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.
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STATE SURVEY REPORT

NAME OF FACILITY: Millcroft Living Assisted Living

DATE SURVEY COMPLETED: October 14, 2025

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 October 13, 2025, through October 14, 2025. 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 fifteen (15). The survey sample totaled seven (7) residents. Abbreviations/definitions used in this state report are as follows: AL – Assisted Living; CG – Caregiver; DOES – Director of Environmental Services; DOFB – Director of Food and Beverage; DON – Director of Nursing; ED - Executive Director; eMAR – Electronic Medication Administration Record; EMR – Electronic Medical Record; LLAM – Limited Lay Administration of Medication; LPN – Licensed Practical Nurse; MCG – Microgram; MT – Med Tech; RDOC – Regional Director of Care; 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; SA to assess the resident's level of care and services that will be needed; SNF – Skilled Nursing Facility; TSH – Thyroid Stimulating Hormone;	**Amended Report**	

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	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**		
3225.12.0	**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** 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 CHARGE at the time of inspection,**	**Lack of Certified Food Protection Manager (CFPM) coverage and unlabeled outside food items in the AL kitchen.** **Corrective Action:** -We will ensure that one CFPM is scheduled for every shift, including weekends. -All personal food items were removed from the AL refrigerator. -All remaining food items were labeled with an open date. **Identification of other residents:** -All residents have the potential to be affected by this deficient practice. -All residents will be protected by taking the corrective actions outlined below. **System Changes:** -Updated staffing schedule created by the Director of Food and Beverage to guarantee CFPM coverage every day.	11/28/2025

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	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. 10/14/25 - During the survey of the facility, at approximately 1:30 PM, a review of the dining staff schedule, certificates, and through interview with E5 (Director of Food and Beverage), revealed there are two Certified Food Protection Managers who work every third weekend. This resulted in a CFPM not being present for one weekend when the previous 30 days were reviewed. 10/14/25 – During an interview with E5 (DOFB) at approximately 1:45 PM, the lack of a CFPM on duty during all hours of operation was confirmed. **3-3 PROTECTION FROM CONTAMINATION AFTER RECEIVING3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.** 10/14/25 – During the survey of the facility at approximately 10:00 AM, observation of the refrigerator in the Assisted Living food service area revealed two cups of water ice, and a frozen microwaveable item that were not labeled and not part of the food service items. These foods from an outside source placed the food service items at risk for cross contamination. 10/14/25 – During an interview with E2 (DON) at approximately 10:15 AM, the food items were confirmed.	-Implemented a policy prohibiting personal food storage in facility refrigerators. -Conduct staff training by the Staff Developer on food safety and contamination prevention. **Success Evaluation**: -An audit of CFPM coverage and kitchen compliance will be conducted weekly for 3 months, then monthly for 3 months by the Director of Food and Beverage – a Certified Food Protection Manager. - The Director of Food and Beverage will maintain audit logs and report them to the Executive Director. - An audit of facility refrigerators will be conducted weekly for 3 months, then monthly for 3 months by the Director of Assisted Living/DON. -The Director of Assisted Living/DON will maintain audit logs and report them to the Executive Director.	

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3225.13.0 **3225.13.1** **S/S – D**	10/14/25 – Findings were reviewed with E5 at approximately 10:30 AM. 10/14/25 – Findings were reviewed with E1 (ED), E2 and E3 (RDOC) at the exit conference beginning at approximately 3:35 PM. **Service Agreements** **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.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R7) out of seven sampled residents, the facility failed to provide evidence that a SA (Service Agreement) had been completed. Findings include: 11/15/24 – R7 was admitted to the facility. The facility failed to provide evidence that a SA was completed at admission. 10/14/25 – Per interview with E2 (DON) at approximately 1:50 PM, E2 confirmed the SA was not in evidence.	**Service agreements must be signed upon admission to the Assisted Living.** **Root Cause Analysis:** -The Director of Assisted Living/DON at the time of the oversight for completing service agreements was not aware of the regulation. **Corrective Action:** -A signed service agreement for R-7 was completed. -An audit of all Assisted Living residents was completed to ensure signed Service Agreements were in place. **Identification of other Residents:** -All residents have the potential to be affected by this deficient practice. -All residents will be protected by taking the corrective actions outlined below. **System changes:**	11/28/2025

