**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:** December 31, 2024

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED | Completion Date |
|---|---|---|---|
| | An unannounced Follow Up Visit Survey was conducted at this facility from December 30, 2024, through December 31, 2024. The survey process included observations, interviews, residents' clinical records, and a review of other facility documentation. The facility census on the first day of the survey was fifty-eight (58). The survey sample totaled three (3) residents.<br><br>Abbreviations/definitions used in this state report are as follows:<br><br>BOM – Business Office Manager;<br>DON – Director of Nursing;<br>ED – Executive Director;<br>POC – Plan of Correction.<br>Elopement – To run away or go missing. | *An assisted living facility that provides direct healthcare services to persons diagnosed as having Alzheimer's disease or other forms of dementia shall provide dementia specific training each year to those healthcare providers who must participate in continuing education programs. The mandatory training must include: communicating with persons diagnosed as having Alzheimer's disease or other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.*<br><br>*This requirement was not met as evidenced by:* | |
| **3225.0**<br><br>**3225.15.0**<br><br>**S/S – F** | **Assisted Living Facilities**<br><br>**Quality Assurance**<br><br>**The assisted living facility shall develop, implement, and adhere to a documented, ongoing quality assurance program that includes an internal monitoring process that tracks performance and measures resident satisfaction.**<br><br>**This requirement was not met as evidenced by:**<br><br>Based on interview and a review of facility documentation, the facility failed to implement an internal monitoring process to ensure the corrective action as indicated per the plan of correction (POC) was completed to prevent elopements. Findings include:<br><br>Cross Refer 3225.16.6 | *Quality Assurance*<br>*The assisted living facility shall develop, implement, and adhere to a documented, ongoing quality assurance program that includes an internal monitoring process that tracks performance and measure resident satisfaction. This requirement was not met as evidence by..*<br>*Facility failed to implement internal monitoring process to ensure corrective action as indicated per plan of corrections as indicated per the plan of correction was completed to*<br>*Criteria #1 (Individual impacted)*<br>The community failed to implement an internal monitoring system and to ensure corrective actions as indicated per the plan of correction. This effected our ability to safely care for residents by ensuring all staff had the appropriate training.<br>Criteria #2 (Identification of other residents)<br>A subsequent meeting will be held to in-service current staff members on elopement training and regulation, along with ongoing | 2/1/25 |

Provider's Signature [signature] Title NHA Date 2/21/25

**NAME OF FACILITY:** AL - Milford Place - Enlivant **DATE SURVEY COMPLETED:** December 31, 2024

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED | Completion Date |
|---|---|---|---|
| | 12/30/24 – A review of the facility's POC stated that, "All community staff will be in-serviced on the community's Elopement policies and procedures and state regulations regarding the care of residents at risk of elopement... ".<br><br>12/30/24 11:38 AM – During an interview, E2 (DON) stated that the in-service sheets dated 9/27/24 were all the employees that received the in-service education, and the facility completed the trainings in one day.<br><br>12/31/24 10:58 AM – During an interview, E2 stated that she would check to determine if there were any additional in-service sign-in sheets in addition to the those that were already given.<br><br>12/31/24 12:58 PM – E2 provided an additional in-service sign-in sheet and confirmed that all the in-service sign-in sheets were provided.<br><br>12/31/24 1:50 PM – A review of the facility in-service sign-in sheets lacked evidence that 26 out of 66 employees had completed the in-service on the elopement policies and procedures.<br><br>12/31/24 2:24 PM – During an interview, E2 stated that each unit oversees any quality assurance measures. Any trainings that are completed are kept with the business office manager (BOM). There is not a process in place that determines if all employees have completed an in-service training.<br><br>12/31/24 3:00 PM – Findings were reviewed during the exit conference with E1 (Interim ED) and E2. | education for new staffers to be given in general orientation.<br>***Criteria #3 (System Changes)***<br>A root cause analysis yielded the following: while the community provided a primary in-service to staff, all staff had in fact not been educated on elopement policy. This was directly related to the absence of an internal monitoring system to ensure compliance. An in-service was conducted for staff see (Attachment X) on elopement education and training. A new internal monitoring system has been set in place for in-service in the future. The Business office manager shall be in charge of storing in-service. When an in-service is being conducted, the BOM will print a list of current employees (separated by department) to serve as the sign in sheets.<br>***Criteria #4 (Success Evaluation)***<br>An audit of a random sample of 10% of resident charts (Attachment X) will be conducted to ensure that authorizations and/or declinations for the latest immunization services are on file in the chart and completed as appropriate. This audit will be completed daily until three consecutive days of 100% compliance, then weekly until three consecutive weeks of 100% compliance, then monthly until three consecutive months of 100% compliance, at which time the issue will be considered sufficiently addressed. Results of these audits shall be reported to the community's Monthly QAPI meeting. | |

