DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
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STATE SURVEY REPORT

NAME OF FACILITY: Milford Place - Enlivant AL **DATE SURVEY COMPLETED:** September 30, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Complaint survey was conducted at this facility from September 26, 2024, through September 30, 2024. The deficiencies contained in this report are based on observation, interview and record review. The census on the day of the survey was sixty-three (63). The survey sample was three (3). Abbreviations/definitions used in this state report are as follows: AA – Activities Assistant; BOM – Business Office Manager; DSD - Dining Services Director; ED – Executive Director; LPN – Licensed Practical Nurse; MD - Maintenance director; MT – Medication Tech; MCPD – Memory Care Program Director; POA – Power of Attorney; Resident Assistant; RWD – Resident Wellness Director; Uniform Assessment Instrument (UAI) assessment tool used to evaluate resident function;		
3225.0 **16 Del. Code, Ch. 11, Sub-Chapter III §1131** **S/S – J**	**Assisted Living Facilities** **Abuse, Neglect, Mistreatment or Financial Exploitation of Residents or Patients Definitions** **(12) "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:** **a. Lack of attention to physical needs of the patient or resident including toileting, bathing, meals, and safety.** Based on record review, interview and review of facility policies and procedures, it was	- Resident was immediately comforted and accompanied by community staff upon discovery until transport to local hospital for evaluation. Resident subsequently returned to the community without injury and was immediately relocated to the secured wing of the community where she now resides. - Upon receipt of the surveyor's observations an Elopement Risk Assessment was initiated for all other residents of the Assisted Living Wing of the community. Division of Healthcare Quality will be apprised of the completion of this Wing-wide sweep. Measures will be put in	11/01/2024

Provider's Signature _____ Title Executive Director Date 12/19/2024

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	determined that for one (R1) out of three sampled residents reviewed for wandering and elopement, the facility failed to provide the needed supervision and services to prevent elopements. R1 eloped from the facility on 9/18/24, exiting the facility through the unsecured, unsupervised front entrance door. R1 was a risk for a severe adverse outcome related to being found outside of the facility unattended, at the end of the driveway leading to a busy roadway. The facility was made aware on 9/26/24 at 3:24 PM, of immediate jeopardy. The immediate jeopardy was abated on 9/27/24 at 9:00 PM. Findings include: Review of the facilities policy on lost or missing residents last updated January 2024, indicated, "Do not let residents wander away from our residence, but if it should happen, do everything possible to find the resident quickly and ensure their safe return. Why it's important...There is a risk of residents with dementia wandering away from our residence, and they could be injured or even die." Review of R1's clinical record revealed: 1/23/24 – An admission UAI assessment was completed for R1. The assessment lacked evidence that Section four - Psychosocial/Cognitive Information which includes the history of wandering segment was completed. 1/24/24 - R1 Admitted to the facility. 1/24/24 – An Elopement risk assessment form scored R1 as a"10" [a score of 10 or greater is risk for elopement. Please list intervention to prevent elopement on the service plan].	place to ensure safety for all residents, based upon the outcome of these assessments. - Root Cause Analysis: Why did the resident elope from the building? The Assisted Living Wing Front door was unlocked beginning at 6:45 am, prior to the 8:00 am arrival of the concierge who surveils the front door. Plan of Action: 1. Front door automatic magnetic lock schedule will be reprogrammed to remain locked from 7:00 pm through 8:30 am, the arrival time for the community's concierge. 2. Until the door lock is reprogrammed the door will be manned physically from 6:45 am until the arrival of the concierge at 8:00 am, at which time the concierge will assume front door surveillance. 3. Community will initiate hourly checks for all residents of the assisted living (AL) wing of the community during the 6:45 am – 8:30 am time period each day until the AL front door locks are reprogrammed (Attachment 1). 4. A log will be established to document that all doors are alarmed and/or manned each shift. This log (Attachment 2) will be signed off by the ranking nurse of each shift and will remain in place until the front door locks of the AL wing of the community are reprogrammed. 5. All AL wing residents shall have a new Elopement Risk Assessment completed. 6. The community's List of Residents At-Risk of Elopement (Attachment 3) shall be updated immediately and will incorporate changes, if any, based on the new Elopement Risk Assessments. 7. All community staff will be in-serviced on the community's Elopement policies and procedures and state regulations regarding the care of residents at risk of elopement (Attachment 4). 8. Community leadership and nurses will be in-serviced on the need to ensure residents receive an Elopement Risk Assessment whenever they engage in a behavior that can be	

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	1/24/24 – Resident service agreement documented that R1 had a diagnosis of dementia. The service plan lacked evidence of interventions related to R1's identified risk of elopement. 8/26/24 6:29 AM – A facility incident report documented, "Found [R1] in the parking lot walking beside [E17 (housekeeper)] towards the building. Second attempt I saw [E15 (DSD)], the chef, walking with the resident from the parking lot. Reduction plan in place frequent checks." R1's clinical record lacked evidence of frequent checks completed for R1. 9/18/24 7:20 AM – A facility incident report documented that R1 had an "Elopement, off property. Witnessed resident on bilateral knees in the grass at the entrance to the property with rollator in front of her. [E14 (RA) and E6 (LPN)] next to [R1]...resident was near the highway. Had a history of elopement." R1 was sent to the hospital for an evaluation. 9/18/24 11:42 AM - A progress note in R1's clinical record documented, "Resident returned from hospital evaluation approximately 9:50 AM within normal limits...Son spoke with E2 (RWD) who recommends resident one on one while on assisted living side. Resident family staying with resident". 9/18/24 – An Elopement risk assessment form scored R1 as a"22". 9/18/24 – The facility reported R1's elopement to the State Agency.	considered an elopement or near-elopement, regardless of the resident's alert/orientation status (Attachment 4). - An audit of nursing notes in 10% of resident charts will be conducted to determine if there is any evidence of elopement or near-elopement since the resident's most recent Elopement Risk Assessment. This audit (Attachment 5 and 6) will be conducted weekly until three consecutive weeks of 100% compliance. Then monthly until three consecutive months of compliance, at which time it will be determined that the issue has been addressed. The results of these audits will be presented to the community's monthly QAPI committee.	

