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: AL - Milford Place Enlivant

DATE SURVEY COMPLETED: June 2, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced revisit survey and Complaint survey were conducted at this facility from May 28, 2026, through June 2, 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 seventy-two (72). The investigative sample totaled eleven (11) residents. Abbreviations/definitions used in this state report are as follows: BOM – Business Office Manager; DOB – Date of birth; DOH – Date of hire; DWS – Director of Wellness Services; ED – Executive Director; LPN- Licensed Practical Nurse; MT – Medical Technician; PCP – Primary Care Provider – a physician, physician's assistant, or nurse practitioner that oversees a resident's medical care; RA – Resident Assistant; RN – Registered Nurse; RWD – Resident Wellness Director; RCD – Resident Care Director; NP – Nurse Practitioner; Service plan/agreement - document developed with each resident that describes the services to be provided, who will provide		

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	the services, when the services will be provided, how the services will be provided, and, if applicable, the expected outcome UAI – Uniform Assessment Instrument- an assessment to collect information on the physical condition, medical status, and psychosocial needs of an applicant/resident to determine eligibility for an assisted living.		7/15/26
3225.0	**Assisted Living Facilities**		
3225.1.0	**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 level of services for residents of assisted living facilities.	**Citation #1: Services** A. The resident identified as R7 is no longer residing in the facility and therefore cannot be corrected. The facility conducted an audit of resident records with documented changes in condition within the previous 90 days to ensure provider notification, nursing follow-up, and appropriate interventions were completed. B. The Director of Nursing (DON) or designee conducted a retrospective audit of all residents who experienced a documented change in condition within the previous three (3) months. The audit included review of nursing progress notes, therapy communications, physician/NP notification documentation, emergency department	
3225.12.0	**Services**		
3225.12.6 S/S – D	**In accordance with the service agreement, the assisted living facility shall be responsible for facilitating access to appropriate health care and social services for the resident.** This requirement is not met as evidenced by:		

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	Based on record review and interview it was determined that for one (R7) out of 11 residents reviewed the facility failed to promptly facilitate access to appropriate care for the residents. R7 experienced a change in status on 8/26/25. R7's primary care provider was not notified of the change until 8/28/25, two days later and staff facilitated hospital transfer for R7 at that time. Findings include: Review of R7's clinical record: 11/5/24 – An annual UAI assessment documented that R7 required supervision for mobility, was independent with transfers, and used no assistive devices for mobility. There were no identified gait problems. 8/1/25 – R7's service agreement indicated that [E4(NP)] was R7's primary care provider. Nursing services to be received by R7 included scheduling of appointments, frequent checks/monitoring and "other services". 8/26/25 11:00 AM – A progress note in R7's clinical record written by E5 (LPN) documented, "Per therapy resident noted with weakness to left lower extremity. States he was unable to perform walking exercise with therapy this shift." R7's clinical record lacked evidence that staff facilitated or completed any monitoring, care, or services in response to R7's change in status. 8/27/25 – E3 (RCD) was the nurse assigned to care for R7.	transfers, and change in condition assessments to verify that appropriate assessments were completed, providers were notified timely, and necessary interventions were initiated without delay. • Any identified concerns were immediately reviewed by the DON and attending provider, and corrective actions were implemented as appropriate. Residents currently receiving therapy services or identified as having recent changes in condition were also reviewed to ensure appropriate monitoring, timely provider notification, and follow-up care were in place. • The facility found no additional residents affected by the deficient practice. Any variances identified during the audit were addressed through staff education and process improvement measures. C. Effective immediately, all licensed nurses and management staff were re-educated regarding requirements for timely provider notification and documentation of all significant changes in condition. A Change in Condition Notification Tool was implemented requiring documentation of assessment findings, provider notification, orders received, interventions initiated, and resident response. D. Audits will be conducted • Weekly x4 weeks	7/15/26

