



**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

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NAME OF FACILITY: The Village at Mount Hope

DATE SURVEY COMPLETED: August 5, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225.0 3225.1.0	An unannounced Initial Survey was conducted at this facility on August 5, 2026. The deficiencies contained in this report are based on interviews, record review, and review of other facility documentation. The facility census on the first day of the survey was four (4). The survey sample totaled two (2) residents. Abbreviations/definitions used in this report are as follows: DON – Director of Nursing; FEMA – Federal Emergency Management Agency; LLAM – Limited Lay Administration of Medications; O – Owner; RCA – Resident Care Aide. Assisted Living Facilities 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 facilities. 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.		

Provider's Signature

H. Rossi RN

Title

ED

Date

9/10/26



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3225.8.5 3225.8.1.5 3225.8.1.5.3 S/S - D	Medication Management Provision for a quarterly pharmacy review conducted by a pharmacist which shall include: Review of each resident's medication regimen with written reports noting any identified irregularities or areas of concern. 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 (R1 and R2) out of four residents sampled, the facility lacked evidence that the quarterly pharmacy review of each resident's medications was completed for the second quarter of 2026. Findings include: 1. 1/29/26 - R1 was admitted to the facility. 8/5/26 - Per the review of R1's medical record and the pharmacy documentation, the 2nd quarter review was not in evidence. 2. 1/29/26 - R2 was admitted to the facility. 8/5/26 - Per the review of R2's medical record and the pharmacy documentation, the 2nd quarter review was not in evidence. 8/5/26 10:40 AM - During an interview, E2 (DON/O) confirmed the second quarter pharmacy review was not in evidence for any of the active residents. E2 stated the pharmacist is scheduled to come in August and will be reminded that quarterly reviews are required. 8/5/26 - Findings were reviewed with E2 and E3 (O) at the exit conference, beginning at approximately 3:00 PM.	A. R1 and R2 were affected by the missing second-quarter pharmacy-review documentation. The consultant pharmacist completed a comprehensive pharmacy review for R1, R2, and all current residents on August 15, 2026. Written reports are maintained in the resident records. Responsible: Administrator/DON. B. The Administrator/DON reviewed 100% of current residents for the same potential deficiency. All current residents received the required pharmacy review on August 15, 2026 and were added to the quarterly tracking process. C. Root cause: there was no formal process to verify that quarterly pharmacist reviews were completed and received. A quarterly pharmacy-review tracking log was implemented. The Administrator/DON or designee will verify completion and receipt of each written report at the end of every quarter and follow up immediately on any missing review. D. Goal: 100% of residents will have a documented pharmacist medication-regimen review each quarter. The Administrator/DON or designee will audit 100% of active resident records at the end of each quarter using the tracking log. Missing reviews will be corrected immediately and audit results retained in QA records.	8/15/2026

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3225.14.0 3225.14.1 S/S - D	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. 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 under § 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 that for two (R1 and R2) out of four 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 form. Findings include: The Resident Rights form (updated September 2023) required each resident or resident representative to sign and date to acknowledge the receipt of a copy of the Resident Rights. 1. 1/29/26 - R1 was admitted to the facility. The facility had on file the outdated Resident Rights Information, not the updated Resident Rights form. 2. 1/29/26 - R2 was admitted to the facility. The facility had on file the outdated Resident Rights Information, not the updated Resident Rights form. 8/5/26 11:30 AM - During an interview, E2 (DON/O) confirmed the resident rights version utilized by the facility was the outdated one, not the updated version.	A. On August 5, 2026, R1 and R2 were provided the current September 2023 DHSS Resident Rights and signed/dated acknowledgments were placed in their records. Responsible: Administrator/DON. B. The Administrator/DON reviewed 100% of current resident records. All current residents and/or authorized representatives received the current September 2023 Resident Rights and completed signed/dated acknowledgments on August 5, 2026. C. Root cause: an outdated form remained in use without a process to verify the current State-issued version. The facility replaced the obsolete form and added verification of the current Resident Rights and signed acknowledgment to the admission checklist. The Administrator/DON or designee will verify the current DHSS version when regulatory updates are received. D. Goal: 100% compliance. The Administrator/DON or designee will audit 100% of new admission records within 72 hours for the current rights form and signed acknowledgment and will verify the State-issued version quarterly. Any deficiency will be corrected immediately and documented on the resident-record audit tool.	8/5/2026

