

STATE SURVEY REPORT

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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	Completion Date
		ANTICIPATED DATES TO BE CORRECTED	
	An unannounced Annual and Complai	nt **Amended Report**	
	Survey was conducted at this facility fro	W .	
	October 13, 2025, through October 1	II	
	2025. The deficiencies contained in this r		
	port are based on interview, record revie		
	and review of other facility documentation		
	as indicated. The facility census on the fir		
	day of the survey was fifteen (15). The su		
	vey sample totaled seven (7) residents.		
	Abbreviations/definitions used in this sta	te	
	report are as follows:		
	·		
	AL – Assisted Living;		
	CG – Caregiver;		
	DOES – Director of Environmental Service	s;	
	DOFB - Director of Food and Beverage;		
	DON – Director of Nursing;		
	ED - Executive Director;		-
	eMAR – Electronic Medication Administr	a-	
	tion Record;		
	EMR – Electronic Medical Record;	.	
	LLAM – Limited Lay Administration of Me	d-	4
	ication;		
	LPN – Licensed Practical Nurse;		
	MCG – Microgram;		
	MT – Med Tech;		
	RDOC – Regional Director of Care;		
	SA (Service Agreement) - Allows both pa		
	ties involved (the resident and the assist	I I	
	living facility) to understand the types	- I	
	care and services the assisted living pr		
	vides. These include: lodging, board, hous		
	keeping, personal care, and supervision se	er-	
	vices;		
	SA to assess the resident's level of care a	nd	
	services that will be needed;		
	SNF – Skilled Nursing Facility;		
	TSH – Thyroid Stimulating Hormone;		

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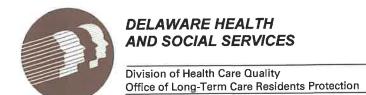
NAME OF FACILITY: Millcroft Living Assisted Living

Office of Long-Term Care Residents Protection

DATE SURVEY COMPLETED: October 14, 2025

SECTION STA	TEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
3225 3225.12.0 3225.12.1 3225.12.1.3 S/S - F	TST - Tuberculin skin test; UAI (Uniform Assessment Instrument) - document setting forth standardized criticial 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 accordance with these regulations. Assisted Living Facilities Services The assisted living facility shall ensurthat: Food service complies with the Delawar Food Code Delaware Food Code Based on observations, interview, and review of other facility documentation it will determined that the facility failed to comply with the Delaware Food Code. Finding include: 2-101.11 Assignment. (A) Except as specified in ¶ (B) of this section, the PERM HOLDER shall be the PERSON IN CHARCO or shall designate a PERSON IN CHARCO and shall ensure that a PERSON IN CHARCO and shall ensure that a PERSON IN CHARCO is present at the FOOD ESTABLISHMENT during all hours of operation. 2-102.12 Certified Food Protection Malager (A) At least one employee, the PESON 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 weekendsAll personal food items were removed from the AL refrigeratorAll remaining food items were labeled with an open date. Identification of other residents: -All residents have the potential to be affected by this deficient practiceAll residents will be protected by taking the corrective actions outlined below. System Changes: -Updated staffing schedule created by the	11/28/2025

Provider's Signature Leal Marinistrator Date 12/9/25



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NAME OF FACILITY: Millcroft Living Assisted Living

DATE SURVEY COMPLETED: October 14, 2025 ADMINISTRATOR'S PLAN FOR

STATEMENT OF DEFICIENCIES **SECTION** SPECIFIC DEFICIENCIES

CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED Completion **Date**

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.

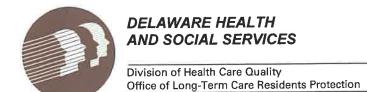
10/14/25 - During an interview with E2 (DON) at approximately 10:15 AM, the food items were confirmed.