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	9/18/24 – A resident service agreement was completed for R1 that documented "no" in response to elopement risk. 9/19/24 - A significant change UAI assessment documented that R1 had a history of wandering. 9/20/24 – R1 was relocated from the assisted living unit to the secured unit. 9/26/24 8:00 AM – Surveyor entered the facility through unsecured doors of the front entry way. The reception/concierge desk was empty. However the surveyor was immediately greeted by E10 (BOM). 9/26/24 10:24 AM - During an interview, E8 (concierge) stated, "The concierges come in at 8:30 AM to 4:00 PM then someone else comes in until 7:00 PM. I believe after that the doors are locked on a timer." The concierge staff are stationed at the front desk supervising the front entry doors from 8:30 AM through 7:00 PM. 9/26/24 10:31 AM - During an interview, E1 (ED) confirmed, "The doors are on a timed lock from 7:00 PM when the concierge leaves until 6:45 AM." The front entry doors are unsecured and unsupervised from 6:45 AM through 8:30 AM. 9/26/24 11:28 AM – During an interview, E17 (housekeeper) stated, that on 8/26/24 "I saw R1 leave and knew she wasn't supposed to unattended, so I immediately went after her and brought her to the nurses station." 9/26/24 – 11:40 AM- During an interview E15 (DSD) confirmed that on 8/26/24 "I saw her go out and was able to catch her before she		

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	got far, I tried to walk with her a bit then returns her back to the staff." 9/26/24 2:46 PM – During an interview R2 (RWD) stated in between R1's 8/26/24 attempted elopement and 9/18/24 elopement the facility "had someone monitor and do frequent checks. From 8:30 AM to 7:00 PM we have someone to monitor, all residents are on an every two-hour check and when the residents return from the hospital the nurses round on them every shift for three days." E2 stated, after the attempted elopement on 8/26/24 "Our initial response was to check for infection then her son wanted to take her to the walk-in clinic, she was admitted, and she spent 2-3 days in the hospital. When she came back on 9/3/26 she was back to her baseline with infrequent periods of confusion, so we determined that the level of care [unsecured assisted living] was still suitable for her. From multiple viewpoints it was determined that she was alert and oriented to person, place, and time and that care was appropriate. At this point [R1's] mental status has changed to a sustained change in mental status." E1 (ED) then stated, "There was a period where multiple folks had determined she was alert and oriented to person, place and time. At some point closer to the 18th [9/18/24] that orientation changed and declined." The facility was not able to provide documentation of the frequent checks. During the same interview, E1 was asked has the facility identified a concern with window time that the front entrance is unsecure and unsupervised? E1 responded, "We have internally discussed adjusting the time the door opens to give us additional time". E2 then stated, "We are asking the care team firsthand from them if there are residents they have concerns about." Both E1 and E2		

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	stated, education on elopements was provided monthly, however their education was "informal" and "undocumented". 9/26/24 3:24 PM – E1 (ED) was presented with the immediate jeopardy template regarding R1's elopement. The facility provided the following corrective measures: 9/27/24 7:30 AM- E1 (ED) observed at the concierge desk supervising the facility entry doors. E1 stated, that a manager on duty will be supervising the facility entry doors until they are re-programmed to lock from 6:45 AM – 8:30 AM. 9/27/24 10:19 AM – The facility submitted their abatement/removal plan received via email. 9/27/24 12:39 PM – During an interview, E4 (LPN) stated, "The night shift nurse [E6 (LPN)] came up and notified us that [R1] had tried to leave the property and that she was down at the end of the road. She was pretty far down, and the doors aren't locked. We hadn't seen her exit and when we got there she was down by the road by the entrance. 9/27/24 12:43 PM -E13 (MD) demonstrated and confirmed the facility entry doors are now programmed to lock from 7:00 PM through 8:30 AM, at which time the concierge will supervise the facility entry doors. 9/27/24 12:45 PM – During an interview, E14 (RA) stated that on 9/18/24, "[E6 (LPN)] came and got us, I hopped in her car and got to [R1]." E14 confirmed that R1 was alone and		

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	at the end of the facility driveway near route 113 when she arrived at the resident. 9/30/24 8:37 AM – 8:52 AM – During interviews, E5 (LPN), E9 (MT), E11 (RA), E(12 (RA), E7 (AA), E10 (BOM) confirmed that they completed education regarding resident elopements, locking of doors and supervision of the front entry door. 9/30/24 8:59 AM – E1 presented education contents related to elopements, and door security, with staff sign on sheets dated 9/27/24. 9/30/24 9:03 AM - E1 (ED) confirmed the abatement of the immediate jeopardy was completed on 9/27/24 at 9:00 PM. Findings were reviewed with E1 (ED) and E2 (RWD) during the exit conference on 9/30/24 at 9:00 AM		

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