



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

NAME OF FACILITY: Shipley Living

DATE SURVEY COMPLETED: October 9, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
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An unannounced Annual and Complaint Survey was conducted at this facility from October 8, 2024 through October 9, 2024. The deficiency contained in this report is based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was ten (10). The survey sample totaled five (5) residents.

Abbreviations/definitions used in this state report are as follows:

ALDON – Assisted Living Director of Nursing;
Contract – A legally binding written agreement between the facility and the resident which enumerates all charges for services, materials, and equipment, as well as non-financial obligations of both parties, as specified in the State regulations;

DON – Director of Nursing;

ED - Executive Director;

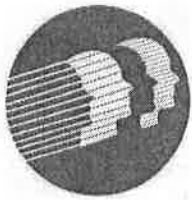
PTO – Paid time off;

SA (Service Agreement) - Allows both parties involved (the resident and the assisted living facility) to understand the types of care and services assisted living provides. These include: lodging, board, housekeeping, personal care, and supervision services;

SLRE (Senior Living Resident Evaluation) – the Facility’s resident evaluation tool in place of the SA to assess the resident’s level of care and services that will be needed;

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.

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<p>3225.0</p> <p>3225.10.0</p> <p>3225.10.10</p> <p>S/S - D</p>	<p>Assisted Living Facilities</p> <p>Contracts</p> <p>No contract shall be signed before a full assessment of the resident has been completed and a service agreement has been executed. If a deposit is required prior to move-in, the deposit shall be fully refundable if the parties cannot agree on the services and fees upon completion of the assessment.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview, record review and review of other facility documentation, it was determined that for one (R4) out of five sampled residents, the facility obtained a signed contract prior to the assessment and service agreements being executed. Findings include:</p> <p>7/8/24 – R4 was admitted to the facility. The SLRE was completed on 7/5/24 and the UAI was completed on 7/8/24. The contract was signed on 7/5/24, prior to the assessments being completed.</p> <p>10/9/24 - Findings were reviewed with E1 (ED), E2 (ALDON), E6 (Clinical Specialist), E7 (Regional Reimbursement), E8 (Food Services Director), E9 (Director of Plant Management), E13 (DON) and E14 (Human Resources Director) at the exit conference, beginning at approximately 1:50 PM.</p> <p>Resident Assessment</p>	<p>3225.10.10 Contracts</p> <p>Corrective Action: Contracts must be signed only after the completion of the admission UAI-based (Uniform Assessment Instrument) and Service Agreement. The contract for resident R4 has already been signed and cannot be retroactively corrected.</p> <p>Identification of Other Residents: All newly admitted residents have the potential to be affected by this issue. The corrective actions outlined below will ensure protection for all residents moving forward.</p> <p>System Changes: For all new admissions to Assisted Living. The UAI will be completed, and Service Plan Agreement will be executed prior to the admission date. The contract will only be signed after both the UAI and Service Plan Agreement have been completed and signed by the resident or their Power of Attorney (POA).</p> <p>Evaluation of Success: The Executive Director or designee will audit the records of all newly admitted residents to ensure that the UAI and Service Agreement are completed and signed prior to the contract being signed. Audits will be conducted weekly for four (4) weeks, then monthly for three (3) months or until 100% compliance is achieved. The results of these audits will be reported to the QAPI (Quality Assurance and</p>	<p>10/28/2024</p>

