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: Milford Place - Enlivant AL

DATE SURVEY COMPLETED: January 23, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Complaint visit was conducted at this facility from January 21, 2026, through January 23, 2026. The deficiencies contained in this report are based on observations, interviews, record reviews, and a review of other facility documentation. The facility census on the entrance day of the survey was sixty-five (65) residents. The survey sample totaled two (2) residents. Abbreviations/definitions used in this report are as follows: ED - Executive Director; DON – Director of Nursing; LPN – Licensed Practical Nurse; MT – Medication Technician; RA – Resident Assistant;	PLAN OF CORRECTION **Facility:** Milford Place – Inspirit Senior Living **Survey Completion Date:** January 23, 2026 **Deficiency Tags:** 3225.1.0; 3225.19.6; 3225.19.7; 3225.19.7.1; 3225.19.7.1.2; 3225.19.7.1.2.2 **Completion Date:** February 20, 2026 3225.19.7.1.2.2 (Citation 1 – Reporting Requirement) A. * Incident involving R1 and R2 was reviewed. * Responsible parties and providers were notified. * Reportable incidents shall be reported immediately, which shall be within 8 hours. All staff were re-educated on:	2/20/26
3225.0 3225.1.0	**Assisted Living Facilities** **Purpose** **The Department of Health and Social Services is issuing these regulations to promote and ensure the health, safety, and well-being of all residents of assisted living facilities. These regulations are also meant to ensure that service providers will be accountable to their residents and the Department, and to differentiate assisted living care from skilled nursing care. The essential nature of assisted living is to offer living arrangements to medically stable persons who do not require skilled nursing services and supervision. The regulations establish the minimal acceptable**	B. *All Residents have the potential to be impacted by the deficient practice. *The facility reviewed incident reports to ensure all incidents were reported timely. * All other incidents were reported timely.	

Provider's Signature _____ Title ED, NHA Date 4/10/26

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3225.19.0 3225.19.6 3225.19.7 3225.19.7.1 3225.19.7.1.2 3225.19.7.1.2.2 S/S – D	**level of services for residents of assisted living facilities.** **Records and Reports** **Reportable incidents shall be reported immediately, which shall be within 8 hours of the occurrence of the incident, to the Division. The method of reporting shall be as directed by the Division.** **Reportable incidents include:** **Abuse as defined in 16 Del.C. §1131** **Sexual abuse** **Resident to resident non-consensual sexual acts.** **This requirement was not met as evidenced by:** Based on interview, record review, and review of facility provided documents, it was determined that for two (R1 and R2) out of two residents sampled for abuse, the facility failed to report the incident to the State Agency within the required 8-hour timeframe. Findings include: 7/22/25 – R2 was admitted to the facility with a diagnosis of dementia. 1/5/26 – R1 was admitted to the facility with a diagnosis of dementia. 1/18/26 7:30 PM – A facility incident report documented that R1 and R2 were witnessed engaging in sexual activity by staff.	C. Preventative Measure to prevent reoccurrence: * Staff was re-educated on abuse reporting requirement, including the requirement to report within the designated time frame. * The facility reinforced expectations for timely reporting on all incidents. * The Administrator/Director of Nusring or designee will review incidents to ensure reports are completed within required timeframes. D. * The Director of Nursing or designee will audit will audit incident reports to ensure compliance with reporting time frames. * Audits will be conducted: * Weekly for 4 weeks. * Monthly for 2 additional months * The facility will remain 100% within reporting timeframes. * Any identified non compliance will result in: * Immediate corrective action. * Additional staff education as indicated.	2/20/26

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Title 16 Health and Safety **Subchapter III** **Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents** **S/S – D**	1/19/26 3:07 PM – A facility incident report was submitted to the State Agency. 1/21/26 12:00 PM – During an interview, E2 (DON) confirmed that the incident report was submitted to the State Agency on 1/19/26 at 3:07 PM and was outside of the required timeframe for reporting. 1/23/26 11:00 AM – Findings were reviewed with E1 (ED) and E2 during the exit conference. **1131. Definitions** **For purposes of this subchapter:** **(12) "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Neglect includes all of the following: ... b. Failure to report patient or resident health problems or changes in health problems or changes in health condition to an immediate supervisor or nurse ...".** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for two (R1 and R2) out of two residents reviewed for abuse, the facility failed to ensure adequate supervision of cognitively impaired residents (R1 and R2) on the secured dementia unit, resulting in resident-to-resident abuse without staff awareness, intervention, or separation. Findings include:	* Audits results will be reviewed through the QAPI process and additional monitoring will be implemented if compliance falls below the established threshold. * The Executive Director and the DON are responsible for oversight and compliance. Citation number 2 – Resident to Resident Non Consensual Sexual interaction A. A. Corrective Action for Residents Affected • The R1/R2 were immediately separated to prevent further interaction. • A Psychiatric Nurse Practitioner evaluated both residents for trauma potential; no trauma was identified, and ongoing follow-up remains in place. • Primary care providers were notified, and appropriate labs were ordered. • Responsible parties/POAs were notified per facility policy.	2/20/26

