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

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

STATE SURVEY REPORT

NAME OF FACILITY: Milford Center

DATE SURVEY COMPLETED: March 9, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from March 2, 2026, through March 9, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records, and other facility documentation as indicated. The facility census on the first day of the survey was ninety (90). The survey sample totaled thirty-seven (37) residents.		3/30/26
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement was not met as evidenced by: Cross Refer to the CMS 2567 – L survey completed March 9, 2026: F578, F605, F641, F657, F658, F685, F686, F756 and F791.	Cross Referred F578, F605, F641, F657, F658, F686, F756, F791	3/30/26

Provider's Signature Rebecca White Title Administrator Date 4/10/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILFORD CENTER	700 MARVEL ROAD , MILFORD, Delaware, 19963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		03/30/2026
F0000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from March 2, 2026, through March 9, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records, and other facility documentation as indicated. The facility census on the first day of the survey was ninety (90). The survey sample totaled thirty-seven (37) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; DON - Director of Nursing; GDR - Gradual dose reduction; IDT - Interdisciplinary Team; MRR - Monthly Medication Review, a pharmacist review of the resident's medication; NHA - Nursing Home Administrator; NP - Nurse Practitioner. AIMS (Abnormal Involuntary Movement Scale) - a rating scale to measure involuntary movements of the face, mouth, trunk, or limbs known as tardive dyskinesia that sometimes develops as a side effect of long-term treatment with antipsychotic medications; Ancillary – various healthcare services provided to	F0000		03/30/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0000	Continued from page 1 support the doctor; Antidepressant – drug to counter depression; Antipsychotic- class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; BIMS (Brief Interview for Mental Status) – assessment of the resident's mental status with score ranges from 0 to 15, 0 indicating severe cognitive impairment, 15 indicating cognitively intact; Insomnia – sleep disorder that is characterized by difficulty falling and/or staying asleep; Non-pharmacologicial - any intervention (therapy or technique) intended to improve health or well-being that does not involve the use of any drug or medicine; Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed).	F0000		
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.	F0578	F578: Request/Refuse/Discontinue Treatment/Formite Advanced Directives Corrective Action of Areas Affected: R7 was offered an opportunity to formulate an advance directive on 03/24/26; the resident declined to make advanced directives at this time Other areas affected: An initial audit of current residents in the facility was completed to ensure that all residents were given the opportunity to formulate advance directives and social services assessments were accurate based on review of questions pertaining to advanced directives on 03/25/26. Systemic Changes to Prevent Future Occurrences: A root-cause analysis was completed on 3/23/26 and it was determined that the social worker needed re-education on offering the advance directives and accurate completion of the social services assessment. To ensure advanced directives are being offered, admissions will be reviewed during the clinical morning meeting after 72 hour meetings for verification. Education on	03/30/2026

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F0578 SS = D	Continued from page 2 (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R7) out of two residents reviewed for Advance Directives, the facility failed to offer an opportunity to formulate an advance directive. Findings include: Review of R7's clinical record revealed: 2/3/26 - R7 was admitted to the facility. 2/6/26 11:31 AM - A BIM's assessment was completed for R7 with a score of 15 indicating R7 was cognitively intact. 2/6/26 11:34 AM - An admission Social Services Assessment was completed and documented that R7 did not have an Advanced Directive (AD) in place and opportunity to complete AD was marked "No". 3/2/26 10:26 AM - During an interview, R7 stated that he did not have an AD and the facility did not offer to assist with formulating one. 3/3/26 9:16 AM - During an interview, E7 (SW) stated that the expectation was to complete the assessment with the resident and if they do not have an AD to offer to assist enacting one. E7 confirmed based on the assessment for R7 that the right to formulate an AD was not offered.	F0578	Continued from page 2 offering advanced directives and completion of the social services assessment will be given by the Nurse Practice Educator to social workers assigned to Milford Center and those who provide assistance as needed by 03/29/26. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment A) to ensure that advanced directives were offered to 100% of new admissions to the facility. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0578 SS = D	Continued from page 3 3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.	F0578		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F0605	F605: Right to be Free from Chemical Restraints Corrective Action of Areas Affected: R8 had a medication added to the current drug regimen without any supporting documentation by the provider. R8 had supporting documentation for trazodone in follow up note as insomnia being controlled 2/28/2026. Other areas affected: An initial audit of current residents in the facility was completed to be sure all residents on any sleep medication have a rationale for use documented by the provider by 3/25/26. Systemic Changes to Prevent Future Occurrences: A root-cause analysis was completed on 3/23/26 and it was determined that the provider was unaware she had to include rationale for use when prescribing a psychotropic medication. To ensure a rationale is included for prescribed psychotropic medications, new orders will be reviewed during the clinical morning meeting. Education on proper documentation for prescribing psychotropic medications will be provided to the Medical Director and Nurse Practitioner by the Nurse Practice Educator by 03/29/26. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment B) to ensure that a rationale for use for sedative-hypnotic medication is documented for 10% of current residents with active orders for this medication class. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	03/30/2026