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<p>3225.11.0 3225.11.4</p> <p>S/S - D</p>	<p>The resident assessment shall be completed in conjunction with the resident.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on interview, record review and review of other facility documentation, it was determined that for one (R1) out of five sampled residents, the facility failed to provide evidence the UAI was completed in conjunction with the resident. Findings include:</p> <p>5/22/24 - R1 was admitted to the facility. The UAI completed on 5/17/24 did not have the resident/family signature confirming the assessment was completed in conjunction with the resident.</p> <p>10/9/24 – Per interview with E2 (ALDON) at approximately 1:00 PM, E2 confirmed the assessment was not signed by the resident/family.</p> <p>10/9/24 - Findings were reviewed with E1 (ED), E2, E6 (Clinical Specialist), E7 (Regional Reimbursement), E8 (Food and Services Director), E9 (Director of Plant Management), E13 (DON) and E14 (Human Resources Director) at the exit conference, beginning at approximately 1:50 PM.</p> <p>Services</p> <p>The assisted living facility shall ensure that:</p> <p>Food service complies with the Delaware.</p> <p>Food Code</p> <p>Delaware Food Code</p>	<p>Performance Improvement) Committee by the ED or designee for review and further action if necessary.</p> <p>3.225.11.4 Resident Assessments</p> <p>Corrective Action: The UAI must be signed by the resident and/or family upon completion in conjunction with the resident. The UAI for R1 has already been completed upon admission and cannot be retroactively corrected.</p> <p>Identification of Other Residents: All newly admitted residents have the potential to be affected by this issue. The corrective action outlined below will ensure protection for all residents and regulatory compliance moving forward.</p> <p>System Changes: All UAI's on new admissions to Assisted Living as well 30 day, annually and upon significant change will be completed and signed in conjunction with the resident and/or family.</p> <p>Evaluation of Success:</p> <p>The Executive Director and/or Designee will audit the records of all newly admitted residents to ensure the UAI is completed and signed in conjunction with the resident and/or family members.</p> <p>Audits will be conducted weekly for four (4) weeks, then monthly for three (3) months or until 100% compliance is achieved.</p> <p>The results of the audits will be reported to the QAPI Committee by the ED and/or Designee for review and further action if necessary.</p>	<p>10/28/ 2024</p>

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	<p>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:</p> <p>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.</p> <p>2-102.12 Certified Food Protection Manager (A) At least one employee, the PERSON IN CHARGE at the time of inspection, 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.</p> <p>10/9/24 – During the survey of the facility at approximately 1:30 PM, it was determined that the Food Services Director (E8) was the only Certified Food Protection Manager.</p> <p>Review of documentation revealed that after 6/20/24, E8 (Food Services Director) was the only Certified Food Protection Manager present. When PTO was taken, there was not a secondary Certified Food Protection Manager to take over the responsibilities of the Person in Charge.</p> <p>10/9/24 – Per interview with E8 at approximately 1:40 PM, E8 confirmed he is the only Certified Food Protection Manager at this time.</p> <p>10/9/24 - Findings were reviewed with E1 (ED), E2 (ALDON), E6 (Clinical Specialist), E7 (Regional Reimbursement), E8, E9 (Director of Plant Management), E13 (DON) and E14</p>	<p>3225.12.13 2-101.11 Assignment</p> <p>Corrected Action: There must be a PERSON IN CHARGE that is a Certified Food Protection Professional during all hours of operation. The Food and Beverage Director has implemented a schedule for all PERSONS IN CHARGE to obtain their CFPP (Certified Food Protection Professional). This cannot be retroactively corrected.</p> <p>3225.13.1</p> <p>Identification of other residents: All residents have the potential to be affected by improper food handling. Corrective actions below will ensure protection for all residents moving forward.</p> <p>System Changes: The root cause of the issue was identified as only one PERSON IN CHARGE educated and trained on proper food handling. The Food and Beverage Director has implemented a schedule for all PERSONS IN CHARGE to obtain their CFPP.</p> <p>The Executive Chef, Assistant Food and Beverage Manager and a Cook have taken the Accredited Program and are scheduled for their tests.</p> <p>An Additional 3 cooks and 1 Dietary Supervisor have been enrolled in the accredited program to ensure proper food handling and compliance of the Delaware Food Code.</p> <p>All job descriptions for lead cooks have had Certified Food Protection Professional added as a condition of employment.</p> <p>Evaluation of Success: The Food and Beverage Director and/or designee will conduct monthly audits of the</p>	<p>10/28/2024</p>

