DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint Survey was conducted at this facility from August 7, 2023 through August 9, 2023. 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 thirty-eight (38). The survey sample totaled eight (8) residents. Abbreviations/definitions used in this report are as follows: BCC – Background Check Center; BO – Business Office; DelVAX - a Web-based, database-driven immunization registry system currently implemented at multiple state and local government agencies in the US; DHSS _DLTCRP_BCC@Delaware.gov - State access site for the BCC; DHW – Director of Health and Wellness; EC – Executive Chef; FSD – Food Service Director; GM - General Manager; KS – Kitchen Staff; LPN – Licensed Practical Nurse; MC – Memory Care; MCM – Memory Care Manager; POM – Plant Operations Manager; PS – Programs Supervisor;		

Provider's Signature Frank DiMarco Title General Manager Date 09/21/22

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	RA – Resident Assistant; Resident Assessment – evaluation of a resident's physical, medical, and psychosocial status as documented in a Uniform Assessment Instrument (UAI), by a Registered Nurse; 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.		
Cross Reference-Title 16 Del.C Ch.11, Subchapter IV **(81 Del. Laws, c. 206, § 40.)** **§ 1141. Criminal background checks.**	**Criminal Background Checks; Mandatory Drug Screening; Long-Term Care Facilities; Nursing Home Compliance with Title XIX of the Social Security Act.** **(a) Purpose. — The purpose of the criminal background check and drug screening requirements of this section and § 1142 of this title is the protection of the safety and well-being of residents of long-term care facilities licensed pursuant to this chapter. These sections shall be construed broadly to accomplish this purpose.** **(2) "Background Check Center (BCC)" means the electronic system which combines the data streams from various sources within and outside the State in order to assist an employer in**	**1141. Criminal Background Checks** A. The GM has ensured E11 has been entered into the BCC system, albeit in arrears of the required timeframe. B. All other staff had the potential to be affected. The GM and BOM conducted a review of employee records to ensure existing employees were registered in the BCC system. C. The root cause was related to the inability to access the BCC prior to the facility being issued a license. This will no longer be an issue. Additionally, an Onboarding Checklist (Attachment A) has been developed for the community to ensure prospective employees are entered into the BCC system prior to determine their suitability for employment.	**09/21/23**

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	determining the suitability of a person for employment in a long-term care facility. This requirement was not met as evidenced by: Based on review of facility documentation and the State DHSS _DLT-CRP_BCC@Delaware.gov, it was determined that for one (E11) out of twelve employees surveyed, the facility lacked evidence of registering E11 in the BCC system. Findings include: 2/27/23 – E11's (LPN) employment began at the facility. There was no evidence of E11 in the BCC. 8/9/23 - Findings were pending at the time of the exit conference with E1 (GM) and E2 (DHW) beginning at approximately 1:10 PM.	D. On an ongoing basis, the GM and respective hiring manager/department head meet weekly and will use the 1:1 Meeting Template (Attachment B) to review each prospect's Onboarding Checklist. The GM is responsible for ensuring an individual is not hired until the proper screening has been completed.	
§ 1142. Mandatory drug screening.	**(a) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screening.** **(b) All applicants must submit to mandatory drug screening, as specified by regulations promulgated by the Department.** **(e) The employer must provide confirmation of the drug screen in the manner prescribed by the Department's regulations.** This requirement was not met as evidenced by: Based on review of facility documentation, review of employee records and	**1142. Mandatory Drug Screening.** A. The GM has ensured the drug testing records for the six affected employees have been obtained and reported to the BCC system, albeit in arrears of the required timeframe. B. All other staff had the potential to be affected. The GM and BOM conducted a review of employee records to ensure existing employees' records were intact. C. The root cause was related to the inability to coordinate third party drug screening due to a contract delay. This will no longer be an issue. Additionally, an Onboarding Checklist (Attachment A) has been developed for the community to ensure prospective employees complete drug screening	**09/21/23**

