



**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

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NAME OF FACILITY: Milford Place - Enlivant AL

DATE SURVEY COMPLETED: August 25, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from August 21, 2026, through August 25, 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-five (75). The investigative sample totaled eleven (11). Abbreviations/definitions used in this state report are as follows: DDS - Director of dining services; DA - Dietary Aide; ED - Executive Director; LPN- Licensed Practical Nurse; Nursing Home Administrator; MT - Medical Technician; RN - Registered Nurse; RA - Resident Assistant; RWD - Resident Wellness Director; RCD - Resident Care Director; SPD - Sage Program Director; Service plan/agreement - document developed with each resident that describes the services to be provided, who will provide the services, when the services will be provided, how the services will be provided, and, if applicable, the expected outcome		10/15/26

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3225.0 3225.1.0	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. 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 level of services for residents of assisted living facilities.		10/16/26
3225.8.0 3225.8.6 S/S -D	Medication Management Within 30 days after a resident's admission and concurrent with all UAI-based assessments, the assisted living facility shall arrange for an on-site review by an RN of the resident's medication regime if he or she self-administers medication. The purpose of the on-site review is to assess the resident's cognitive and physical ability to self-administer medication or the need for assistance with or staff administration of medication. Based on record review and interview, it was determined for one (R2) out of one resident reviewed for self-medication administration		

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	the facility failed to ensure that the resident was assessed by an RN for ability to self-administer medications. Findings include: Undated – The facility policy and agreement for residents who self-administer medications indicated, "Community licensed nursing staff will perform periodic assessments to determine ability to safely self-administer medications." Review of R2's clinical record revealed: 7/8/26 – An initial UAI assessment completed for R2 documented that the resident was independent for medication management. 8/7/26 – A Service Agreement completed for R2 documented that the resident was independent for medication administration. 8/24/26 – Review of R2's MAR indicated that R2 self-administered medications. 8/24/26 12:10 PM – During an interview R2 confirmed self-administering medications when needed and that she did not recall an assessment by the facility to assess ability to safely self-administer medications. 8/24/26 1:00 PM – During an interview, E2 (RWD) confirmed the facility did not perform a self-medication assessment for safety for R2. 8/25/26 11:30 AM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (RWD).	<u>3325.8.4</u> A. R2 still resides in the community. R2 was assessed for the ability to self-administrate medications on 8/25/26 B. All residents, who self-medicate, have the potential to be affected by this deficient practice. C. The facility implemented a process requiring all residents designated as self-administering medications to receive the required RN review and documentation, regardless of whether they currently have active medication orders, and licensed nursing staff were educated on the requirements. D. The DON/designee will audit 100% of self-medication residents, including applicable new admissions and residents undergoing UAI-based assessments, weekly for four weeks and then monthly for three months, with a goal of 100% compliance.	<u>10/16/26</u>
3225.18.0	Emergency Preparedness		
3225.18.4	The staff on all shifts shall be trained on emergency and evacuation plans.	<u>3225.18.4</u> A. There were no residents identified in this deficient practice. E7 is no longer employed by community. B. All residents have the potential to be affected by this deficient practice. C. Every orientation will have all required documents filled out,	

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S/S - D	Based on record review and interview it was determined that for one (E7) out of five employees reviewed for annual training the facility failed to ensure completion of required annual training. Findings include: 6/11/25 - E7 (LPN) was hired by the facility. 8/24/26 9:29 AM - E4 (BOM) returned the facility's staffing worksheet that documented completion of required training by employees. Review of the worksheet and contents lacked evidence that E7 (LPN) completed annual training on emergency preparedness. 8/24/26 10:20 AM - During an interview E4 (BOM) confirmed that E7 (LPN) had not completed the mandatory annual trainings. 8/25/26 11:30 AM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (RWD).	training performed and signature complete prior to first shift. D. An audit will be completed on all current employees. All new employees will be audited monthly x's 3 months until 100% compliance is achieved. A. No residents were affected by this deficient practice. B. All residents have the potential to be affected by the deficient practice C. Daily checks will be completed to ensure food temperatures are being taken and recorded. Staff will be educated regarding the importance of the correct temperatures and how food borne illnesses can occur. D. Food logs will be monitored daily and monthly x's 3 months, to ensure all temperatures are taken and recorded. All results will be brought forward to QAPI to ensure accuracy of documentation until compliance is achieved.	10/16/26
S/S - E	3-501 Temperature and Time Control 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under §3-501.19, and except as specified under ¶ (B) and in ¶ (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in ¶ 3-401.11(B) or reheated as specified in ¶ 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or (2) At 5°C (41°F) or less. Based on interview and record review it was determined that the facility failed to ensure		