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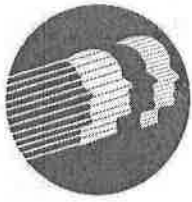
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	<p>(Human Resources Director) at the exit conference, beginning at approximately 1:50 PM.</p> <p>3-5 LIMITATION OF GROWTH OF ORGANISMS OF PUBLIC HEALTH CONCERN 3-501 Temperature and Time Control 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above.</p> <p>10/9/24 – During the survey of the facility at approximately 1:30 PM, it was determined that Food Temperature Logs between June and July 2024 were missing 18% of temperatures.</p> <p>10/9/24 – Per interview with E8 at approximately 1:40 PM, E8 confirmed the temperature logs were not complete.</p> <p>10/9/24 - Findings were reviewed with E1 (ED), E2 (ALDON), E6 (Clinical Specialist), E7 (Regional Reimbursement), E8, E9 (Director of Plant Management), E13 (DON) and E14 (Human Resources Director) at the exit conference, beginning at approximately 1:50 PM.</p>	<p>schedules to ensure a Certified Food Protection Professional is scheduled on duty every day, during working hours.</p> <p>Audits will be conducted weekly for four (4) weeks, then monthly for three (3) months or until 100% compliance is achieved.</p> <p>Results of the audits will be shared with the QAPI Committee for review and compliance of the Delaware Food Code.</p> <p>The Food and Beverage Director and or designee will track all potential expiring certifications and schedule staff for recertification as needed.</p> <p>3-5, 3-501, 30501.16, 3-501.19 Temperature and time control.</p> <p>Corrective Action: All employees involved in food handling have been educated by the Food and Beverage Director on proper procedures for safety and compliance with the Delaware Food Code. This education included maintaining temperature logs for safe and proper food handling. The root cause of this issue was identified that between June and July 2024, 18% of the temperature logs were missing and cannot be retroactively corrected.</p> <p>Identification of other residents: All residents have the potential to be affected by improper food handling. Corrective actions below will ensure protection for all residents moving forward.</p> <p>System Changes:</p>	<p>10/28/2024</p>

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<p>3225.13.0</p> <p>3225.13.1</p> <p>S/S - E</p>	<p>Service Agreements</p> <p>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.</p> <p>This requirement was not met as evidenced by:</p> <p>Based on record review, interview and review of other facility documentation, it was determined that for four (R1, R2, R3 and R4) out of five sampled residents, the facility failed to provide evidence that the resident or family participated in the development of the agreement or that the resident was provided a copy. Findings include:</p> <p>1. 5/22/24 - R1 was admitted to the facility. The pre-admission service agreement was without a date of completion but was not signed by the resident/family confirming participation in the development. The SLRE done 5/24/24 did not have the resident/family signature confirming participation in the development. The facility failed to have evidence that a copy of either was given to the resident.</p> <p>2. 2/5/24 – R2 was admitted to the facility. The SLRE done 9/19/24 did not have the res-</p>	<p>All staff have been educated on the importance of taking and recording daily temperatures on foods being served to residents.</p> <p>Daily monitoring of temperature logs will be completed by the Assistant Director of Food and Beverage and/or Designee.</p> <p>Evaluation of Success: Weekly audits will be conducted by the Executive Chef to assure compliance of maintaining proper temperature control and safe food handling.</p> <p>Audits will be conducted by the Food and Beverage Director weekly for four (4) weeks, then monthly for three (3) months or until 100% compliance is achieved.</p> <p>The results of these audits will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and further action if necessary.</p> <p>3225.13.1 Service Agreements</p> <p>Corrective Action: The resident shall participate in the development of the agreement. The resident and 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. The evaluations and agreements have not been signed by resident R1, R2, and R3 and cannot be retroactively corrected.</p> <p>Identification of other residents: All residents have the potential to be affected by</p>	<p>10/28/2024</p>