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	the State DHSS _DLTCRP_BCC@Delaware.gov, it was determined that for six (E2, E5, E6, E7, E10 and E11) out of twelve employees surveyed, the facility lacked evidence of drug screening being completed prior to hire or reported to the BCC system. Findings include: 1. 12/12/22 – E2's (DHW) employment began at the facility. There was no evidence the mandatory drug screening was completed prior to or after hire with no evidence of any testing in the BCC. 2. 1/30/23 – E5's (PS) employment began at the facility. There was no evidence the mandatory drug screening was completed prior to after hire with no evidence of any testing in the BCC. 3. 1/30/23 – E6's (MC PS) employment began at the facility. The mandatory drug screening was completed on 3/23/23, after hire and after the first resident was admitted on 3/22/23. 4. 3/2/23 – E7's (MC LPN) employment began at the facility. The mandatory drug screening was completed on 3/2/23, the day of hire and there was no evidence the result was reported in the BCC. 5. 3/18/23 – E10's (RS) employment began at the facility. There was no evidence the mandatory drug screening was completed prior to or after hire with no evidence of any testing in the BCC. 6. 2/27/23 – E11's (LPN) employment began at the facility. The mandatory drug screening was completed on	in the prescribed timeframe and are entered into the BCC system. D. On an ongoing basis, the GM and respective hiring manager/department head meet weekly and will use the 1:1 Meeting Template (Attachment B) to review each prospect's Onboarding Checklist. The GM is responsible for ensuring an individual is not hired until the proper screening has been completed and they are entered into the BCC system.	

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	3/25/23, after hire and after the first resident was admitted on 3/22/23; and there was no evidence the result was reported in the BCC. 8/9/23 - Findings were pending at the time of the exit conference with E1 (GM) and E2 (DHW) beginning at approximately 1:10 PM.		
3225.9.0	**Infection Control**		
3225.9.5	**Requirements for tuberculosis and immunizations:**		
3225.9.5.2	**Minimum requirements for pre-employment require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.** This requirement was not met as evidenced by: Based on interview and review of facility documentation, it was determined that for two (E10 and E11) out of twelve employees surveyed, the facility lacked evidence of a two-step tuberculin test prior to hire. Findings include:	**3225.9.0.5.2 Tuberculosis Testing** A. Appropriate records for the two affected employees have been obtained. B. All other staff had the potential to be affected. The GM and BOM conducted a review of employee records to ensure existing employees' records were intact. C. The root cause was related to the inability to coordinate third party TB screening due to a contract delay. In addition to securing the contract for TB testing, the community established the means to conduct on-site TB testing if necessary to ensure the pre-hire documentation is completed. The community's Onboarding Checklist (Attachment A) has been revised to include the addition of procuring pre-employment TB records for each prospective employee. D. On an ongoing basis, the GM and respective hiring manager/department head meet weekly and will use the 1:1 Meeting Template (Attachment B) to review each prospect's Onboarding Checklist. The GM is responsible for	09/25/23

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	1. 1/30/23 – E5 was hired. The first step tuberculin testing was performed on 4/11/23 and the second step tuberculin testing was done on 4/20/23, both after hire. 2. 1/30/23 – E6 was hired. The first step tuberculin testing was performed on 4/11/23 and the second step tuberculin testing was done on 4/22/23, both after hire. 8/9/23 – Per interview with E2 (DHW) at approximately 1:05 PM, E2 confirmed the testing was completed after hire and after the first resident was admitted. 8/9/23 - Findings were reviewed with E1 (GM) and E2 (DHW) at the exit conference, beginning at approximately 1:10 PM.	ensuring an individual is not hired until the proper screening has been completed and they are entered into the BCC system.	
3225.9.7	**The assisted living facility shall have on file evidence of vaccination against pneumococcal pneumonia for all residents older than 65 years, or those who received the pneumococcal vaccine before they became 65 years and 5 years have elapsed, and as recommended by the Immunization Practice Advisory Committee of the Centers for Disease Control, unless medically contraindicated. All residents who refuse to be vaccinated against pneumococcal pneumonia must be fully informed by the facility of the health risks involved. The reason for the refusal shall be documented in the resident's medical record.**	**3225.9.7 Pneumococcal Pneumonia** A. The appropriate records for the three affected residents have been obtained and are included in the respective health records. B. All residents had the potential to be affected. The Health and Wellness Director (HWD) and Opal Manager reviewed records for existing residents to ensure documentation meets the requirement. C. A Health Care Practitioner's Statement has been developed for the facility and must be completed prior to occupancy (Attachment C). It includes a date of last pneumonia vaccination date. It is the responsibility of the HWD to review this document prior to permitting a perspective resident to move in so their status can be identified in the pre-move in assessment and their preferences regarding vaccinations can be	**09/25/23**