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	8/28/25 5:51 PM - A progress note in R7's clinical record written by E5 (LPN) documented, "Resident sent to emergency department for acute drop left foot. Verbal order from E4 (NP). Sent via ambulance to [hospital] for evaluation and treatment." 6/2/26 10:18 AM – During an interview E5 (LPN) confirmed that therapy staff reported R7's change of status. E5 confirmed that R7's primary care provider was notified on 8/28/25 and that care was facilitated at that time, two days after R7's change in status. 6/2/26 10:52 AM – During an interview E3 (RCD) stated, "I remember him having what looked like drop foot. Usually any change we do a head toe assessment." When asked whether [E4 (NP)] was notified, E3 stated, "We would most likely have put him on the list to be seen." E3 then confirmed the facility lacked evidence that care and services were facilitated for R7 prior to 8/28/25, two days after R7's change in status. 6/2/26 11:07 AM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (RWD).	• Monthly for two additional months • The facility will remain 100% compliant and audit results will be reviewed through QAPI process and additional monitoring will be implanted if compliance falls below the established threshold • The ED and DON are responsible for oversite and completion	7/15/26
3225.16.0 3225.16.2 S/S- D	**Staffing** **A staff of persons sufficient in number and adequately trained, certified, or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.** **Per the State of Delaware Board of Nursing's Scope of Practice document entitled "RN, LPN, and NA/UAP Duties 2024", last revised 4/10/24, only a Registered Nurse**	**Citation #2: Staffing** A. The facility immediately revised its fall management procedure to align with Delaware Board of Nursing Scope of Practice requirements. Licensed Practical Nurses were educated that an RN must complete or oversee the initial post-fall assessment and documentation.	

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	(RN) can perform post fall assessment and documentation. **This requirement is not met as evidenced by:** Based on record review and interview it was determined that for two (R2 and R8) out of six residents reviewed for falls the facility failed to ensure that the initial post fall assessment on 4/1/26 was completed by a registered nurse. Findings include: 1. Review of R2's clinical record revealed: 3/26/26 10:45 PM – R2 experienced a fall in the facility. 4/1/26 5:45 AM – R2 experienced a fall in the facility. 5/29/26 – Review of incident reports/investigations for R2's falls that occurred on 3/26/26 and 4/1/26, lacked evidence an initial post-fall assessment completed by an RN. 2. Review of R8's clinical record revealed: 8/5/25 5:30 AM – R8 experienced a fall in the facility. 6/1/26 – Review of the incident report/investigation completed by E7 (LPN) for R8's fall that occurred on 8/5/26 lacked evidence of an initial post-fall assessment from an RN. 6/1/26 9:33 AM – During an interview E2 (DON) confirmed that LPN's complete initial post fall assessments in the facility. E2 stated, "They help get the resident to the sitting position, they look at range of motion	B. A retrospective audit of all falls occurring within the previous six months was completed to identify any additional incidents lacking RN assessment documentation. C. All licensed nurses received education regarding post-fall assessment requirements, documentation expectations, RN responsibilities, and procedures when an RN is not on site. • A Post-Fall Review Checklist was implemented requiring verification of RN assessment prior to closure of any fall investigation. D. Audits will be conducted • Weekly x4 weeks • Monthly for two additional months • The facility will remain 100% compliant and audit results will be reviewed through QAPI process and additional monitoring will be implanted if compliance falls below the established threshold • The ED and DON are responsible for oversite and completion	7/15/26