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3225.17.0 3225.17.1	Environment and Physical Plant Each assisted living facility shall comply with applicable federal, state and local laws Assisted living facilities shall: Be in good repair; Be clean; Have a hazard-free environment Based on interview, it was determined that the facility failed to comply with the Delaware water quality standards ensuring potable water for residents. Findings include: 8/5/26 12:30 PM - During the survey of the facility and an interview with E3 (O) confirmed the water quality testing had not been conducted through a certified laboratory to ensure the water conforms to safety standards. 8/5/26 - Findings were reviewed with E2 (DON/O) and E3 at approximately 2:00 PM.	A. The impacted area is the facility private-well drinking-water system. The facility contacted the Delaware Public Health Laboratory and a water sample was delivered on August 26, 2026. Certified laboratory results are pending. Responsible: Administrator. B. Because the private well supplies the entire facility, all residents and potable-water areas have the potential to be affected. The Administrator will review the certified result facility-wide and promptly implement and document any required corrective measures if a result is outside an acceptable standard. C. Root cause: there was no formal environmental-compliance tracking process to ensure certified private-well testing was obtained and retained. The facility established a water-quality compliance file and tracking process. Future testing will be through the Delaware Public Health Laboratory or another appropriately certified drinking-water laboratory. Responsible: Administrator or designee. D. Goal: 100% completion and retention of required certified water-quality testing. The Administrator/designee will track the pending report until received, document review and any required corrective action, then review the water-quality compliance file quarterly. The tracking log and laboratory reports will be the audit tools.	9/8/2026

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3225.17.2 3225.17.2.1 3225.17.2.2 3225.17.2.3 S/S - F	Emergency Preparedness Nursing facilities shall comply with the rules and regulations adopted and enforced by the State Fire Prevention Commission or the municipality with jurisdiction. Based on observation and interview, it was determined that the facility failed to comply with sprinkler protection and Delaware fire extinguisher requirements. Findings include: 8/5/26 12:00 PM – During the survey of the facility, an observation of the fire protection system revealed it was not in operation. 8/5/26 12:00 PM – During an interview, E3 (O) stated that work was still being completed on the sprinkler system and that the system was not operational. A letter or other documentation of approval from the Fire Marshal having jurisdiction was not available for review. 8/5/26 – Findings were reviewed with E2 (DON/O) and E3 at approximately 2:00 PM.	A. The impacted area is the facility fire-protection system. The facility contacted the authority having jurisdiction for clarification and written direction. Based on the fire-safety recommendation received, an interim fire watch was implemented. Rounds occurred approximately every 60 minutes, with designated personnel physically touring and observing all important areas of the building within 45 minutes. Rounds are documented. Responsible: Administrator. B. Because fire protection affects the entire building, all residents, staff, and facility areas have the potential to be affected. The fire watch applies facility-wide. The Administrator/designee ensures all important areas are included and sufficient personnel are available to complete the building tour within 45 minutes. C. Root cause: sprinkler-system work was in progress and written approval/clarification from the authority having jurisdiction was not available at survey. The facility implemented the recommended interim fire-watch procedure and Fire Watch/Safety Rounding Log. Fire Marshal correspondence, determinations, inspections, approvals, and recommendations will be retained in the life-safety file. Monitoring continues until the sprinkler system is operational and/or further written Fire Marshal direction is received. D. Goal: 100% completion and documentation of required interim fire-watch rounds. The Administrator/designee will review the Fire Watch/Safety Rounding Log daily for missed rounds, incomplete tours, or hazards. Any issue will be addressed immediately. Logs will be retained in the life-safety file until further Fire Marshal direction or sprinkler restoration.	8/10/2026
3225.18.0 3225.18.1 S/S - F			