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for three (R2, R3 and R4) out of eight residents sampled, the facility lacked evidence of the vaccination against pneumococcal pneumonia or a vaccination declination. Findings include: 1. 3/30/23 – R2 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 2. 6/30/23 – R3 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 3. 5/17/23 – R4 was admitted to the facility. The facility lacked evidence of a pneumococcal vaccination or of a declination of such. 8/9/23 – Per interview with E2 (DHW) at approximately 1:05 PM, E2 confirmed the vaccination status was not in evidence. E2 stated she has no access to the DelVAX site but will apply to the State for access. 8/9/23 - Findings were reviewed with E1 (GM) and E2 at the exit conference, beginning at approximately 1:10 PM.	discussed to develop the individual's initial service plan. The facility hosts annual vaccination clinics each fall. All residents are offered the pneumonia vaccination as a part of the annual clinic. A resident's status and preferences regarding the pneumonia vaccination will be reviewed and documented with each scheduled or change of condition assessment. D. The facility's electronic assessment platform identifies the scheduled assessment timeline for each resident. The GM and HWD and/or Opal Manager are to review the assessment schedule and change of condition assessments as part of the weekly 1:1 Meeting Agenda (Attachment B). Additionally, the facility's Exposure Control Plan identifies the infection control plan/compliance with Delaware pneumonia vaccine documentation. The GM is responsible for documenting a review of the plan at least annually.	
3225.11.0 **3225.11.2**	**Resident Assessment** **A resident seeking entrance shall have an initial UAI-based resident assessment completed by a registered nurse**	**3225.11.0 Resident Assessment** A. The HWD has ensured Resident #1 has a current UAI and Service Care Plan as per regulatory requirements.	**09/25/23**

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	(RN) acting on behalf of the assisted living facility no more than 30 days prior to admission. In all cases, the assessment shall be completed prior to admission. Such assessment shall be reviewed by an RN within 30 days after admission and, if appropriate, revised. If the resident requires specialized medical, therapeutic, nursing services, or assistive technology, that component of the assessment must be performed by personnel qualified in that specialty area. This requirement was not met as evidenced by: Based on record review, interview and review of other facility documentation, it was determined that for one (R5) out of eight residents sampled, the facility lacked evidence that the UAIs was completed within 30 days prior to admission or a 30-day UAI review after admission. Findings include: 4/10/23 – R5 was admitted to the facility. The initial UAI was completed on 3/2/23, over 30 days prior to admission. 8/9/23 – Per interview with E2 (DHW) at approximately 1:05 PM, E2 confirmed the UAI was completed over 30 days prior to admission. 8/9/23 - Findings were reviewed with E1 (GM) and E2 at the exit conference, beginning at approximately 1:10 PM.	The initial deficiency is not able to be corrected. B. All residents had the potential to be affected. The HWD has overseen an audit of resident records to ensure all other residents have current UAI's and Service Care Plans. C. The HWD and Opal Manager have been oriented to the Electronic Resident Reporting which will be used to identify and flag scheduled UAI dates based on company policy, which meet or exceed Delaware requirements. The platform generates "dashboards" that are monitored by the Department Head or designee (daily) and GM (weekly). D. On an ongoing basis, the GM and HWD or Opal Manager will meet weekly and will use the 1:1 Meeting Template (Attachment B) to review the dashboards and move in process for each prospective resident. The GM is responsible for ensuring compliance with company policies and Delaware requirements.	
3225.12.0 **3225.12.1**	**Services**		

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3225.12.1.3	**The assisted living facility shall ensure that:** **Food service complies with the Delaware Food Code** **Cross Reference to 2019 Edition of Delaware Food Code** **2.0 Management and Personnel** **2-4 HYGIENIC PRACTICES2-402 Hair Restraints** **2-402.11 Effectiveness.** **(A) Except as provided in ¶ (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.** This requirement was not met as evidenced by: Based on observation and interview, it was determined that the facility failed to adhere to the 2019 edition of the Delaware Food code. Findings include: 8/7/23 from 9:10 AM to 9:45 AM it was observed that neither E14 (KS) or E15 (KS) had hair restraints on. Upon interview of E13 (EC/FSD), it was further determined that the Regional Dietician instructed the kitchen staff that	**3225.12.1.3 Services** A. The use of hair restraints was implemented for all affected individuals upon discovery for the affected staff, under the oversight of the Chef. B. All staff must comply with Delaware Food Code when required by their assigned tasks. The GM ensured all staff were oriented to the Code and ensured proper restraints were available and used (Attachment G). C. The GM/designee is to observe the food handling practices daily and all supervisors are responsible for making safety observation, which include sanitation practices, and corrections on an ongoing basis. New employees will be oriented to the hair restraint requirements as part of their onboarding and supervisors will monitor compliance on an ongoing basis. D. The GM and Chef will discuss Risk Management concerns at their weekly 1:1 meeting, including use of hair restraints, to ensure compliance and document any action plans as necessary.	08/09/23