- -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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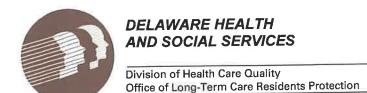
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3225.13.0 3225.13.1 S/S – D	10/14/25 – Findings were reviewed with E5 at approximately 10:30 AM. 10/14/25 – Findings were reviewed with E1 (ED), E2 and E3 (RDOC) at the exit conference beginning at approximately 3:35 PM. Service Agreements A service 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 completedAn 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 practiceAll residents will be protected by taking the corrective actions outlined below. System changes:	11/28/2025	
			the second	

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STATE SURVEY REPORT

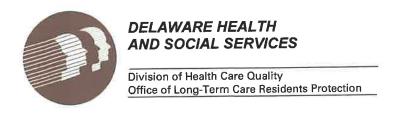
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3225.16.12 3225.16.13 S/S – E	10/14/24 – Findings were reviewed with (ED), E2 and E3 (RDOC) at the exit confeence beginning at approximately 3:35 PN Staffing The Director of Nursing shall comply with the provisions of 24 Del.C. Ch. 19 and trules and regulations of the Board of Nursing. The Director of Nursing shall have over responsibility for the coordination, supvision and provision of the nursing deparent /services. This requirement was not met as evidence by: Based on record review and interview was determined that the DON failed to sure the provision of the nursing deparent/services which resulted in a plonged medication administration error R4. Findings include: 10/13/25 – Per interview with E2 (DON) approximately 1:45 PM, E2 stated a medication error was not discovered until a retine TSH lab test was completed 3/18/25. The test result indicated R4 had elevated TSH level and investigation valued to determine the cause. The invegation confirmed the Levothyroxine dium was not administered as ordered the Physician; and R4's medication was administered for fifteen (15) days in February 2025 and twelve (12) days in Ma	Success Evaluation: -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. -The DON/Director of Assisted Living will review compliance and report findings to the Executive Director. The facility failed to ensure the provision of the nursing department/services which resulted in a prolonged medication error. 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.		
	2025.			
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DATE SURVEY COMPLETED: October 14, 2025 NAME OF FACILITY: Millcroft Living Assisted Living ADMINISTRATOR'S PLAN FOR Completion STATEMENT OF DEFICIENCIES CORRECTION OF DEFICIENCIES WITH **Date** SECTION SPECIFIC DEFICIENCIES ANTICIPATED DATES TO BE CORRECTED -An audit was completed on all resident E2 confirmed the eMAR alerts were not medication records for October and Novemmonitored, and the alert indicating a ber 2025 to identify any additional errors. missed medication was not identified. E2 No other errors were identified. stated she nor staff had not been checking -All residents have the potential to be afthe eMAR messages over this period of fected by this deficient practice. time which would have identified R4's -All residents will be protected by taking the missed medication doses. corrective actions outlined below. E2 stated a procedure was put in place after **System changes:** the incident to run daily pharmacy alerts -Retrained/Trained staff on eMAR alert monitoring. Training was conducted by the checking for the accurate delivery of medications. E2 stated the facility is attempting Staff Developer. Training included the communication process that medication staff to train additional staff for LLAM certificashould follow to report medication admintion. istration problem(s) as soon as they occur. -Implemented daily pharmacy alert review. 10/14/24 - Findings were reviewed with E1 (ED), E2 and E3 (RDOC) at the exit confer-Success evaluation: ence beginning at approximately 3:35 PM. - The DON/Director of Assisted Living will 11/28/2025 complete daily audits of pharmacy alerts **Staffing** 3225.16.0 daily for 30 days, then weekly for 3 months. -The DON/Director of Assisted Living will At a minimum, every assisted living facility monitor audit data and report findings to the 3225.16.22 shall have an awake staff person on-site 24 Executive Director. hours per day who is qualified to adminis-S/S-E ter 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

economistation Date 12/8/25 Provider's Signature

to administer medications on the overnight

shift. Findings include:



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

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SECTION STA	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	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 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.	