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S/S - F	700 Delaware State Fire Prevention Regulations 703 Installation, Operation, Maintenance, Testing and Sales of Signaling Systems, Fire Protection Systems and Fire Extinguishers Chapter 1 Operation, Maintenance, and Testing of Fire Protection Systems 2.0 Servicing or Repair of Portable Fire Extinguishers 2.3 Servicing of Fire Extinguishers 2.3.1 All portable fire extinguishers shall be serviced or maintained on an annual (every 12 months) basis. Based on interview and documentation review, it was determined that the facility failed to maintain the facility fire extinguishers. Findings include: 8/5/26 11:00 AM – During the survey of the facility, an observation of the fire extinguisher located in the kitchen revealed the initial date the extinguisher was assessed was April 7, 2025. In addition, the tamper seal was missing from the extinguisher. 8/5/26 11:00 AM – During an interview, E3 (O) revealed this was the date when the extinguisher was purchased and it had not completed annual servicing. 8/5/26 – Findings were reviewed with E2 (DON/O) and E3 at approximately 2:00 PM.	A. On August 5, 2026, the identified fire extinguishers, including the kitchen extinguisher cited during survey, were replaced. Responsible: Administrator. B. The Administrator reviewed all facility portable fire extinguishers for overdue service, missing seals, improper placement, and other visible concerns. Corrective action applies to all facility extinguishers. C. Root cause: there was no formal tracking process for annual extinguisher servicing and routine condition checks. A monitoring process was implemented to track annual service dates and routine visual checks for placement, condition, tamper seals, pressure/status, and service documentation. Responsible: Administrator or designee. D. Goal: 100% of facility extinguishers will be maintained in compliant condition with current required servicing. The Administrator/designee will visually inspect 100% monthly and document findings on a fire-safety checklist. Annual professional servicing dates will.	8/5/2026

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3225.18.2 S/S - F	Regular fire drills shall be held at least quarterly on each shift. Written records shall be kept of attendance at such drills. Based on interview and documentation review, it was determined that the facility failed to maintain an attendance record for the fire drills. Findings include: 8/5/26 10:30 AM –Review of fire drill logs revealed the attendance was not indicated on the log. 8/5/26 10:30 AM – During an interview, E2 (DON/O) confirmed attendance was not taken for the fire drills. 8/5/26 – Findings were reviewed with E2 and E3 (O) at approximately 2:00 PM.	A. A fire drill was completed on August 5, 2026 and the documentation included the residents and staff present/participating. Responsible: Administrator/DON. B. The Administrator/DON reviewed the fire-drill documentation process because all residents and staff present during drills may be affected by incomplete records. The revised process requires date, shift, drill details, residents present/participating, and staff attendance. C. Root cause: the prior fire-drill documentation process did not ensure attendance was recorded. The process was revised to require attendance for every drill. Fire drills will continue at least quarterly on each shift. The Administrator/DON or designee will review each completed drill form before filing. D. Goal: 100% of required fire drills will have complete attendance documentation. The Administrator/DON or designee will audit 100% of fire-drill records after each drill for date, shift, resident attendance, staff attendance, and required drill.	8/6/2026

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3225.18.6	Each facility shall submit with an application for a license and annual renewal of a license:	A. On August 6, 2026, a second active full-time employee completed the required FEMA ICS-100 and NIMS-700a courses. The facility now maintains documentation for at least two active full-time employees. Responsible: Administrator/DON.	8/6/2026
3225.18.6.2 S/S - F	Copies of the FEMA certificate of achievement which demonstrate that at least two active, full-time employees have completed FEMA training in ICS-100 and NIMS-700a in the past 24 months. This requirement was not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility procured only one full time employee with FEMA certification. Findings include: 3/13/26 - E5 (RCA/LLAM) was hired. 7/18/26 - E5 FEMA certification was completed for both ICS-100 and NIMS-700a. 8/5/26 11:30 AM - During an interview, E2 (DON/O) confirmed only one full time employee had the FEMA certification. E2 stated she had made attempts to obtain certification but was having difficulty accessing the website. 8/5/26 - Findings were reviewed with E2 and E3 (O) at the exit conference, beginning at approximately 3:00 PM.	B. The Administrator/DON reviewed the FEMA certification status of active full-time employees and verified that at least two currently meet the requirement. Certificates are maintained in facility file records. C. Root cause: required FEMA training for a second active full-time employee had not been completed/documented before survey. A FEMA training/certification tracking record was implemented. The Administrator/DON or designee will monitor certificate dates and employment status and identify another eligible full-time employee for training if a designated employee separates or no longer qualifies. D. Goal: 100% compliance with maintaining at least two active full-time employees with current ICS-100 and NIMS-700a certificates completed within the preceding 24 months. The Administrator/DON or designee will audit the FEMA tracking record quarterly and before annual license renewal and immediately address any gap.	

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