

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

STATE SURVEY REPORT

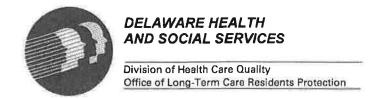
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NAME OF FACILITY: Meadowcrest At Middletown Senior Living

DATE SURVEY COMPLETED: March 4, 2025

SECTION	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 3, 2025, through March 4, 2025.			
	The deficiencies contained in this report			
	are based on interview, record review, re-			
	view of other facility documentation and		1	
	State reports. The facility census on the		1	
	first day of the survey was sixty-four (64).		1	
	The survey sample totaled eight (8) resi-			
	dents plus one (1) additional subsampled		1	
	resident.			
	Abbreviations/definitions used in this state			
	report are as follows:			
	CNA – Certified Nurse Assistant;	-		
	CSD – Culinary Services Director;			
	ED - Executive Director;			
	FO - Facilities Operation;			
	LPN - Licensed Practical Nurse;			
	RN - Registered Nurse;	+		
	RSD – Resident Services Director.			
3225	Assisted Living Facilities			
3225.19.0	Records and Reports	3225.19.6		
3225.19.6	Reportable incidents shall be reported im-	A Resident R5 continues to reside in the		
JEEJ.13.U	mediately, which shall be within 8 hours of	The state of the s		
	the occurrence of the incident, to the Divi	Total in hegative outcome		
	sion. The method of reporting shall be as			
	directed by the Division.		()	
	1	B All residents have the potential to be		
3225.19.7	Reportable incidents include:	affected.		
3225.19.7.1.3	Emotional abuse.	C A review of reportable incidents over the		
3225.19.7.1.3.1	Staff to resident.	last 30 days has been conducted with no		
		findings of deficient practices identified. A		
S/S - D	This requirement was not met as evi-	review of policies and procedures was		
	denced by:	conducted with no required changes		
	<u></u>	needed. The individual responsible for		

___ Title GXSCUTIVE DIRECTOR Date 3/21/25



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NAME OF FACILITY:	Maadowerest	At Middletown	Sonior Living
NAME OF FACILITY.	Meadowcrest	At Wildaletown	Senior Living

DATE SURVEY COMPLETED: March 4, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	Based on interview and review of clinical record, the State Reporting System and other facility documentation, it was determined that for one (E5) out of nine sampled employee files, the facility failed to report a staff to resident altercation to the State Incident Reporting System within the 8-hour reporting regulation. Findings include: 5/31/23 – R5 was admitted to the facility. 10/9/24 - R5 expressed concerns regarding an incident of care that occurred on 10/6/24 by R9 (CNA). When the concern was expressed, E8 (former RSD) immedi-	reporting the incident timely is no longer employed with the community. D The RSD/designee will conduct audits weekly until compliance 100% is achieved over 4 consecutive evaluations. Finally, the RSD/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been corrected and reportable incidents will be reviewed at quarterly QA. Completion Date: 3/21/2025	
	ately suspended E9 and began an investigation. The investigation revealed and confirmed the allegation of some intimidating words and care actions that caused R5 some emotional distress. The facility and employee record confirmed that E9's employment was terminated.		
	10/11/24 – E8 reported the incident to the State Reporting System at approximately 1:00 PM, two days after the incident had occurred and not within the 8-hour regulation timeline.		
	3/4/25 –Per interview with E1 (ED) at approximately 1:25 PM, E1 confirmed the staff to resident altercation was reported late and not within eight hours after the incident occurrence.	-	
	3/4/25 – Per interview with E2 (RSD) at approximately 1:25 PM, E2 stated she was not in the position at the time of this incident. E2 stated she reports the incidents		

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when they occur and will then conduct the



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SECTION STA	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	investigation. E2 stated she submits the 5 day follow-up at the conclusion of the investigation. 3/4/25 - Findings were reviewed with E1 and E2 at the exit conference, beginning approximately 1:30 PM.		
*			

Provider's Signature	Mats a exell	Title	EXECUTIVE	DIAGOTUR	Date	3/21/25	
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