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	10/14/24 – Findings were reviewed with E1 (ED), E2 and E3 (RDOC) at the exit conference beginning at approximately 3:35 PM.	-The Service Agreement completion was added to the admission checklist.	
3225.16.0	**Staffing**	**Success Evaluation:**	11/28/2025
3225.16.12	**The Director of Nursing shall comply with the provisions of 24 Del.C. Ch. 19 and the rules and regulations of the Board of Nursing.**	-A monthly audit will be completed by the Director of Assisted Living/DON on all new admissions to ensure that a signed Service Agreement is in place. The audit will be conducted weekly for 3 months, then monthly for 3 months.	
3225.16.13	**The Director of Nursing shall have overall responsibility for the coordination, supervision and provision of the nursing department /services.**	-The DON/Director of Assisted Living will review compliance and report findings to the Executive Director.	
S/S – E	This requirement was not met as evidenced by:		
	Based on record review and interview, it was determined that the DON failed to ensure the provision of the nursing department/services which resulted in a prolonged medication administration error for R4. Findings include:	**The facility failed to ensure the provision of the nursing department/services which resulted in a prolonged medication error.**	
	10/13/25 – Per interview with E2 (DON) at approximately 1:45 PM, E2 stated a medication error was not discovered until a routine TSH lab test was completed on 3/18/25. The test result indicated R4 had an elevated TSH level and investigation was done to determine the cause. The investigation confirmed the Levothyroxine Sodium was not administered as ordered by the Physician; and R4's medication was not administered for fifteen (15) days in February 2025 and twelve (12) days in March 2025.	**Corrective action:** -The DON/Director of Assisted Living immediately reviewed and corrected the medication administration schedule for R-4. A change in the schedule was instituted immediately which added a Med Tech with a start time of 6:00am to cover early morning administration of medications. **Identification of other residents:**	

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	E2 confirmed the eMAR alerts were not monitored, and the alert indicating a missed medication was not identified. E2 stated she nor staff had not been checking the eMAR messages over this period of time which would have identified R4's missed medication doses. E2 stated a procedure was put in place after the incident to run daily pharmacy alerts checking for the accurate delivery of medications. E2 stated the facility is attempting to train additional staff for LLAM certification. 10/14/24 – Findings were reviewed with E1 (ED), E2 and E3 (RDOC) at the exit conference beginning at approximately 3:35 PM.	-An audit was completed on all resident medication records for October and November 2025 to identify any additional errors. No other errors were identified. -All residents have the potential to be affected by this deficient practice. -All residents will be protected by taking the corrective actions outlined below. **System changes:** -Retrained/Trained staff on eMAR alert monitoring. Training was conducted by the Staff Developer. Training included the communication process that medication staff should follow to report medication administration problem(s) as soon as they occur. -Implemented daily pharmacy alert review. **Success evaluation:** - The DON/Director of Assisted Living will complete daily audits of pharmacy alerts daily for 30 days, then weekly for 3 months. -The DON/Director of Assisted Living will monitor audit data and report findings to the Executive Director.	11/28/2025
3225.16.0 **3225.16.22** **S/S – E**	**Staffing** **At a minimum, every assisted living facility shall have an awake staff person on-site 24 hours per day who is qualified to administer or assist with self-administration of medication ("AWSAM") and who has knowledge of emergency procedures, basic first aid, CPR, and the Heimlich Maneuver.** This requirement was not met as evidenced by: Based on record review and interview, it was determined that the facility staffing did not include an employee who was qualified to administer medications on the overnight shift. Findings include:		