3225.18.0

Provider's Signature

Emergency Preparedness

recipe vientitle Administrator Date 12/8/25

11/28/2025

occurs. In the event of an emergency, 911

will be called.



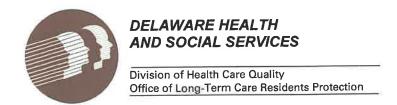
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SECTION STA	TEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
		the DOM/Director	
3225.18.3	Each facility shall develop and mainta		
	all-hazard emergency plans for evacuation	مانيمس النبي ماء المسيدين المارين	
S/S – F	and sheltering in place. The plan must l		
	submitted to the Division and DEMA in	a coverage.	
	digital format and it must conform to the	ne Identification of other residents:	
	template prescribed by the Division. The	ne	
	all-hazard emergency plan must include	-All residents have the potential to be af-	
	plans to address staffing shortages and f	rected by this deficient practice.	
	cility demands.	-All residents will be protected by taking the corrective actions outlined below.	
	cincy domands.	corrective actions outlined below.	
	Based on review of facility documentation	on 	
	it was determined that the facility's Eme	-A MT/LLAM training class is being con-	
	gency Operations Plan was incomplet	ducted.	
	Findings include:	-Moving forward we will focus on hiring	
		NAT/LLANA trained staff	
	10/14/25 - During the survey of the facilit	· NAAD alama will be reviewed daily by the	
	at approximately 2:00 PM, a review of t	DON/Director of Assisted Living	
	Emergency Plan revealed incomplete info	Dharmacy reviews is currently being han-	
	mation. Contact information for the cu	dled by the DON/Director of Assisted Living	
	rent Administrator and the Director of pla	nt on a daily basis.	
	operations were not available. These a	re -In the event of a eMAR discrepancy, the	
	the main contacts in charge of carrying o	ut DON/Director of Assisted Living will be noti-	
	the emergency plan. Contact numbers f	_	
	emergency backup resources were also u		
	available. In addition, information relate		
	to local incoming communications f		
	emergency notifications was unavailable		
	5	-An audit of daily pharmacy reviews will be	
	10/14/25 – Findings were reviewed with		
	(ED), E2 (DON) and E3 (RDOC) at the e		
	conference beginning at approximate	ely -An audit of MT/LLAM coverage will be con-	
	3:35 PM.	ducted daily for 1 month, then weekly for 3	
		months by the Director of Assisted Living.	
3225.18.0	Emergency Preparedness	-The DON/Director of Assisted Living will	11/28/2025
	The staff on all shifts shall be trained	monitor the results of this audit and report	
3225.18.4	emergency and evacuation plans.	findings to the Executive Director.	
6/6 5	emergency and evacuation plans.		
S/S – F	This requirement was not met as evidenc	ed	
	by:		
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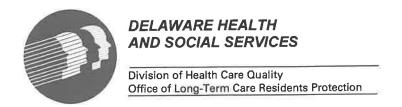
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DATE SURVEY COMPLETED: October 14, 2025 NAME OF FACILITY: Millcroft Living Assisted Living ADMINISTRATOR'S PLAN FOR Completion STATEMENT OF DEFICIENCIES CORRECTION OF DEFICIENCIES WITH Date SPECIFIC DEFICIENCIES SECTION ANTICIPATED DATES TO BE CORRECTED 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. The facility's emergency preparedness was **Emergency Preparedness** 3225.18.0 incomplete. Copies of the FEMA certificate of achieve-3225.18.6.2 ment which demonstrate that at least two Corrective action: S/S-Factive, full-time employees have com-11/28/2025 -The facility's Emergency Operations Plan pleted FEMA training in ICS-100 and NIMSwas updated to include the current contact 700a in the past 24 months. information of the Executive Director and the Plant Operations Director. Backup re-This requirement was not met as evidenced sources will include the DON and ADON in that order - contact information to be added Based on record review and interviews, it to the plan. was determined that the facility only had one full time employee with FEMA certifica-Identification of other residents: -All residents have the potential to be aftion. Findings include: fected by this deficient practice. 4/11/25 - E1 (ED) was hired at the facility. -All residents will be protected by taking the

Provider's Signature Relative Nota Title Administrator Date 12/9/20

corrective actions outlined below.