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F0605 SS = D	Continued from page 4 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are	F0605		

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F0605 SS = D	Continued from page 5 limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R8) out of five residents sampled for medication review, the facility failed to ensure that the resident was free from unnecessary meds. Findings include: Review of R8's clinical record revealed: 7/12/23 - R8 was admitted to the facility. 10/8/24 - A physician's order for R8 documented Trazodone 50 mg give 0.5 tablet by mouth at bedtime for insomnia. 1/10/25 - A physician's order for R8 documented Seroquel 12.5 mg give by mouth at bedtime for schizoaffective disorder. 11/13/25 9:07 AM - A provider's progress note documented for R8 to initiate GDR of Seroquel. 11/13/25 8:00 PM - A physician's order for R8 documented Trazadone 50 mg give one tablet by mouth at bedtime for insomnia. 11/13/25 7:48 PM - An IDT progress note documented that R8, "had no change in behaviors, no increase or change in medications in the last 30 days, and pharmacy recommendation to GDR: noted will attempt when resident [R8] is clinically stable. [R8] is currently on Seroquel and Trazodone 50 mg." 3/4/26 11:43 AM - During an interview, E8 (CNA) stated that if a resident had insomnia, staff are expected to monitor them and maintain safety while the resident is awake and stated that CNA's do not document sleep patterns, including times, or frequency of awakenings.	F0605		

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F0605 SS = D	Continued from page 6 3/4/26 12:04 PM - During an interview, E9 (LPN) stated that staff are expected to monitor residents with insomnia and document any non-pharmacological interventions in the progress notes. E9 also stated that nurses should document how often a resident is awake during the night and duration of time the resident remains awake. 3/6/26 9:13 AM - During an interview, E14 (NP) stated that staff should monitor and document residents' sleep patterns and interventions, specifically residents taking medications to assist with sleep. E14 also stated that if residents have a change in patterns that the provider should be notified to address those changes. E14 confirmed that R8 was on a GDR of Seroquel and stated that typically when one medication is decreased, another medication may be increased to offset the decrease. E14 stated the reason was to decrease polypharmacy and overuse of psychotropic medications; however, in this case, E14 stated she was not sure the reason for the increase in the Trazodone. According to E14, R8 was stable on the combination of medication and did not have increased behaviors or concerns. The facility failed to monitor and document effectiveness of medications used for sleep and failed to document the rationale for increase of Trazodone for R8. 3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.	F0605		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.	F0641	F641: Accuracy of Assessments Corrective Action of Areas Affected: R42's MDS was coded incorrectly to reflect vision and hearing needs. R42's MDS was corrected on 3/9/26 to reflect current vision, dental and hearing needs. Other areas affected: An initial audit of current residents admitted to the facility within the last 30 days was completed to ensure Section B of the MDS for vision, dental and hearing was accurate based on assessments by 3/25/26. Systemic Changes to Prevent Future Occurrences: A root-cause analysis was completed on 3/23/26 and it was determined that communication between the rehabilitation department and nursing, including the	03/30/2026