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16 Del. Code Part II Ch. 11, Subchap- ter III §1131 S/S- D	measures to prevent food-borne illnesses were completed when the facility failed to document temperatures of food prepared to serve residents twelve times in ninety days. Findings include: 8/25/26 9:00 AM – Review of the facility's cooking temperature logs revealed temperatures were not logged for the following meals: June 2026 – 6/11 dinner, 6/18 dinner, 6/19 dinner, 6/28 breakfast and lunch, 6/29 all meals. July 2026 – 7/2 dinner, 7/7 breakfast and lunch, 7/8 breakfast and lunch, 7/9 breakfast and lunch, 7/12 breakfast and lunch. August 2026 – 8/11 lunch and dinner and 8/12 lunch. 8/25/26 9:15 AM- During an interview, E14 (DDS) confirmed the absent temperatures. 8/25/26 11:30 AM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (RWD). Abuse, Neglect, Mistreatment, Financial Exploitation, or Medication Diversion of Patients or Residents Rights of Residents (30) Each resident shall be free from verbal, physical or mental abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food, and deprivation of sleep. Definitions.		10/14/26

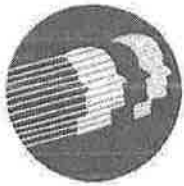
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	Based on record review and interview it was determined that for one (R1) out of one resident reviewed for abuse the facility failed to protect R1 from physical abuse by staff. This was determined to be past non-compliance with a correction date of 7/6/26. The facility policy on abuse indicated, "We will not tolerate any form of abuse, neglect, or exploitation. Staff must be skilled in working with confused residents so that challenging behavior is avoided whenever possible and handled with dignity and compassion when it occurs. Maintain a work and living environment that is professional and free from the threat of and/or occurrence of harassment, abuse (verbal, physical, mental, psychological, or sexual)." Review of R1's clinical record revealed: 7/23/25 – R1 was admitted to the facility with multiple diagnoses including dementia. 3/18/26 – A Mini Mental Exam assessed R1 as a score of 16/30 indicating mental impairment. 6/9/26 – E6 (RA) completed training on abuse prevention and signed a "Zero Tolerance for Violence" form provided by the facility. 7/1/26 - A UAI assessment documented that R1 was independent for mobility and transfers. R1 was oriented to person with memory problems, disruptive, socially inappropriate, assaultive, and destructive behaviors. 7/1/26 – A Service Agreement completed for R1 documented, "Resident has current or history of occasional disruptive, aggressive, or		

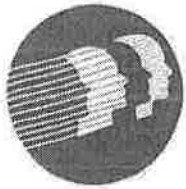
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	socially inappropriate behavior, either verbally or physically improper." 7/1/26 9:10 AM – Review of hospital records documented, R1 was transported to the hospital for treatment of a "laceration to the left forearm and right hand." The hospital record documented, "[R1] chest bumped staff member and grabber [sic] her wrist with the other hand he choked her, she pulled away and [R1] got the skin tear from the struggle." R1's wounds were cleaned and treated with medicated ointment and tetanus shot. 7/1/26 8:45 AM – E6 (RA) completed a written statement that documented, "[R1] backed me up then poked me with his finger in my chest. I tried to restrain him." 7/1/26 8:45 AM – E13 (RA) completed a written statement that documented, "[R1] went on the side of me and chest bumped [E6 (RA)], [E6] grabbed his hand." 7/5/25 – E11 (DA) completed a written statement that documented, "[E6 (RA)] said that [R1] tried to attack her and he poked her in the chest too then she got him up against the wall and put her fingers against his windpipe and he was saying he couldn't breathe and he grabbed a fork and then she bent his hand." 7/5/26 – E12 (DA) completed a written statement that documented, "I was told by [E6 (RA)] that she grabbed [R1] by the throat and he was turning red in the face and she was just waiting for him to turn blue. She was waiting for him to pass out so she could stab him with the fork up and down his body."		10/16/26