Provider's Signature _____ Title NHA Date 2/21/25

**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:** December 31, 2024

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED | Completion Date |
|---|---|---|---|
| 3225.16.0<br><br>3225.16.6<br><br>S/S – F | **Staffing**<br><br>**The Director/Nursing Home Administrator shall have overall responsibility for managing the assisted living facility such that all requirements of state law and regulations are met.**<br><br>**This requirement was not met as evidenced by:**<br><br>Based on review of facility documentation and interviews, it was determined that the Executive Director and Director of Nursing did not ensure the completion of the Plan of Correction (POC) in-service education for Elopement was 100% completion. Findings include:<br><br>Cross Refer 3225.15.0<br><br>9/27/24 – A review of in-service sign in sheets for POC elopement training revealed that twenty-six out of sixty-six employee's signatures were not noted on the sign in sheets.<br><br>11/1/24 – A review of the facilities POC documented that "All community staff will be in-serviced on the communities Elopement policies and procedures and state regulations regarding the care of resident's at risk for elopement... ".<br><br>12/30/24 11:38 AM – An interview with E2 (DON) confirmed that the in-service sheets from 9/27/24 contained all staff trained related to elopement and the POC education.<br><br>12/31/24 2:24 PM – An interview with E2 confirmed that the facility does not have a process in place to confirm that all trainings were completed or tracked by a delegated | ***Staffing***<br>*The Director/Nursing home Administrator shall have overall responsibility for managing the assisted living facility such that all requirements of state law and regulations are met. This Requirement was not met as evidence by:*<br>*1.) Executive Director and the Director of nursing did not ensure the completion of the plan of correction POC in-service education for Elopement was 100% complete.*<br>***Criteria #1 (Individual impacted)***<br>2.) The Executive Director and Director of nursing did not ensure completion of plan of correction by ensuring POC In-service education for elopement was 100% complete. This prevented us from providing the most holistic care to resident because of lack of information.<br>**Criteria #2 (Identification of other residents)**<br>3.) A subsequent meeting will be held to in-service current staff members on elopement training and regulation, along with ongoing education for new staffers to be given in general orientation.<br>***Criteria #3 (System Changes)***<br>4.) A root cause analysis yielded the following: while the community offered an in- services to staffers, 100% of staff were not in-serviced related to a lack in oversight of completion. An in-service was conducted for all staff (Attachment X) on elopement policy and procedure.<br>***Criteria #4 (Success Evaluation)***<br>A current employee list was printed and matched against, in-service sign in sheet to en- | 2/1/25 |

Provider's Signature _____ Title NHA Date 2/21/25

**NAME OF FACILITY:** AL - Milford Place - Enlivant

**DATE SURVEY COMPLETED:** December 31, 2024

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED | Completion Date |
|---|---|---|---|
| | staff member or herself. E2 confirmed that all staff members are expected to sign in on the sheets but could not provide insight who was expected to audit to confirm 100% completion.<br><br>12/31/24 3:00 PM - Findings were reviewed during the exit conference with E1 (Interim ED) and E2. | sure that all employees in fact had been In-serviced. We will continue to monitor progress and these finding shall be reported in the community's QAPI meeting. | |

Provider's Signature _____ Title NHA Date 2/21/25