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F0641 SS = D	Continued from page 7 §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for one resident (R42) out of 37 residents in the investigative sample, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's dental, vision, and hearing status. Findings include: Review of R42's clinical record revealed: 8/21/25 – A facility Clinical Admission Assessment included a dental assessment section with options to document dental status such as having natural teeth, dentures, or no natural teeth (edentulous). The assessment also included components to evaluate oral/dental status such as cavities, broken teeth, oral abnormalities, gum condition, and mouth pain. A review of the assessment revealed the oral/dental examination was documented as "not assessed/no information." 8/28/25 – The Admission MDS assessment documented in Section B (Hearing, Speech, and Vision) that R42's hearing and vision were adequate. The assessment documented a BIMS score of 15, indicating the resident was cognitively intact. Section L (Oral/Dental Status) was coded as "none of the above." 11/28/25 - A quarterly MDS documented that R42 had adequate hearing, no hearing aid, adequate vision, and no corrective lenses.	F0641	Continued from page 7 MDS nurse on assessment findings related to vision, dental and hearing needs for residents was not optimal. To ensure communication between the departments, identified needs are reviewed during the clinical morning meeting (DON and RN) to address documented resident needs and added to the clinical follow up sheet, review of long term care evals will be completed to ensure completion. Education will be given by the Nurse Practice Educator (RN) to rehabilitation staff, licensed nurses, including MDS to review the communication process which includes assessment findings to identify residents in need of vision, hearing and dental services by 03/29/26. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment C) to ensure that 10% of new admissions needs for vision, dental and hearing were met. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0641 SS = D	Continued from page 8 2/26/26 - A quarterly MDS documented that R42 had adequate hearing, no hearing aid, adequate vision, and no corrective lenses. 3/2/26 8:59 AM – During observation and interview, R42 was asked if he had any dental concerns. R42 stated, "I have told them I need to go to the dentist, and I don't have any teeth." During the interview, R42 frequently stated "huh" and was observed holding his hand to his left ear when questions were asked. Questions had to be repeated, and the interviewer had to raise their voice for R42 to hear and respond. 3/9/26 12:02 PM – During an interview, E17 (MDS Coordinator) confirmed that R42 had been coded on the MDS as having no issues with hearing or vision. E17 reviewed the Physical Therapy (PT) and Occupational Therapy (OT) evaluations, which documented hearing loss. E17 stated the MDS assessments would need to be updated to reflect accurate information. 3/9/26 12:10 PM – During an interview, E16 (Physical Therapist) stated the initial evaluation documented hearing loss in the left ear during the admission assessment. E16 stated this information is not routinely reported to nursing unless the deficit affects therapy participation. 3/9/26 3:00 PM – The findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.	F0641		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F0656	F656: Develop/Implement Comprehensive Care Plan Corrective Action of Areas Affected: The care plan for R8 was updated to reflect measurable goals and person-centered interventions for sleep, specifically, provide non-pharm interventions such as aromatherapy, HS snack, toileting before bed and administration of medications on 3/24/26. Other areas affected: An initial audit of current residents prescribed medicinal interventions for sleep was completed to ensure that measurable goals (ex: sleep quality) and person-centered care plans were documented by 3/25/26. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 3/23/26 and it was determined that education on the policy, OPS416: Person-Centered Care Plan for licensed nurses was	03/30/2026

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F0656 SS = D	Continued from page 9 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R8) out of 37 residents in the investigative sample, the facility failed to develop a comprehensive care plan with measurable goals and person centered interventions. Findings include: Review of R8's clinical record revealed: 7/12/23 - R8 was admitted to the facility. 4/10/25 - A care plan documented that R8 experiences sleep pattern disturbances as evidenced by insomnia with the following interventions: increase daytime activity, maintain bedtime preferred by resident, and provide an environment that is conducive to the resident's ability to get adequate sleep and maintain preferred sleep/wake schedule. The goal documented R8 will maintain a pattern of sleep sufficient to promote	F0656	Continued from page 9 needed to ensure person-centered care plans included measurable goals related to sleep. To ensure person-centered care plans for residents prescribed this medication class are completed, care plans will be reviewed during the clinical morning meeting (DON and RN) for all new medications for sleep and all new admissions. Education will be given on person-centered care plans to include measurable goals by the Nurse Practice Educator to licensed nurses by 3/29/26. Monitoring of Corrective Action:The Director of Nursing and/or designee will conduct audits (attachment D) to ensure 10% of residents prescribed medicinal interventions for sleep have measurable goals (ex: sleep quality) and person-centered interventions within their care plans. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/09/2026