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	7/22/25 – R2 was admitted to the facility with a diagnosis of dementia. 7/22/25 – An initial Uniform Assessment Instrument (UAI) documented that R2 was oriented to person and place, had short-term and long-term memory problems, and had no history of behaviors. 7/22/25 – An initial Service Agreement (SA) documented that R2 was oriented to person and place, disoriented, and behavior pattern appropriate. 12/31/25 – A change of condition SA documented R2 was oriented to person and place, disoriented, with mild cognitive impairment, a history of wandering, resistive to care, and socially inappropriate behavior. The SA also documented that R2 required supervision due to making unsafe and inappropriate decisions. 1/5/26 – R1 was admitted to the facility with a diagnosis of dementia. 1/5/26 – An initial Uniform Assessment Instrument (UAI) documented that R1 was oriented to person, had short-term and long-term memory problems, a history of wandering, and no history of behaviors. 1/5/26 – An initial Service Agreement (SA) documented that R1 was oriented to person, disoriented, and behavior pattern unmarked. 1/18/26 7:30 PM – A facility incident report documented that R1 and R2 were witnessed engaging in sexual activity by staff.	• Care plans were updated to reflect increased supervision and individualized interventions. B. Identification of Other Residents Who May Be Affected • All residents in the memory care unit have the potential to be affected due to cognitive impairment and wandering behaviors. • All memory care residents were reviewed for supervision needs, wandering behaviors, and risk of entering other residents' rooms. • Care plans were updated as indicated to reflect individualized supervision and interventions. C. Systemic Changes Implemented (Root Cause and Prevention) The incident occurred due to a failure to ensure adequate supervision and monitoring of cognitively impaired residents, which allowed unsupervised room entry and resulted in inappropriate resident-to-resident interaction. • Staff were re-educated on: o Supervision and monitoring requirements for residents in the memory care unit	2/20/26

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	• 1/19/26 1:20 PM - A progress note documented that R1 had a BIMS score of three indicating severe cognitive impairment. 1/19/26 1:25 PM – A progress note documented that R2 had a BIMS score of three indicating severe cognitive impairment. 1/21/26 10:05 AM – During an interview, E3 (LPN) stated that R1 and R2 historically did not have any behaviors prior to the incident and stated both R1 and R2 were cooperative with staff. E3 also stated that R1 and R2 have been on every 15-minute checks since the incident. 1/21/26 12:36 PM – During an interview, E4 (RA) stated that during rounds of the unit, she heard noises coming from R2's room and knocked on the door. E4 did not hear a response, so she entered the room. After opening the door, E4 observed R2 standing and R1 leaning over in front of R2 in the wheelchair. E4 stated she observed R1 performing oral sex on R2. At this time, E4 stated she closed the door of the room and went to check on the resident in the room next door. Approximately five minutes later, E4 stated she observed R1 leaving R2's room. After witnessing R1 leaving R2's room, E4 stated she reported the incident to E5 (MT). After reporting the incident, E4 stated she was advised to keep R1 and R2 separated and to perform 15-minute safety checks on them. Additionally, E4 stated that the expectation is for staff to perform	o Immediate intervention when residents enter another resident's room o Abuse prevention and reporting requirements • Increased supervision was implemented, including 15-minute safety checks for residents as indicated. • Door alarms/chimes were installed or verified as functioning in the memory care unit. • Ongoing monitoring of resident behaviors and supervision needs will be maintained. D. Monitoring of Corrective Actions • The Director of Nursing (DON) and/or designee will conduct audits of: o Resident supervision and monitoring practices o Completion of safety checks o Accuracy of care plans related to supervision and wandering behaviors • Audits will be conducted: o Weekly for 4 weeks o Monthly for 2 additional months	2/20/26

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	hourly safety checks to account for all residents being present on the unit. E4 stated that R1 and R2 were observed in the common area prior to 7:00 PM. E4 indicated this was the last time she saw them before the incident. E4 confirmed that she did not witness R2 entering R1's room. It was unclear exactly when R1 and R2 were last observed prior to the incident. 1/21/26 12:47 PM – During an interview, E5 (MT) stated that E4 reported she saw R1 performing oral sex on R2 in R2's room. E5 stated she then called the supervisor to report the incident, was advised to keep R1 and R2 separated, and initiate 15-minute safety checks. E5 stated she collected statements from staff members involved at this time. E5 stated that prior to the incident, hourly safety checks were performed on the unit to account for all residents. E5 stated that R2 tends to stay in his room at night. E5 was unable to state how R1 was able to go into R2's room prior to the incident. E5 confirmed that R1 was new to the facility and would wander the unit and possibly thought R2's room was hers. The facility failed to provide adequate supervision for R1 and R2, which resulted in resident-to-resident non-consensual sexual acts, as both residents were severely cognitively impaired.	• The facility will maintain 100% compliance with supervision, monitoring, and care plan interventions. • Any identified non-compliance will result in: o Immediate corrective action o Additional staff education and/or disciplinary action as indicated • Audit results will be reviewed through the Quality Assurance and Performance Improvement (QAPI) process, and additional monitoring will be implemented if compliance falls below the established threshold. • The Executive Director and Director of Nursing are responsible for oversight and compliance.	2/20/26

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	1/23/26 11:00 AM – Findings were reviewed with E1 (ED) and E2 (DON) during the exit conference.		2/20/26

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