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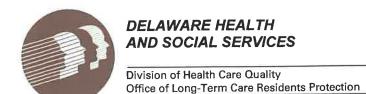
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	ATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR	Completion
SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES WITH	Date
	<u> </u>	ANTICIPATED DATES TO BE CORRECTED	
	7/17/25 - E1 completed the ICS-100, the		
	ICS-200 and the IS-700b (the new version of	System changes:	
	the NIMS-700a) on July 17, 2025.	-The Emergency Operations Plan will be re-	
		viewed at the QAPI meeting on at least an	
	10/13/25 – Per interview with E1 at approx-	annual basis.	
	imately 11:00 AM, E1 confirmed the second	-This plan will be reviewed more frequently	
	full time employee who had completed the	if any change in personnel occurs.	
	FEMA certifications that were in evidence,	Success evaluation:	
	was no longer an active employee.	-A complete audit of the Emergency Opera-	
	10/14/24 - Findings were reviewed with	tions Plan will be conducted by the Executive	
	E1, E2 (DON) and E3 (RDOC) at the exit con-	Director along with the Plant Operations Di-	
	ference beginning at approximately 3:35	rector. The Emergency Operations plan will	
	PM.	be reviewed quarterly for completeness.	44/00/005
	Records and Reports	-Any errors identified will be brought to the	11/28/2025
3225.19.0	Records and Reports	QAPI committee and immediate corrections	
3225.19.6	Reportable incidents shall be reported im-	will be made.	
	mediately, which shall be within 8 hours of		
	the occurrence of the incident, to the Divi-		
	sion. The method of reporting shall be as		
	directed by the Division.		
3225.19.7	Reportable incidents include		
		The staff on all shifts were not all trained on	
3225.19.7.2	Neglect as defined in 16 Del.C. §1131.	emergency and evacuation plans.	
		Corrective action:	
3225.19.7.7	Significant injuries.	-An audit of all employees was conducted	
2225 40 7 7 2	Injury from a fall which results in transfer	to determine any staff members who had	
3225.19.7.7.2	to an acute care facility	not been educated on emergency and evac-	
S/S - D	to all acute care facility	uation plans.	
-,	This requirement was not met as evidenced	-Any employees identified were given im-	
	by:	mediate emergency training.	
	()	mediate emergency duming.	
	Based on record review, interview, and re-		
	view of State Agency Reporting System, it	Identification of other residents:	
	was determined that the facility failed to re-	-All residents have the potential to be affected by this deficient practice.	
	port one (R2) out of one incident reviewed for falls within the eight-hour regulation.	-All residents will be protected by taking the	1
	Findings include:	corrective actions outlined below.	
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Date 12/4/25



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

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training.



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NAME OF FACILITY: Millcroft Living Assisted Living

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STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
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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.

Office of Long-Term Care Residents Protection

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:

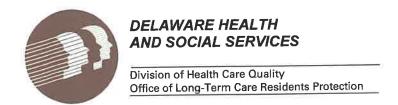
-All residents have the potential of being affected by this deficient practice.

-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.

Provider's Signature Color of the Administrator Date 12/9/25



STATE SURVEY REPORT

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DATE SURVEY COMPLETED: October 14, 2025 NAME OF FACILITY: Millcroft Living Assisted Living ADMINISTRATOR'S PLAN FOR Completion STATEMENT OF DEFICIENCIES CORRECTION OF DEFICIENCIES WITH **Date** SPECIFIC DEFICIENCIES SECTION ANTICIPATED DATES TO BE CORRECTED -Education on reportable events will be con-Abuse, Neglect, Mistreatment, Financial ducted by the Staff Developer with all staff Exploitation, or Medication Diversion of 11/28/2025 DE code, Title members. Patients or Residents (81 Del. Laws, c. 206, 16, Chapter 11 § 31; 83 Del. Laws, c. 22, § 1.) Success criteria: -The DON/Director of Assisted Living will re-§ 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.

view 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.