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F0656 SS = D	Continued from page 10 health and well-being throughout the review period. 3/4/26 12:04 PM - During an interview, E9 (LPN) stated that the expectation is for nurse's to document in progress notes any non-pharmacological interventions used to assist resident's who have insomnia and those interventions should be documented in the care plan. E9 also stated that care plans should have measurable goals and interventions should be person centered. 3/6/26 11:12 AM - During an interview, E2 (Director of Nursing) confirmed that the care plan was initiated but lacked person centered interventions related to R8's insomnia. 3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.	F0656		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R42) out of twenty-seven residents in the investigative sample, the facility failed to ensure services were provided in accordance with professional standards of quality by allowing a Licensed Practical Nurse (LPN) to complete admission assessments that are required to be completed by a Registered Nurse (RN) under the Delaware Board of Nursing scope of practice. Findings include: Delaware Board of Nursing RN, LPN, and NA/UAP Duties (2024) documented: "Admission assessments – RN. Once a care plan is established, the LPN may perform ongoing assessments." Review of R42's clinical record revealed: 8/21/25 – R42 was admitted to the facility. 8/21/25 12:00 PM – E11 (LPN) completed the Clinical Admission Assessment, Braden Scale Assessment, and Lift Evaluation.	F0658	F658: Services Provided Meet Professional Standards Corrective Action of Areas Affected: R42's admission assessment was reviewed for accuracy and completion by the Director of Nursing on 3/24/2026 which is in accordance with professional standards under the Delaware Board of Nursing scope of practice. The admission assessment was accurate and complete. Other areas affected: An initial audit of current residents admitted to the facility within the last 30 days was completed to ensure admission assessments were reviewed by a Registered Nurse (RN) by 3/25/26. Systemic Changes to Prevent Future Occurrences: A root-cause analysis was completed on 3/23/26 and it was determined that the Licensed Practical Nurse (LPN) was unaware that admission assessments must be completed by a Registered Nurse (RN). To ensure that licensed nurses are aware of the expectations for completion of admission assessments, the LPN and RN scope of practice will be reviewed for new hires during orientation. The RN on duty will be responsible for completing the N-Adv clinical admission. Education will be given by the Nurse Practice Educator to licensed nurses on professional standards under the Delaware Board of Nursing scope of practice to include completion of admission assessments by a Registered Nurse (RN) by 03/29/26. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment	03/30/2026

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F0658 SS = D	Continued from page 11 The admission assessments for R42 were completed by an LPN rather than a RN, as required under the Delaware Board of Nursing scope of practice. 3/9/26 11:20 AM – During an interview, E12 (RN) stated that the expectation was for a Registered Nurse to complete all admission assessments for new residents. E12 confirmed that E11, whose job title is Licensed Practical Nurse, completed the aforementioned assessments. 3/9/26 3:00 PM – Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.	F0658	Continued from page 11 E) to ensure that 100% of new admission assessments were completed by a Registered Nurse (RN). The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	
F0685 SS = D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R42) out of one sampled resident reviewed for hearing/vision, it was determined that the facility failed to ensure that R42 received proper treatment and assistive device to maintain hearing and vision abilities. Findings include: Review of R42's clinical record revealed: 8/21/25 - R42 was admitted to the facility. 8/21/25 12:00 PM - A Clinical Admission assessment documented that R42 was not using hearing aids to complete the assessment. Hearing ability and vision ability were not assessed, and the assessment documented no corrective lenses in use.	F0685	F685: Treatment/Devices to Maintain Hearing/Vision Corrective Action of Areas Affected: Upon reassessment, R42 requested vision and hearing services. R42's vision appointment was done 3/17/2026. R42's hearing appointment is scheduled with Bayhealth ENT on 7/29/26. Other areas affected: An initial audit of current residents admitted to the facility was completed to ensure hearing and vision assessments were completed and appointments scheduled (if applicable) by 3/25/26. Systemic Changes to Prevent Future Occurrences: A root-cause analysis conducted on 3/23/26 identified that licensed nurses were not consistently completing vision and hearing assessments on admission or quarterly, and the rehabilitation department was not communicating observations related to residents needing hearing or vision services to nursing leadership and/or social services. The facility identified that licensed nurses were not consistently completing assessments due to not automatically populating in the electronic medical record (EMR). To ensure vision and hearing assessments are completed, review of new assessments will occur during the clinical morning meeting. Education will be given by the Nurse Practice Educator to licensed nurses on completion of vision and hearing assessments on admission and quarterly by 3/29/26. Additionally, education will be given by the Nurse Practice Educator to the rehabilitation department and social services on the communication process of observations related to residents needing visions or hearing services to nursing leadership by 3/29/26. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment	03/30/2026