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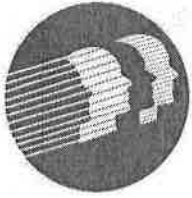
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<p>3225.13.3</p> <p>S/S- B</p>	<p>ident/family signature confirming participation in the development. The facility failed to have evidence that a copy was given to the resident.</p> <p>3. 10/18/22 - R3 was admitted to the facility. The annual SLRE done 10/3/24 did not have the resident/family signature confirming participation in the development. The facility failed to have evidence that a copy was given to the resident.</p> <p>4. 7/8/24 - R4 was admitted to the facility. The SLRE done 7/5/24 did not have the resident/family signature confirming participation in the development. The facility failed to have evidence that a copy was given to the resident.</p> <p>10/9/24 – Per interview with E2 (ALDON) at approximately 1:00 PM, E2 confirmed the assessments were not signed by the resident/family and there was no evidence that a copy was provided to the residents.</p> <p>10/9/24 - Findings were reviewed with E1 (ED), E2, E6 (Clinical Specialist), E7 (Regional Reimbursement), E8 (Food and Services Director), E9 (Director of Plant Management), E13 (DON) and E14 (Human Resources Director) at the exit conference, beginning at approximately 1:50 PM.</p> <p>The resident's personal attending physician(s) shall be identified in the service agreement by name, address, and telephone number.</p> <p>These requirements were not met as evidenced by: Based on record review, interview and review of other facility documentation, it was</p>	<p>this deficient practice. Corrective actions below will ensure protection for all residents and regulatory compliance moving forward:</p> <p>System Changes:</p> <p>All residents and/or family will participate in the development of the agreement and sign the completed document (s).</p> <p>An acknowledgement document will be developed and implemented for evaluations, agreements and contracts to show evidence the resident and/or family have received a copy.</p> <p>Evaluation of Success:</p> <p>The Executive Director and/or designee will conduct audits to ensure residents and families are participating in the development of the agreements and they have all received a copy.</p> <p>Audits will be conducted weekly audits for four (4) months, then monthly for 3 months monthly after 100% compliance is achieved.</p> <p>The results of these audits will be reported to the QAPI (Quality Assurance and Performance Improvement) Committee by the ED or designee for review and further action if necessary.</p> <p>3225.13.3 Residents Attending Physician identification</p>	<p>10/28/2024</p>

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	<p>determined that for four (R1, R2, R3 and R4) out of five sampled residents, the facility failed to include the Physician's address and phone number on the SA/SLRE assessments. Findings include:</p> <ol style="list-style-type: none"> 5/22/24 - R1 was admitted to the facility. The pre-admission service agreement and the SLRE done 5/24/24 did not include the resident's personal Physician's address and phone number. 2/5/24 – R2 was admitted to the facility. The SLRE done 9/19/24 did not include the resident's personal Physician's address and phone number. 10/18/22 - R3 was admitted to the facility. The annual SLRE done 10/3/24 did not include the resident's personal Physician's address and phone number. 7/8/24 - R4 was admitted to the facility. The SLRE done 7/5/24 did not include the resident's personal Physician's address and phone number. <p>10/9/24 – Per interview with E6 (Clinical Specialist) at approximately 1:30 PM, E6 confirmed the current assessment forms being utilized by the facility do not contain the residents' Physician's address and phone number.</p> <p>10/9/24 - Findings were reviewed with E1 (ED), E2 (ALDON), E6, E7 (Regional Reimbursement), E8 (Food and Services Director), E9 (Director of Plant Management), E13 (DON) and E14 (Human Resources Director) at the exit conference, beginning at approximately 1:50 PM.</p>	<p>Corrective Action: The Service Agreements have been revised to include the attending physician's name, address and telephone number. R1, R2, R3 and R4 Service agreements do not include the Physicians address and phone number on the SA/SLRE assessments. This can not be retroactively corrected.</p> <p>Identification of all other residents All residents have the potential to be affected by this issue. The corrective action taken above will ensure all service agreements include the residents attending physician's address and phone number.</p> <p>System Changes: All service agreements have been amended to include the attending Physicians Name, address and telephone number.</p> <p>Success Evaluation The Executive Director (*ED) or designee will audit the records of all residents to ensure that the Service Agreement include the Attending Physicians name, address and telephone number. Audits will be conducted weekly for four (4) weeks, then monthly for three (3) months or until 100% compliance is achieved.</p>	

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