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	10/13/25 – Per interview with E2 (DON) at approximately 3:30 PM, E2 stated the fulltime MT's employment was terminated February 12, 2025. E2 stated that there was no one consistently assigned to the 11:00 PM-7:00 AM afterwards, but a SNF LPN could come over to the AL if a PRN (as needed) medication was indicated. E2 stated once a 6:00 AM medication error was discovered on 3/19/225, the hours were adjusted to have an employee available to administer this medication. 10/14/25 – Per interview with E2 at approximately 12:10 PM, E2 stated there is one part time MT (E14) hired on March 4, 2025 available on the 11:00 PM-7:00 AM shift. E2 stated that if E14 is scheduled off, a MT/LLAM is not available for the overnight shift. E2 stated that she has had difficulty in scheduling the LLAM training for the two other employees who work the overnight shift. 10/14/25 – Per staffing schedules and employee job titles review, the facility failed to consistently have a MT/LLAM certified employee available on the overnight shift two to three times per week from 2/12/25 through 10/14/25. 10/14/24 – Findings were reviewed with E1 (ED), E2 and E3 (RDOC) at the exit conference beginning at approximately 3:35 PM.	**Root Cause Analysis:** -A qualified MT/LLAM trained staff member was not consistently scheduled for the overnight shift. There were no staff members present in the community to administer the early morning dose. eMAR alerts were inadvertently overlooked. Once identified, the medication administration problem should have been reported immediately to the DON/Director of Assisted Living. **Corrective action:** -A MT/LLAM trained staff was scheduled to begin the dayshift at 6am. -This MT/LLAM trained staff member will administer all 6am scheduled medications. - Training conducted by Staff Developer included eMAR alert monitoring, communication process to be followed when an administration problem is identified. - The administration error identified for R4 could not be corrected. - The DON/Director of Assisted Living will be called if a medication administration issue occurs. In the event of an emergency, 911 will be called.	
3225.18.0	**Emergency Preparedness**		11/28/2025

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3225.18.3 **S/S – F**	**Each facility shall develop and maintain all-hazard emergency plans for evacuation and sheltering in place. The plan must be submitted to the Division and DEMA in a digital format and it must conform to the template prescribed by the Division. The all-hazard emergency plan must include plans to address staffing shortages and facility demands.** Based on review of facility documentation it was determined that the facility's Emergency Operations Plan was incomplete. Findings include: 10/14/25 - During the survey of the facility, at approximately 2:00 PM, a review of the Emergency Plan revealed incomplete information. Contact information for the current Administrator and the Director of plant operations were not available. These are the main contacts in charge of carrying out the emergency plan. Contact numbers for emergency backup resources were also unavailable. In addition, information related to local incoming communications for emergency notifications was unavailable. 10/14/25 – Findings were reviewed with E1 (ED), E2 (DON) and E3 (RDOC) at the exit conference beginning at approximately 3:35 PM.	-In the Event of a call out, the DON/Director of Assisted Living will be notified and if coverage cannot be secured, she will provide coverage. **Identification of other residents:** -All residents have the potential to be affected by this deficient practice. -All residents will be protected by taking the corrective actions outlined below. **System changes:** -A MT/LLAM training class is being conducted. -Moving forward we will focus on hiring MT/LLAM trained staff. -eMAR alerts will be reviewed daily by the DON/Director of Assisted Living. -Pharmacy reviews is currently being handled by the DON/Director of Assisted Living on a daily basis. -In the event of a eMAR discrepancy, the DON/Director of Assisted Living will be notified immediately and determine the most appropriate corrective action. The Physician on record and the ED will be notified. **Success evaluation:** -An audit of daily pharmacy reviews will be conducted daily for 1 month, then weekly for 3 months by the Executive Director. -An audit of MT/LLAM coverage will be conducted daily for 1 month, then weekly for 3 months by the Director of Assisted Living. -The DON/Director of Assisted Living will monitor the results of this audit and report findings to the Executive Director.	
3225.18.0 **3225.18.4** **S/S – F**	**Emergency Preparedness** **The staff on all shifts shall be trained on emergency and evacuation plans.** This requirement was not met as evidenced by:		11/28/2025