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F0685 SS = D	Continued from page 12 8/22/25 - A physical therapy evaluation documented that R42 had vision impairment and left ear hearing impairment. 8/22/25 - An occupation therapy evaluation documented that R42 had adequate vision with eye condition of cataracts and had minimal difficulty hearing. 8/28/25 - An admission MDS documented that R42 had adequate hearing, no hearing aid, adequate vision, and no corrective lenses. The MDS also documented R42 was a BIMs of 15 indicating cognitively intact. 11/4/25 - A progress note documented that Director of Social Services "met with [R42] to discuss ancillary services (podiatry, dental, vision and hearing). [R42] declined podiatry however wished to be referred to dental, hearing and vision. [Social Services] will notify clinical team." 11/6/25 - A care plan for R42 documented that resident or responsible party accepts ancillary services (vision/hearing/dental/podiatry) as part of the ongoing care with the following interventions: encourage resident to verbalize concerns related to ancillary care, educate resident on benefits of ancillary services, and offer opportunities to revisit decision at care conference. 11/28/25 - A quarterly MDS documented that R42 had adequate hearing, no hearing aid, adequate vision, and no corrective lenses. 2/26/26 - A quarterly MDS documented that R42 had adequate hearing, no hearing aid, adequate vision, and no corrective lenses. 3/2/26 9:01 AM - During an interview and observation, R42 was unable to hear and asked interviewer to speak up during the interview or repeat what was said. 3/5/26 12:45 PM – During an interview, R42 stated that staff were aware he did not have glasses and that he did not have teeth. R42 stated, "They talked about it at the meeting. They know about my glasses hearing and my teeth." R42 further stated he was using readers/ glasses but reported they were not helping him see clearly. During the interview, R42 frequently stated "huh" and was observed holding his hand to his left ear when questions were asked. Questions had to be repeated, and the interviewer had to raise their voice in order for R42 to respond. 3/9/26 10:30 AM - During an interview and observation,	F0685	Continued from page 12 F) to ensure 100% of new admissions have vision and hearing assessments completed and if these services are needed, appointments are scheduled. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0685 SS = D	Continued from page 13 R42 stated he was willing to go to appointments if they would acquire hearing aids and glasses he would go to the appointments. During this interview, an observation of R42 holding the phone close to his face and the volume turned up so R42 could hear the video he was watching. 3/9/26 10:35 AM - During an interview, E18 (CNA) stated that if a resident had a change in vision or hearing staff should report it to the nurse so it can be evaluated. 3/9/26 10:40 AM - During an interview, E10 (LPN) stated that if a resident had a change in vision or hearing the nurse would add them to the provider to be seen list to have them evaluated for the change. E10 confirmed that nurses do not typically assess vision and hearing on the quarterly assessments and once the provider sees the resident nursing will monitor until they are referred to the appropriate specialist. 3/9/26 11:20 AM - During an interview, E12 (RN) stated that the IDT team will discuss any residents that need services related to vision and hearing and once determined services are required the SW (social worker) will then call and set up appointments. 3/9/26 11:34 AM - During an interview, E7 (SW) stated the expectation is for the SW to make the appointments for outside services once the IDT determines its needed for the resident. E7 stated he was not sure if R42 was receiving services but would find out. 3/9/26 12:10 PM - During an interview, E16 (Physical Therapist) confirmed that R42 had a hearing deficit in the left ear and that it was identified on his initial PT/OT screening. E16 further stated that PT does not notify nursing of the deficit unless it affects the resident receiving therapy services. The facility failed to identify R42's vision and hearing deficit, routinely assess and evaluate, and refer for necessary services related to vision and hearing. 3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.	F0685		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F0686	F686: Treatment/Services to Prevent/Heal Pressure Ulcer Corrective Action of Areas Affected: For R64, as per order, the dressing was changed and the order was corrected to reflect on the TAR on 3/4/26. Upon	03/30/2026