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	hair restraint was not needed unless working on the cooking line. Findings were reviewed and confirmed by E13 on 8/7/23 at approximately 10:00 AM. **3 Food:** **3-5 LIMITATION OF GROWTH OF ORGANISMS OF PUBLIC HEALTH CONCERN:** **3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking.** **(A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under § 3-502.12, and except as specified in ¶¶ (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5ºC (41ºF) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.** **Commercially processed food• open and hold cold** **(B) Except as specified in ¶¶ (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is**	**3-501.17 Ready-to-Eat...Date Marking.** A. Under the supervision of the GM, ready to eat foods that were identified as unmarked were disposed of. Food that was marked but exceeded the holding date were disposed of. B. All ready to eat foods had the potential be affected. The Chef confirmed all remaining ready to eat foods stored by the facility were properly labeled and did not exceed the specified storage time. C. The root cause was related to insufficient training related to ensuring foods were clearly datemarked. The Chef, in conjunction with GM conducted training for all staff with food handling responsibilities to ensure they understood the datemarking and disposal requirements (Attachment G). The Chef will ensure the task sheet for individual responsible for closing the back of house each day verifies items are clearly datemarked. The Chef will ensure the task sheet for the individual responsible for opening the back of the house each day disposes of any items that are not clearly datemarked, or have expired, documenting it on a waste sheet. The Chef/designee is responsible for verifying the performance of these tasks on a daily basis and ensuring new staff members are oriented to the tasks. Additionally, a Sanitation Inspection (Attachment D) form has been developed for use at the community as a quality assurance monitoring	**08/09/23**

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in ¶ (A) of this section and: **(1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1;** **(2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety.** **(C) A refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD ingredient or a portion of a refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is subsequently combined with additional ingredients or portions of FOOD shall retain the date marking of the earliest-prepared or first-prepared ingredient.** **(D) A date marking system that meets the criteria stated in ¶¶ (A) and (B) of this section may include:** **(1) Using a method APPROVED by the REGULATORY AUTHORITY for refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD that is frequently rewrapped, such as lunchmeat or a roast, or for which date marking is impractical, such as soft serve mix or milk in a dispensing machine;**	tool. It is to be completed monthly by a different staff member and includes an evaluation of proper labeling/food storage practices and reviewed by the Chef. D. To monitor compliance and evaluate success, the GM and Chef will review foodmarking and storage practices weekly during the 1:1 meeting (Attachment E). Should the review indicate anything less than 100% compliance, action items and follow up will be documented and addressed promptly.	

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	(2) Marking the date or day of preparation, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (A) of this section; (3) Marking the date or day the original container is opened in a FOOD ESTABLISHMENT, with a procedure to discard the FOOD on or before the last date or day by which the FOOD must be consumed on the premises, sold, or discarded as specified under ¶ (B) of this section; or (4) Using calendar dates, days of the week, color-coded marks, or other effective marking methods, provided that the marking system is disclosed to the REGULATORY AUTHORITY upon request. Furthermore: 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition: (A) A FOOD specified in ¶ 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in ¶ 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in ¶ 3- 501.17(A).		

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	This requirement was not met as evidenced by: Based on the observation and interview, it was determined that the facility failed to ensure most of the foods have clear date marking. Subsequently, the facility failed to dispose of the food that were not clearly datemarked or were over a month past the best by dat. Findings include: The following were discovered during the kitchen tour on 8/7/23 from 9:10 AM to 9:45 AM. 1. Several soup items and salads in the walk-in refrigerator were not date marked. According to E13 (EC/FSD) confirmed these items were made the night before. Ready to eat foods if observed without labeling on date or day must be disposed. 2. Several cheeses in clear plastic container in the walk-in refrigerator had date marking bearing in the month of July. The food exceeds the time specified and were not disposed of. Findings were reviewed and confirmed by E13 on 8/7/23 at approximately 10:00 AM. **4-6 CLEANING OF EQUIPMENT AND UTENSILS:** **4-601.11 Equipment, Food-Contact Surfaces, Nonfood- Contact Surfaces, and Utensils.** **(B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be**	**4-601.11 Food Contact Surfaces...Utensils** A. Under the supervision of the GM, staff took immediate corrective action at the time of the survey to clean the fume hood exhausts and kitchen air ducts.	**09/21/23**