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	for injury, they take vital signs. If they hit their head they immediately send them to the ER. They'll call me and if I need to I will come over." 6/1/26 1:57 PM - During an interview E5 (LPN) confirmed that initial post fall assessments are completed independently without the assistance of an RN in the facility. 6/2/26 8:50 AM - During an interview E7 (LPN) confirmed completing the initial post fall assessments independently without the assistance of an RN for R8's fall that occurred on 8/5/25 and R2's fall that occurred on 3/26/26. 6/2/26 11:07 AM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (RWD).		7/15/26
3225.16.14 **3225.16.14.1** **S/S – D**	**Assisted living facility resident assistants shall, at a minimum:** **Be at least 18 years old;** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that for three (E8, E9, and E10) out of five employee personnel files reviewed the facility failed to ensure that resident assistants were at least 18 years old. Findings include: 6/1/26 10:40 AM – E6 (BOM) provided the surveyor with the personnel files of a sample of five resident assistants.	**Citation #3: Resident Assistants** A. The facility immediately reviewed the personnel files of all resident assistants to verify compliance with minimum age requirements. • Employees identified as having been hired prior to age 18 were reviewed and corrective action was taken to ensure compliance with Delaware Assisted Living regulations. • The Business Office Manager and Executive Director were re-educated regarding hiring requirements and personnel file verification procedures. B. A revised hiring checklist was implemented requiring verification of date	

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	6/1/26 11:00 AM – Review of personnel revealed the following resident assistants began employment with the facility prior to being 18 years old: E9 DOB 1/30/08 DOH 4/7/25. E10 DOB 9/6/07 DOH 4/7/25. E8 DOB 11/21/07 DOH 4/7/25. 6/1/26 11:25 AM – During an interview E6 (BOM) confirmed that E8 (RA), E9 (RA), and E10 (RA) were hired prior to turning 18 years old and prior to E6's employment at the facility. E6 stated that she started working at the facility in June 2025 and was educated by E1 (NHA) that resident assistant's must be 18 years' old to be hired. E6 confirmed that E8, E9, and E10 were hired prior to turning 18 years old and prior to E6's employment at the facility. 6/2/26 11:07 AM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (RWD).	of birth, age eligibility, required credentials, and completed pre-employment documentation. C. All new hires will undergo a secondary review by management prior to final hire approval. D. Audits will be conducted • Weekly x4 weeks • Monthly for two additional months • The facility will remain 100% compliant and audit results will be reviewed through QAPI process and additional monitoring will be implanted if compliance falls below the established threshold • The ED and DON are responsible for oversite and completion	7/15/26
3225.19.0 3225.19.2 S/S – B	**Records and Reports** **Records shall be available, along with the equipment to read them if electronically maintained, at all times to legally authorized persons; otherwise such records shall be held confidential. This requirement is not met as evidenced by:** **Based on record review and interview it was determined that for four (R5, R6, R7 and R8) out of four discharged residents the facility failed to ensure electronic records were available to legally authorized persons. Findings include:**	**Citation#4: Records and Reports** A. The facility worked with corporate's Information Technology department to restore access to discharged resident records and ensure records remain accessible to legally authorized individuals, including state surveyors. B. A review was completed of discharged resident records to verify accessibility. • A process was implemented requiring quarterly verification that discharged resident records remain accessible.	

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	6/1/26 – 10:33 AM – An email was sent from the surveyor to E1 (NHA) and E2 (RWD) requesting access to electronic medical records (EMR) for discharged residents. 6/1/26 – 2:18 PM – An email was sent from the surveyor to E1 (NHA) and E11 (DWS) with an accompanying screenshot that displayed an "access denied" warning from the facility's EMR software that prohibited survey access to read discharged residents records. 6/1/26 – 5:53 PM – E11 (DWS) sent an email that a work ticket was going to be put in to allow surveyor access to EMR for discharged residents. At the time of exit, access was not available. 6/2/26 11:07 AM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (RWD).	within the electronic medical record system. C. Facility leadership received education regarding record retention and accessibility requirements. D. Audits will be conducted • Weekly x4 weeks • Monthly for two additional months • The facility will remain 100% compliant and audit results will be reviewed through QAPI process and additional monitoring will be implanted if compliance falls below the established threshold • The ED and DON are responsible for oversite and completion	7/15/26
3225.19.3 **S/S – D**	**The assisted living facility resident clinical records shall be retained for a minimum of 5 years following discharge before being destroyed.** **This requirement is not met as evidenced by:** Based on record review and interview, it was determined that for one (R7) out of four closed records reviewed the facility failed to ensure resident records were retained for a minimum of five years. Findings include: 11/6/23 – 8/28/25 – R7 resided at the facility.	**Citation #5: Clinical Records** A. The facility conducted a review of closed records to identify any missing therapy documentation, provider notes, or other required clinical records. B. A new discharge record checklist was implemented to ensure all clinical documentation is obtained and maintained prior to record closure. C. Licensed nursing staff, therapy providers, and administrative staff received education regarding record retention requirements D. Audits will be conducted • Weekly x4 weeks	