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F0686 SS = D	Continued from page 14 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that for one (R64) out of two residents reviewed for pressure injury, the facility failed to follow a physician's order for dressing change. Findings include: A review of R64's clinical record revealed: 2/19/26 – R64 was admitted to the facility with diagnoses including displaced fracture of the left femur, acute kidney failure, and diabetes. 2/26/26 – An initial MDS assessment documented R64 was cognitively intact and had one unstageable pressure injury present on admission. 2/27/26 – A physician's order documented to apply skin prep to the right heel blister, then apply a foam dressing twice daily. February 2026 – A review of R64's Treatment Administration Record (TAR) revealed the right heel treatment order had been entered as an ancillary order and did not appear on the TAR. As a result, there was no designated area for nursing staff to document completion of the ordered treatment. 3/5/26 10:30 AM – During wound rounds, observation of R64's right heel revealed the foam dressing was dated 3/2/26, indicating the dressing had not been changed twice daily as ordered. 3/5/26 10:30 AM – During an interview, E4 (LPN) confirmed the foam dressing was dated 3/2/26, indicating the dressing had not been changed twice daily. E4 immediately changed the dressing.	F0686	Continued from page 14 completion of a skin assessment on 3/26/26 from the Certified Wound Care Nurse Practitioner, the status of the wound to the right heel was healed. Other areas affected: An initial audit of current residents with active wound treatment orders was completed to ensure the orders were coded to reflect on the TAR by 3/25/26. No wound treatment orders were found to be coded incorrectly. Systemic Changes to Prevent Future Occurrences: A root-cause analysis was completed on 3/23/26 and it was determined that licensed nurses were unaware of the wound treatment order since it was coded as "ancillary" rather than "treatment administration record (TAR)." Only one wound care order was entered incorrectly which was erroneous. The nurses who cared for R64, did not revise the order since they were unaware that orders could be coded as "ancillary" vs. "treatment administration record (TAR)." The Certified Wound Care Nurse Practitioner completes wound assessments and makes recommendations for treatments; the medical director and NP reviews the recommendations and approves the treatment orders. The Certified Wound Care Nurse Practitioner evaluated R64 on 2/26/26 and 3/5/26. To ensure that wound care orders are inputted correctly in the electronic medical record (EMR), all new wound treatment orders will be reviewed during the clinical morning meeting (DON and RN) for accuracy. Education will be given by the Nurse Practice Educator to licensed nurses on the protocol to input wound treatment orders to ensure they are displayed on the treatment administration record by 03/29/26. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment G) to ensure that 100% of new wound treatment orders are coded accurately to reflect on the TAR. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0686 SS = D	Continued from page 15 3/5/26 10:45 AM – During an interview, E5 (RN) confirmed the treatment order had been incorrectly entered as an ancillary order rather than on the TAR, resulting in no designated location for nursing staff to document completion of the dressing changes. 3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Leader) during the exit conference.	F0686		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps	F0756	F756: Drug Regimen Review, Report Irregular, Act On Corrective Action of Areas Affected: On 3/4/26, the provider documented the rationale for not attempting a GDR on R6 due to previous attempts having failed and benefits outweigh risk of continued use. The medication regime review recommendations for R72 was completed by the medical director and the medication changed on 1/12/2026, as verified by the facility. Other areas affected: An initial audit for all medication regime review recommendations was conducted of all current residents within the last 30 days to ensure a rationale was documented for a GDR was completed by 3/25/26. Additionally, medication regime review recommendations were reviewed to ensure they were completed as per facility protocol (within 30 days of receiving the recommendations) by 3/25/26. Systemic Changes to Prevent Future Occurrences: A root-cause analysis was completed on 3/23/26 and it was determined that the medical providers were unaware of the requirement to document a rationale for not attempting a GDR (Policy: Medication Management Section 8.4) and reviewing pharmacy recommendations as per policy, MMR Review & Reporting Section 8.1. To ensure MMRs are reviewed and completed as per policy, MMRs will be reviewed weekly by the DON and physician. The GDR pharm recommendations will also be reviewed monthly during the facility GDR meeting with psych providers. Education will be provided by the Nurse Practice Educator to all medical providers on documentation of a rationale for GDRs that are not indicated and completion of MMRs within 30 days by 03/29/26. Monitoring of Corrective Action: (1) The Director of Nursing and/or designee will conduct audits (attachment	03/30/2026