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	7/6/26 – 10:00 AM – E2 (RWD) completed a statement that documented, "A meeting was held to address additional information that had been reported to management. The morning of the meeting staff members reported to RWD and BOM that [E6 (RA)] had made statements indicating that she 'bent [R1's] finger back and didn't care if it broke and that she choked him until he turned red and was hoping he would pass out.' During the interview [E6] stated that 'after the second poke, she told him not to do that and bent his finger back, stating 'if it broke it broke'. [E6] further stated that she and [R1] had tussled. She stated that when the resident attempted to grab her, she grabbed his shirt by the throat area." 7/6/26 11:12 AM – The facility submitted an incident report to the State Agency that alleged physical abuse of R1 from E6 (RA). 7/6/26 – The facility conducted an in-service to educate resident assistants and nurses on abuse and de-escalation of resident behaviors and reporting of abuse. 8/25/26 10:00 AM – 11:15 AM – Interviews to verify completion of education on signs of abuse, abuse types, and de-escalation were completed. 8/25/25 10:19 AM – During an interview, E5 (SPD) stated, "I was not here during the incident, but I was told he physically harmed her and she attacked him also." 8/25/26 10:35 AM – During an interview E16 (RA) stated, "I heard from [E6 (RA)] came up to me and was saying that [R1] was going on about his car keys I don't know what he did		10/16/26

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	to her maybe pushed her up against a wall and she grabbed him by his arms. She said she grabbed him like that [gestures thumb and hand on throat]." 8/25/26 10:43 AM – During an interview E11 (DA) confirmed her written statement and stated, "Me and another co-worker were rolling silverware and [E6 (RA)] told us the story. She said she was choking him while waiting for him to turn colors. Then we wrote a statement and gave it to the manager." 8/25/26 11:00 AM – During an interview E12 confirmed her written statement and stated, "I was sitting in the dining room and [E6 (RA)] was complaining of her shoulder hurting and she said [R1] attacked me and she said yeah so I grabbed him by the windpipe and was waiting for him to turn blue so I could stab him with fork up and down his body." 8/25/26 11:09 AM – During an interview, E13 (RA) stated, "[E6 (RA)] choked him, [R1] was after me at first. I was inside the dining room. I removed [E6] from [R1] I got in the middle of them and moved her from in front of him. I called on the walkie [radio] for help and they came over." E13 explained she could not see everything during the entire incident. "I was in the kitchen sometimes and it was a lot going on". 8/25/26 11:19 AM – During an interview, E2 (RWD) confirmed that [E6 (RA)] physically abused [R1] on 7/1/26 and the facility was unaware until 7/6/26. E2 stated, "On July 1st [E6] informed us of the incident. That [R1] chest bumped her, and she said she grabbed him by the arms. According to her and Donna then he was the aggressor. Over the weekend		10/16/26

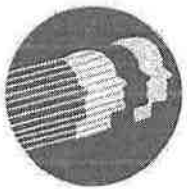
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	[E6] was telling staff she choked him wanting him to turn blue and bent his fingers back. We re-investigated and she said, yeah I bent his fingers back and if it broke, it broke and I don't remember choking him but I could have.' We removed her from the facility and terminated her. We called the police a file was reported. I educated staff and do oral audits randomly when situation arise; I talk with staff about how they are addressing situations." 8/21/26 – 8/25/26 – Review of the facility response to the staff to resident abuse that occurred on 7/1/26 against R1 included termination of E6 (RA), reporting of the incident to the State Agency, education of all direct care staff and audits for ongoing compliance. As a result of the review, it was determined that the facilities past non-compliance was corrected as of 7/6/26. 8/25/26 11:30 AM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (RWD).		10/16/26

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