with E6 (CSD), the findings were confirmed. **7-204.11 Sanitizers, Criteria.** **Chemical SANITIZERS, including chemical sanitizing solutions generated on-site, and other chemical antimicrobials applied to FOOD-CONTACT SURFACEs shall:** **(A) Meet the requirements specified in 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (Food-contact surface sanitizing solutions).** 3/30/26 10:00 AM – During the survey of the facility, an observation of E6 (CSD) testing the Sanitation Solution revealed the solution in two out of three sanitizer buckets were below the required sanitation levels reading the minimum of 0 ppm. 3/30/26 - Findings were reviewed with E1 (ED), E2 (C), E3 (RSD), E4 (ARSD), E6 and E7 (FO) at the exit conference, beginning at approximately 2:40 PM.	ED will review sanitation logs weekly for six months	
3225.13.0 **3225.13.3** **S/S – E**	**Service Agreements** **The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.**	• All five service agreements were corrected with complete physician information by 3/30/26	

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	This requirement was not met as evidenced by: Based on interview, record review and other facility documentation, it was determined that for five (R1, R4, R6, R8 and R9) out of nine residents sampled for service agreements, the facility failed to provide the resident's personal physician's name, address and phone number. Findings include: 1. 2/25/26 - R1 was admitted to the facility. The service agreement completed on 2/16/26 failed to provide any of the personal physician's information. 2. 1/30/26 - R4 was admitted to the facility. The service agreement completed on 1/13/26 failed to provide any of the personal physician's information. 3. 10/1/24 - R6 was admitted to the facility. The service agreement completed on 10/2/25 failed to provide any of the personal physician's information. 4. 11/4/25 - R8 was admitted to the facility. The service agreement completed on 11/12/25 contained the name and phone number but failed to provide the address of the personal physician's information. 5. 10/15/25 - R9 was admitted to the facility. The service agreement completed on 10/14/25 failed to provide any of the personal physician's information. 3/30/26 2:30 PM – Per interview with E3 (RSD), E3 stated the current EMR system had	• A full audit of all current service agreements was completed. Missing physician information was obtained and updated_3/30/2026 • EMR template updated to require physician name, address, and phone number before the agreement can be finalized. RSD and ARSD retrained on the updated workflow by Executive Director • RSD and/or ARSD will audit all new admissions weekly for 90 days, then monthly for six months. Any missing information must be corrected within 24 hours.	7/01/26

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	been deleting some entered information but confirmed the physician's information was not in evidence. 3/30/26 - Findings were reviewed with E1 (ED), E2 (C), E3, E4 (ARSD), E6 (CSD) and E7 (FO) at the exit conference, beginning at approximately 2:40 PM.		
3225.18.0	**Emergency Preparedness**		
3225.18.1 **S/S - F**	**18.1 Nursing facilities shall comply with the rules and regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction.** This requirement was not met as evidenced by: Based on observations, interview, and review of other facility documentation it was determined that the facility failed to comply with NFPA 25 standards. Findings include: 3/30/26 2:00 PM – During the survey of the facility, documentation review of the annual inspection of the sprinkler and fire system, completed by Anaconda on January 27, 2026, identified recommended repairs, including replacement of three water gauges due to age and replacement of a backflow relief valve. The inspection also noted that both K-Class fire extinguishers are due for hydrostatic testing. Additionally, the ABC fire extinguisher on the bus has been due for its six-year service since	• Repairs were scheduled with Anaconda and completed on 4/22/26 and 5/7/26. Updated inspection certificates were obtained and filed 6/8/26. • A full review of all fire safety equipment was completed, including extinguishers, gauges, alarms, and suppression systems. Any additional items requiring service were scheduled • Facility Operations implemented a Fire Safety Compliance Calendar with automatic reminders 60 days before due dates. • Facility Operations will review fire safety log weekly • Executive Director will verify compliance monthly for six months and results will be reported in QA meetings	7/01/26

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	2023. These recommendations are based on NFPA 25 standards. 3/30/26 2:00 PM – During an interview with E7 (FO), the surveyor requested additional information to indicate whether the deficiencies identified were addressed. It was revealed that Anaconda, the fire and safety company, was awaiting a response from the facility to schedule the repairs. E7 had reported that after speaking with Anaconda that the repairs are now scheduled. 3/30/26 - Findings were reviewed with E1 (ED), E2 (C), E3 (RSD), E4 (ARSD), E6 (CSD) and E7 at the exit conference, beginning at approximately 2:40 PM.		

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