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F0756 SS = D	Continued from page 16 the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review it was determined that for two (R6 and R72) out of five residents reviewed for unnecessary medications, the facility failed to ensure a clinical rationale was documented for not completing a gradual dose reduction (GDR) of an anti-psychotic medication and failed to respond to a Medication Regimen Review (MRR) pharmacy recommendation promptly. Findings include: A policy titled "Medication Monitoring: Medication Regimen Review and Reporting" last updated 1/2024 documented ... "8. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols." 1.Review of R6's clinical record revealed: 3/1/24 - R6 was admitted to the facility. 7/18/25 - A physician's order for R6 documented Abilify (antipsychotic) 15 mg by mouth daily for the treatment of schizophrenia. 1/2/26 - A Medication Regimen Review (MRR) documented R6's Abilify to consider a trial dose reduction to 10 mg daily. The provider documented that a GDR (gradual dose reduction) is not indicated due to: dose reduction attempt at this time would risk decompensation of patient and "See physician's progress note for rationale." 2/9/26 - A physician's progress note documented "Gradual dose reduction of patient's antipsychotic medication was not recommended or ordered during this visit." The providers progress note lacked documentation of a clinical rationale explaining why a GDR was not attempted. 3/3/26 3:30 PM - During an interview, E2 (DON) and E5 (Clinical Lead) confirmed the providers progress note lacked a rationale explaining why a GDR was not attempted. 2. Review of R72's clinical record revealed:	F0756	Continued from page 16 H1) for 10% of current residents prescribed psychotropic medication to ensure a rationale was documented if a GDR was not attempted. (2) The Director of Nursing and/or designee will conduct audits (attachment H2) for 10% of current residents with active medication regime review recommendations to verify completion in accordance with policy. The audits will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0756 SS = D	Continued from page 17 5/2/22 - R72 was admitted to the facility. 5/31/25 - A physician's order for R72 documented Depakote Sprinkles 125 mg give two capsules by mouth two times a day for increased agitation. 12/2/25 - A Medication Regimen Review (MRR) documented for provider to evaluate and consider dose reduction on the following psychotropic medications: duloxetine (antidepressant), Depakote (anticonvulsant) and Seroquel (antipsychotic). The provider (E15, MD) documented that R72 was stable clinically and to attempt GDR (Gradual Dose Reduction) on Depakote. E15 signed the document on 1/7/26. The provider signed the GDR form 36 days after the pharmacy recommendation was completed. 1/2/26 - A physician's order for R72 documented Depakote Sprinkles 125 mg give one capsule by mouth two times a day for agitation. The provider changed the order 41 days after the pharmacy recommendation was completed. 3/6/26 11:12 AM - During an interview, E2 (DON) stated the expectation is for MRR recommendations to be addressed as soon as possible and within 30 days. E2 stated the process was the pharmacy sends the recommendations by email to her, then they are printed, and then the provider reviews them. E2 stated that E15 was not prompt in completing recommendations and that recommendations were not always resolved within the expected 30-day timeframe. E2 confirmed that R72's medication was not reduced until 41 days after the pharmacy recommendation. 3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.	F0756		
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility-	F0791	F791: Routine/Emergency Dental Services in NFs Corrective Action of Areas Affected: A dental appointment was scheduled for both R24 and R42 on 3/9/26. Other areas affected: An initial audit of current residents to ensure dental appointments were made for those who accepted dental services, based on responses from the MDS Section L was completed by 3/25/26.	03/30/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILFORD CENTER	700 MARVEL ROAD , MILFORD, Delaware, 19963