Provider's Signature _____ Title _____ Date _____

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	kept free of encrusted grease deposits and other soil accumulations. **(C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.** This requirement was not met as evidenced by: Based on the observation and interview, it was determined that the facility failed to ensure the cooking exhaust was properly maintained and the air intake and ventilation systems were free of excess dust, dirt, and outside contaminants. Findings include: The following were discovered during the kitchen tour on 8/7/23 from 9:10 AM to 9:45 AM. 1. The fume hood exhausts at the cooking area were dusty and greasy, 2. The kitchen air duct vents are dusty with layers of dust and appears to be outside debris. Findings were reviewed and confirmed by E13 (EC/FSD) on 8/7/23 at approximately 10:00 AM. **5.0 Water, Plumbing, and Waste:** **5-2 PLUMBING SYSTEM5-205.11 Using a Handwashing Sink:** **(A) A HANDWASHING SINK shall be maintained so that it is accessible at all times for EMPLOYEE use.**	B. The cleaning included all affected areas. C. Insufficient post-construction cleaning/detailing contributed to the findings and subsequent task/cleaning assignments failed to adequately correct the original root cause. The Chef will ensure the task lists identify cleaning of these areas (Attachment G). The GM has secured a service agreement with a third party vendor to replace filters and provide routine service. The Sanitation Inspection Form (Attachment D) will be used to ensure all Food and Beverage staff are evaluating the cleanliness of the kitchen area on a monthly basis. Additionally, the GM and Chef are responsible for monitoring the safety/sanitation conditions in the facility on a daily basis and take immediate corrective action as necessary. D. To monitor and evaluate success, the Chef will review the monthly Sanitation Inspection reports and document corrective actions as needed. The Chef and GM will review and document compliance with this plan of correction on a weekly basis using the 1:1 meeting agenda (Attachment E). **205.11 Using a Handwashing Sink** A. Under the direction of the GM, immediate action was taken at the time of the survey to remove the mat that was blocking the handwashing sink.	**8/9/23**

Provider's Signature _____ Title _____ Date _____

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	This requirement was not met as evidenced by: Based on the observation and interview, it was determined that hand sink handwashing sink in the dish washing area was not accessible. Finding include: The hand washing sink was observed to be blocked with a non-slip mat during the initial kitchen tour on 8/7/23 from 9:10 AM to 9:45 AM. Findings were reviewed and confirmed by E13 (EC/FSD) on 8/7/23 at approximately 10:00 AM. **Assisted living facility resident assistants shall, at a minimum:** **Participate in a facility-specific orientation program that covers the following topics:** **Fire and life safety, and emergency disaster plans.** This requirement was not met as evidenced by: Based on interview and review of other facility documentation, it was determined that the facility lacked evidence of life safety resident elopement drills being conducted for staff. There was evidence of training on fire drills and evacuation routes. 8/9/23 – Per interview with E3 (POM) at approximately 9:00 AM, E3 confirmed elopement drills had not been held since the facility opened.	B. Observation of all handwashing sinks indicated that no other sinks were affected. C. The Chef will ensure that the task list for the individual responsible for opening the back of the house on a daily basis verifies that the handwashing sinks are accessible (Attachment G). The Chef and GM are responsible for making safety/sanitation observations on a daily basis and taking immediate corrective action, as needed. D. To evaluate success, the GM and Chef will review during the weekly 1:1 meeting, documenting concerns/action items if reviews indicate less than 100% success on themeeting agenda (Attachment E). **3225.16.14 Resident Assistants** A. Assisted living facility resident assistants did participate in a facility-specific orientation program covering fire and life safety, and emergency disaster plans (Attachment F), so it appear that the requirement was met. B. The facility continues to orient resident assistants to fire and life safety, and emergency disaster plan as part of New Employee Orientation. C. The finding related to conducting specific elopement drills does not appear to be a requirement of this section of 3225.	**09/21/23**
3225.16.14 **3225.16.14.2** **3225.16.14.2.1**			

Provider's Signature _____ Title _____ Date _____

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: The Vero at Newark

DATE SURVEY COMPLETED: August 9, 2023

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	8/9/23 - Findings were reviewed with E1 (GM) and E2 (DHW) at the exit conference, beginning at approximately 1:10 PM.	D. The GM is responsible for overseeing employee orientation, ongoing drills and emergency procedures training, which may include elopement scenarios as well as other disaster preparedness training. The GM will use the facility's Quality Management review process to identify and prioritize emergency disaster preparedness training.	

Provider's Signature _____ Title _____ Date _____