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	Based on record review, interview and review of other facility documentation, it was determined that for two (E11 and E12) out of four sampled employees, the facility failed to provide evidence that the Emergency Preparedness training had taken place. Findings include: 1. 9/23/13 – E11 (CG) was hired. The facility lacked evidence that E11 had any Emergency Preparedness training. 2. 9/20/22 – E12 (MT) was hired. The facility lacked evidence that E12 had any Emergency Preparedness training. 10/14/25 – Per interview with E2 (DON) at approximately 1:45 PM, E2 confirmed these trainings were not in evidence. 10/14/24 – Findings were reviewed with E1 (ED), E2 and E3 (RDOC) at the exit conference beginning at approximately 3:35 PM.		
3225.18.0 **3225.18.6.2** **S/S – F**	**Emergency Preparedness** **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 record review and interviews, it was determined that the facility only had one full time employee with FEMA certification. Findings include: 4/11/25 – E1 (ED) was hired at the facility.	**The facility's emergency preparedness was incomplete.** **Corrective action:** -The facility's Emergency Operations Plan was updated to include the current contact information of the Executive Director and the Plant Operations Director. Backup resources will include the DON and ADON in that order – contact information to be added to the plan. **Identification of other residents:** -All residents have the potential to be affected by this deficient practice. -All residents will be protected by taking the corrective actions outlined below.	11/28/2025

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	7/17/25 – E1 completed the ICS-100, the ICS-200 and the IS-700b (the new version of the NIMS-700a) on July 17, 2025. 10/13/25 – Per interview with E1 at approximately 11:00 AM, E1 confirmed the second full time employee who had completed the FEMA certifications that were in evidence, was no longer an active employee. 10/14/24 – Findings were reviewed with E1, E2 (DON) and E3 (RDOC) at the exit conference beginning at approximately 3:35 PM.	**System changes**: -The Emergency Operations Plan will be reviewed at the QAPI meeting on at least an annual basis. -This plan will be reviewed more frequently if any change in personnel occurs. **Success evaluation**: -A complete audit of the Emergency Operations Plan will be conducted by the Executive Director along with the Plant Operations Director. The Emergency Operations plan will be reviewed quarterly for completeness. -Any errors identified will be brought to the QAPI committee and immediate corrections will be made.	11/28/2025
3225.19.0 **3225.19.6**	**Records and Reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.**		
3225.19.7 **3225.19.7.2** **3225.19.7.7** **3225.19.7.7.2** **S/S – D**	**Reportable incidents include** **Neglect as defined in 16 Del.C. §1131.** **Significant injuries.** **Injury from a fall which results in transfer to an acute care facility** This requirement was not met as evidenced by: Based on record review, interview, and review of State Agency Reporting System, it was determined that the facility failed to report one (R2) out of one incident reviewed for falls within the eight-hour regulation. Findings include:	**The staff on all shifts were not all trained on emergency and evacuation plans.** **Corrective action**: -An audit of all employees was conducted to determine any staff members who had not been educated on emergency and evacuation plans. -Any employees identified were given immediate emergency training. **Identification of other residents**: -All residents have the potential to be affected by this deficient practice. -All residents will be protected by taking the corrective actions outlined below.	