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F0791 SS = D	Continued from page 18 §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for two residents (R24 and R42) out of two residents reviewed for dental services, the facility failed to assist residents in obtaining routine dental services. Findings include: 1. Review of R24's clinical record revealed:	F0791	Continued from page 18 Systemic Changes to Prevent Future Occurrences: A root-cause analysis was completed on 3/23/26 and it was determined that staff were unaware that dental appointments were needed. Dental needs are identified from the clinical admission assessment and the LTC evaluation. This information is discussed in the clinical morning meeting (DON and RNs). The residents are educated about dental care during the care plan meeting. Education will be given by the Nurse Practice Educator to licensed nurses and social services to review the process which include scheduling dental appointments based on resident needs identified through assessments or adding the resident to the dental list to be seen in the facility by a provider by 03/29/26. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment I) to ensure 100% of new admissions who accepted dental services were scheduled for an appointment. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0791 SS = D	Continued from page 19 11/15/25 – The Admission MDS assessment documented a BIMS score of 15 and in Section L0200 (Oral/Dental Status) coded "D," indicating broken teeth or cavities. A care plan created in November 2025 documented a focus area stating: "Resident/Responsible Party accepts ancillary services (vision/hearing/dental) as part of ongoing care." Interventions included encouraging the resident to verbalize concerns related to ancillary care, educating the resident on the benefits of ancillary services, and the nurse initiating a response to address areas of concern. 3/2/26 12:01 PM – During observation and interview, R24 was observed to be missing multiple teeth, including the middle top three teeth, and had only one tooth remaining on the bottom. R24 stated that a tooth fell out on Friday while eating a cheeseburger and reported that he sometimes has pain. R24 stated that he told E10 (LPN) on Friday when the tooth fell out. 3/4/26 2:30 PM – During an interview, E10 (LPN) stated that when residents are assessed for dental needs or request dental services, they are placed on the dental list in a dental binder. E10 showed the surveyor a dental binder that contained a list of residents to be seen by the dental provider and residents scheduled for dental services. R24 was not listed on either list. E10 stated he did not recall R24 reporting that a tooth had fallen out or mentioning any concerns. 3/6/26 – A review of the unit dental book revealed that R24 was added to the list for an appointment after surveyor inquiry. 2. Review of R42's clinical record revealed: 8/21/25 – A facility Clinical Admission Assessment revealed a dental assessment section with options to document dental status including: has own teeth, has dentures, or has no natural teeth (edentulous). The assessment also included components to evaluate oral/dental status including cavities, broken teeth, oral abnormalities, gum condition, and mouth pain. Review of the assessment revealed the oral/dental examination was documented as "not assessed/no information." 8/28/25 – The Admission MDS assessment documented a BIMS score of 15, indicating the resident was cognitively intact. Section L0200 (Oral/Dental Status) was coded as "none of the above." 11/4/25 2:32 PM – A progress note by E13 (Former Social	F0791		

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F0791 SS = D	Continued from page 20 Services Director) documented: "Met with [R42] to discuss ancillary services (podiatry, dental, vision, and hearing). [R42] declined podiatry; however, wished to be referred to dental, hearing, and vision. [Social Services] will notify the clinical team." There was no evidence in the clinical record that a referral for dental services was initiated. A care plan last revised 2/25/26 revealed a focus area titled "Resident/Responsible Party accepts ancillary services (vision/hearing/dental) as part of their ongoing care," initiated 11/6/25. Interventions included encouraging the resident to verbalize concerns related to ancillary services, educating the resident on the benefits of ancillary services, and offering opportunities to revisit decisions at care conferences. The care plan did not include resident-specific interventions addressing the resident's edentulous status, monitoring of oral health, or referral for dental services. 3/2/26 8:59 AM – During observation and interview, R42 was asked if he had any dental concerns. Observation revealed R42 was missing both upper and lower teeth. R42 stated, "I have told them I need to go to the dentist, and I don't have any teeth." 3/4/26 – During an interview, E10 (Licensed Practical Nurse) stated that the process for a resident to be seen by the dentist is for the resident to notify staff of a problem or request to see a dentist, after which the resident is placed on the list in the dental book. Review of the dental book revealed that R42 was not listed for dental services. 3/9/26 – During an interview, E2 (DON) confirmed that R42 was not listed for dental services and had not been referred for dental evaluation despite the resident requesting dental services. As a result, the facility failed to ensure residents received assistance in obtaining routine dental services to maintain oral health and comfort. 3/9/26 3:00 PM – Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.	F0791		