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: Meadowcrest at Middletown

DATE SURVEY COMPLETED: March 6, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES
	An unannounced Annual and Complaint Survey was conducted at this facility from March 1, 2024, through March 6, 2024. The deficiencies contained in this report are based on interview, record review, review of other facility documentation and State reports. The facility census on the first day of the survey was sixty-four (64). The survey sample totaled twelve (12) residents. Abbreviations/definitions used in this state report are as follows: ARSD – Assistant Resident Services Director; ED - Executive Director; LPN – Licensed Practical Nurse; RSD – Resident Services Director.	
3225.5.0	**General Requirements**	3225.5.12
3225.5.12	**An assisted living facility that provides direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.** This requirement was not met as evidenced by:	A. No residents were identified as being affected by the deficient practice. Employees E13 and E16 were provided required Dementia Training. B. All residents diagnosed as having Alzheimer's Disease or other forms of dementia, have the potential to be affected. C. An audit was completed for employees who are required to have dementia specific annual training to ensure compliance. A review of policies and procedures related to employee education/training requirements was conducted. No required changes / modifications were identified but it was determined that the process / system, to verify compliance, needs to be re-addressed, with management, to assure that those individuals are completing their required education. D. The ED/designee will conduct audits monthly until compliance is achieved over three consecutive evaluations. Finally, the ED/designee will conduct an audit 1 month later. If 100% compliance is achieved, the community will conclude the deficiency has been

Provider's Signature [signature] Title Executive Director Date 4/3/24

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	Based on interview and review of other facility documentation, it was determined that for two (E13 and E16) out of seven sampled employee files, the facility lacked evidence of annual training pursuant to the Memory Impaired resident. Findings include: 1. 11/15/22 - E13 (LPN) was hired. Per the facility training record, E13 was provided dementia training on 12/28/22. The facility lacked evidence of E13's annual training for the year 2023. 2. 8/32/21 - E16 (LPN) was hired. Per the facility training record, E16 was provided dementia training on 1/20/22. The facility lacked evidence of E16's annual training for the year 2023. 3/4/24 –Per interview with E1 on 3/6/24 at approximately 12:30 PM, E1 confirmed the trainings were not in evidence for the above employees. 3/6/24 - Findings were reviewed with E1, E2 and E3 (ARSD) at the exit conference, beginning at approximately 12:50 PM.	corrected. Results of audits will be reviewed during the community's QA meeting. Completion Date: 4/3/2024

Provider's Signature Kate A Mylld Title Executive Director Date 4/3/24