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	6/14/23 – R2 was admitted to the facility. 8/13/25 - R2 experienced an unwitnessed fall, denied any discomfort and declined to be transferred to the ER for evaluation. 8/15/25 – Per EMR progress notes, R2 continued to complain of right arm pain not relieved by Tylenol. The Physician was again notified, and an x-ray of the wrist and arm was ordered. X-ray results on 8/18/25 at 8:00 AM indicated an acute non-displaced humerus fracture. R2 was transferred to the hospital for treatment. 8/20/25 - Per the Incident Summary Report, the facility reported the incident at 2:15 PM, two days after the discovered injury occurrence, not within the required eight hours. 10/14/25 – Per interview with E2 (DON) at approximately 2:30 PM, E2 confirmed the fall with injury was reported late, not within the eight-hour requirement. **Records and Reports** **Reportable incidents include** **Neglect as defined in 16 Del.C. §1131.** **Medication error or omission which causes or prolongs the resident's discomfort, jeopardizes the resident's health or safety, or requires periodic reassessment of the resident's clinical status by facility professional staff.** Cross reference **DE code, Title 16, Chapter 11**	**System changes:** -The emergency preparedness training guidelines were reviewed. -Training will occur upon hire and then on an annual basis. -The staff developer and the ED will ensure that all staff members have and will be educated per the guidelines. **Success criteria:** -An audit of all employees was conducted by the ED to ensure all staff have received Emergency Preparedness training. -Ongoing audits will be conducted weekly by the ED for 3 months then monthly for 3 months. **The facility failed to ensure that two full-time employees were FEMA certified.** **Corrective action:** -Two employees were identified and have taken the FEMA training. **Identification of other residents:** -All residents have the potential to be affected by this deficient practice. -All residents will be protected by taking the corrective action outlined below. **System changes:** -Two full-time employees will be FEMA always trained. -The identification of FEMA trained employees will be monitored by the Executive Director. -In the event that a FEMA trained employee leaves, immediate steps will be taken for another staff member to complete the FEMA training.	11/28/2025
3225.19.0 **3225.19.7** **3225.19.7.2** **3225.19.7.7.5** **S/S – D**			

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	Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.) § 1131. Definitions. This requirement was not met as evidenced by: Based on record review, interview, and review of State Agency Reporting System, it was determined that the facility failed to report one (R4) medication error out of one incident reviewed for medication administration within the eight-hour regulation. 2/17/23 - R4 was admitted to the facility. 3/19/25 – R4's prolonged medication administration error was discovered at 1:30 PM when a routine lab test was not in therapeutic range. This error resulted in potential health complication when the medication was not administered for fifteen (15) days in February 2025 and twelve (12) days in March 2025. 3/21/25 - Per the Incident Summary Report, the facility reported the incident at 1:30 PM, two days after the discovered medication error, not within the required eight hours. 10/14/25 – Per interview with E2 (DON) at approximately 2:30 PM, E2 confirmed the medication error was reported late, not within the eight-hour requirement. 10/14/24 – Findings were reviewed with E1 (ED), E2 and E3 (RDOC) at the exit conference beginning at approximately 3:35 PM.	**Success Criteria:** -An audit of FEMA trained employees will be conducted daily for 1 month, then weekly for 3 months by the Executive Director and reported to the QAPI committee. **The facility failed to report one (R2) out of one incident reviewed for falls within the eight-hour regulation.** **Corrective action:** -As soon as the DON/Director of Assisted Living was made aware of the incident it was reported to the State. In the absence of the DON/ Director of Assisted Living, the ED will be the point person. -All incident reports submitted over the last 6 months were reviewed for the need to submit a State report. -No other incidents were identified. **Identification of other residents:** -All residents have the potential of being affected by this deficient practice. -All residents will be protected by following the corrective actions outlined below. **System changes:** -All incidents will be reported to the DON/Director of Assisted Living even during off hours. -The DON/Director of Assisted Living will determine if there is a need to submit a State report. -If needed, a report will be filed with the State within the state required timeframe.	