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	6/1/26 12:49 PM – An email was to sent E1 (NHA) and E2 (RWD) from the surveyor requesting R7's paper closed record. 6/1/26 3:31 PM – Review of R7's paper closed record lacked evidence of physical therapy documentation for 2025 and provider [MD/NP] progress notes for 2025. 6/2/26 9:24 AM – During an interview E2 (RWD) confirmed that the facility did not have R7's progress notes from physical therapy, and progress notes from R7's primary care provider. 6/2/26 11:07 AM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (RWD).	• Monthly for two additional months • The facility will remain 100% compliant and audit results will be reviewed through QAPI process and additional monitoring will be implanted if compliance falls below the established threshold • The ED and DON are responsible for oversite and completion	7/15/26
3225.19.5 3225.19.5.2 S/S – D	**Incident reports, with adequate documentation, shall be completed for each incident.** **Falls without injury and falls with injuries that do not require transfer to an acute care facility or do not require reassessment of the resident.** **This requirement is not met as evidenced by:** Based on record review and interview it was determined that for three (R2, R7 and R8) out of six residents reviewed for falls the facility failed to ensure adequate documentation such as statements from direct care staff assigned and a root cause analysis to determine the cause of the fall was completed for each incident. Findings include: 1. Review of R2's clinical record revealed:	**Citation #6: Adequate Documentation** A. The facility reviewed all fall investigations from the previous six months to identify missing witness statements, staff statements, root cause analyses, or conclusions. B. The facility revised its fall investigation process and implemented a standardized Fall Investigation Packet requiring staff witness statements, assessment findings, environmental review and corrective actions/interventions. C. All licensed nurses and management staff received education regarding completion of comprehensive fall investigations regardless of whether the incident is state reportable. D Audits will be conducted • Weekly x4 weeks	

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	3/26/26 – R2 experienced a fall in the facility. 4/1/26 – R2 experienced a fall in the facility. 5/8/26 – R2 experienced a fall in the facility. 5/29/26 – Review of incident reports/investigations for R2's falls that occurred on 3/26/26, 4/1/26, and 5/8/26 lacked evidence of statements from all staff involved in R2's care at the time of the fall and a conclusion of the root cause analysis of the falls. 2. Review of R8's clinical record revealed: 8/5/25 12:28 PM – R8 experienced a fall in the facility. 6/1/26 – Review of the incident report/investigation for R8's fall that occurred on 8/5/26 lacked evidence of statements from all staff involved in R2's care at the time of the fall. 3. Review of R7's clinical record revealed: 8/19/25 2:30 AM – R7 experienced a fall in the facility. 6/1/26 – Review of the incident report/investigation for R8's fall that occurred on 8/5/26 lacked evidence of statements from all staff involved in R2's care at the time of the fall. 6/1/26 8:59 AM – During an interview E2 (RWD) confirmed that the facility incident reports lacked adequate documentation such as statements from staff and residents and conclusion of a root cause analysis of the fall. E2 stated, "we don't for our falls that aren't reportable [to the state agency]."	• Monthly for two additional months • The facility will remain 100% compliant and audit results will be reviewed through QAPI process and additional monitoring will be implanted if compliance falls below the established threshold • The ED and DON are responsible for oversite and completion	7/15/26

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	6/2/26 11:07 AM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (RWD).		

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