Provider's Signature Scholles NOA Title Administrata Date 12/9/27

S/S - D



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

STATE SURVEY REPORT

DATE SURVEY COMPLETED: October 14, 2025

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NAME OF FACILITY: Millcroft Living Assisted Living

Completion ADMINISTRATOR'S PLAN FOR STATEMENT OF DEFICIENCIES **CORRECTION OF DEFICIENCIES WITH Date SPECIFIC DEFICIENCIES** SECTION ANTICIPATED DATES TO BE CORRECTED

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 onetime 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.

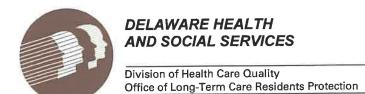
System changes:

- -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 Endows MATITE Advisor hote Date 12/8/25



STATE SURVEY REPORT

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NAME OF FACILITY: Millcroft Living Assisted Living		DATE SURVEY COMPLETED: Octo	ober 14, 2025
SECTION STA	SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	morning medication was not being given at ter that employee's termination. E2 state once the discovery was identified, the shift hours were adjusted so a medication tec (MT) was to be available to administer R4' 6:00 AM dosing schedule. E2 confirmed the eMAR alerts were not monitored, and the alert indicating missed medication was not identified.	within the state required timeframe t t t t	
	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 alert checking for the accurate delivery of medications. E2 stated the facility is attempting to train additional staff for LLAM certifications.	The facility failed to provide the prescribed medications as ordered by the physician.	
	tion. 10/14/24 — Findings were reviewed with E (ED), E2 and E3 (RDOC) at the exit confe ence beginning at approximately 3:35 PM Title 16 - Health and Safety Past Non-Compliance Completion date 8/1/25	-As soon as the medication error was discovered, the medication was administered to the resident daily thereafter.	11/28/2025
	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.	fected by this deficient practiceAll residents will be protected by following the corrective actions outlined below.	

2000, NOTATITLE Administration Date 12/8/25 Provider's Signature

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STATE SURVEY REPORT

DATE SURVEY COMPLETED: October 14, 2025

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NAME OF FACILITY: Millcroft Living Assisted Living

STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES ADMINISTRATOR'S PLAN FOR Completion CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED

- (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.

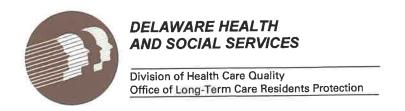
Identification of other residents:

- Employees of HPH hired to work at Mill-croft 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.

Provider's Signature Manager NHA Title Administrator Date 12/8/25



STATE SURVEY REPORT

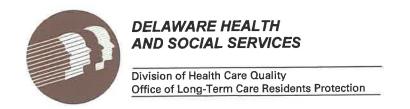
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NAME OF FACILITY: Millcroft Living Assisted Living

DATE SURVEY COMPLETED: October 14, 2025

STATEMENT OF DEFICIENCIES ECTION SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
10/14/24 – Findings were reviewed with I (ED), E2 (DON) and E3 at the exit confeence beginning at approximately 3:35 PM	E1 Success evaluation:	

Provider's Signature I Many MATitle Administrator Date 12/9/25



STATE SURVEY REPORT

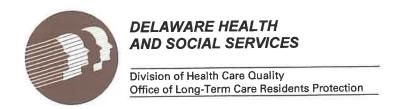
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NAME OF FACILITY: Millcroft	Living	Assisted Living
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DATE SURVEY COMPLETED: October 14, 2025

SECTION	FATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date

Provider's Signature Schologow NHA Title Administration Date 12/8/27



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DATE SURVEY COMPLETED: October 14, 2025

STATEMENT OF DEFICIENCIES SECTION SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date