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DE code, Title 16, Chapter 11 S/S – D	**Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents (81 Del. Laws, c. 206, § 31; 83 Del. Laws, c. 22, § 1.)** **§ 1131. Definitions.** **Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.** **Neglect includes all of the following:** **c. Failure to carry out a prescribed treatment plan for a patient or resident.** This requirement was not met as evidenced by: Based on record review, interview, facility documentation including incident reports and review of the State Agency report, it was determined that for one (R4) out of seven sampled residents, the facility failed to have provide the prescribed medications as ordered by the physician. Findings include: 2/17/23 - R4 was admitted to the facility from a SNF with diagnosis including hypothyroidism. On admission the Physician ordered Synthroid Oral Tablet 75 MCG (levothyroxine sodium). Give 1 tablet by mouth in the morning for thyroid. The Physician also ordered lab testing periodically to check R4's thyroid levels. 2/5/25 – Synthroid Oral Tablet 75 MCG was discontinued by the Physician.	-Education on reportable events will be conducted by the Staff Developer with all staff members. **Success criteria:** -The DON/Director of Assisted Living will review daily all incidents. In the absence of the DON/Director of Assisted Living, the ED will be the point person. -Any reportable incidents will be reported within the required timeframe. **The facility failed to report one (R4) medication error out of one incident reviewed for medication administration within the eight-hour regulation.**	11/28/2025

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	2/6/25 - The Physician ordered Levoxyl Tablet 88 MCG (levothyroxine sodium). Give 1 tablet by mouth one time a day for low thyroid hormone. 3/18/25 – Per routine TSH (Thyroid Stimulating Hormone) testing, the results came back with an elevated TSH level of 62.19. Per the laboratory reference range, the acceptable levels for the Thyroid level (TSH) was between 0.04 – 4.00. 3/19/25 – The Physician discontinued the Levoxyl Tablet 88 MCG and ordered a one-time dose of Levothyroxine Sodium 100 MCG for thyroid. 3/20/25 - The Physician ordered levothyroxine sodium 100 MCG by mouth in the morning for low thyroid hormone. 10/13/25 – Per interview with E2 (DON) at approximately 1:45 PM, E2 stated the error was not discovered until a routine TSH lab test was completed on 3/18/25. The test result indicated R4 had an elevated TSH level and investigation was done to determine the cause. The investigation confirmed the levothyroxine sodium was not administered as ordered by the Physician; and R4's medication was not administered for fifteen (15) days in February 2025 and twelve (12) days in March 2025. E2 stated the full-time employee working the overnight shift who administered the 6:00 AM dose to R4, stopped working at the facility in February 2025. E2 stated the follow-up investigation showed that R4's	**Corrective action**: - As soon as the DON/Director of Assisted Living was made aware of the incident it was reported to the State. In the absence of the DON/Director of Assisted Living, the ED will be the point person. -All incident reports submitted over the last 6 months were reviewed for the need to submit a State report. -No other incidents were identified. **Identification of other residents**: -All residents have the potential of being affected by this deficient practice. -All residents will be protected by following the corrective actions outlined below. **System changes**: -All incidents will be reported to the DON/Director of Assisted Living even during off hours. -The DON/Director of Assisted Living will determine if there is a need to submit a State report. -If needed, a report will be filed with the State within the required timeframe. -Education on reportable events will be conducted by the Staff Developer with all staff members. **Success criteria**: -The DON/Director of Assisted Living will review daily all incidents. In the absence of the DON/Director of Assisted Living, the ED will be the point person.	

Provider's Signature [signature], NHA Title Administrator Date 12/9/25

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	morning medication was not being given after that employee's termination. E2 stated once the discovery was identified, the shift hours were adjusted so a medication tech (MT) was to be available to administer R4's 6:00 AM dosing schedule. E2 confirmed the eMAR alerts were not monitored, and the alert indicating a missed medication was not identified. E2 stated staff had not been checking the eMAR messages over this period of time which would have identified R4's missed medication doses. E2 stated a procedure was put in place after the incident to run daily pharmacy alerts checking for the accurate delivery of medications. E2 stated the facility is attempting to train additional staff for LLAM certification. 10/14/24 – Findings were reviewed with E1 (ED), E2 and E3 (RDOC) at the exit conference beginning at approximately 3:35 PM. **Title 16 - Health and Safety** **Past Non-Compliance** **Completion date 8/1/25** **1142. Mandatory drug screening.** **(c) The Department shall promulgate regulations, regarding the pre-employment testing of all applicants, for use of all of the following** **illegal drugs:** **(1) Marijuana/cannabis.** **(2) Cocaine.** **(3) Opiates.**	-Any reportable incidents will be reported within the state required timeframe **The facility failed to provide the prescribed medications as ordered by the physician.** **Corrective Action**: -As soon as the medication error was discovered, the medication was administered to the resident daily thereafter. **Identification of other residents**: -All residents' eMAR were reviewed by the DON/Director of Assisted Living for missing medication doses. -No other errors were noted. -All residents have the potential of being affected by this deficient practice. -All residents will be protected by following the corrective actions outlined below. **System changes**: -Retrained nursing staff by the staff developer (RN) on eMAR alert monitoring. -Implemented daily pharmacy alert reviews by the DON/Director of Assisted Living.	11/28/2025

Provider's Signature [signature], NHA Title Administrator Date 12/8/25

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	(4) Phencyclidine ("PCP"). **(5) Amphetamines.** **(6) Any other illegal drug specified by the Department under regulations promulgated under this section.** 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 (E2 and E6) out of four sampled employees, the facility failed to provide evidence that the pre-hire drug screening contained testing for marijuana/cannabis. Findings include: 1. 12/17/24 – E12 (RA) was hired at the facility. The pre-hire drug testing done on 12/2/24 did not contain testing for marijuana/cannabis. 2. 2/4/25 – E6 (MT) was hired at the facility. The pre-hire drug testing done on 1/27/25 did not contain testing for marijuana/cannabis. 10/14/25 - Per interview with E3 (RDOC) at approximately 3:00 PM, E3 stated the facility noted that the pre-hire drug screen testing did not contain the required marijuana/cannabis screening. As of 8/1/25, and any employee hired as of that date had the complete drug testing substances which included marijuana/cannabis screened. 10/14/25 – This was confirmed by the Surveyor at the time of the survey. Completion date 8/1/25.	**Success evaluation**: -Pharmacy alerts will be audited by the DON/Director of Assisted Living daily for 30 days, then weekly for 3 months. In the presence of a finding, further training will be conducted immediately by the DON/Director of Assisted Living with the individual identified during the audit process. -The DON/Director of Assisted Living will track the audit results and report the findings to the Executive Director. **Corrective Action**: -As soon as the findings were discovered, the Regional Director of Health-Pro Heritage, the contracted therapy company, was contacted. Pre-hire drug screening for employment with HPH does not previously include marijuana/cannabis. - Unable to correct the findings for E12 and E6 **Root cause analysis**: -HPH did not include marijuana/cannabis use in their pre-hire drug screening. **Identification of other residents**: - Employees of HPH hired to work at Millcroft Living prior to 8/1/25 were not screened for marijuana/cannabis as part of the pre-hire process. -All residents have the potential to be affected by this deficient practice. -All residents will be protected by taking the corrective actions outlined below. **System changes**: -Pre-hire drug testing for all employees hired to work at Millcroft Living including those providing services through outside vendors will include marijuana/cannabis.	

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	10/14/24 – Findings were reviewed with E1 (ED), E2 (DON) and E3 at the exit conference beginning at approximately 3:35 PM.	**Success evaluation:** - A whole house audit was conducted to verify that marijuana/cannabis screening was completed pre-hire. Effective 8/1/25, all employees were screened pre-hire for marijuana/cannabis use. -The Director of Human Resources will audit all newly hired employees prior to their start date to ensure that the pre-hire drug testing included marijuana/cannabis.	

Provider's Signature [signature] Title Administrator Date 12/9/25

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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