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: August 12, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual and Complaint visit was conducted at this facility from August 7, 2025, through August 12, 2025. 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-nine (69) residents. The survey sample size totaled sixteen (16) residents. Abbreviations/definitions used in this report are as follows: ED - Executive Director; LPN – Licensed Practical Nurse; QuantiFeron – blood test for tuberculosis test RA – Resident Assistant; RWD – Resident Wellness Director; TST – two-step tuberculin skin test for tuberculosis test	**3225.12 Dementia Training** **A. Corrective Action Taken:** • On 8/13/25, staff E9 and E14 completed dementia-specific training (communication techniques, psychosocial/physical needs, safety). Certificates filed. • On 8/14/25, the RWD audited all staff files; no other staff found noncompliant. **B. Measures to Prevent Recurrence:** • A Dementia Training Tracking Log was created (effective 8/15/25). New hires must complete training within 30 days of hire; annual refresher scheduled each January. **C. Root Cause Analysis Outcome:** • Deficiency occurred due to lack of a centralized tracking system for dementia-specific training, which led to oversight of E9 and E14's requirements. • The Resident Wellness Director (RWD, RN licensed in DE) is designated to maintain the log. **D. Monitoring:** • The Executive Director (ED) will review the training log monthly for six months, with findings reported at QAPI meetings. Sustained compliance will be verified through continued quarterly reviews.	9/25/25
3225.5.0 **3225.5.0** **3225.5.12** **S/S – D**	**Assisted Living Facilities** **General Requirements** **An assisted living facility that provides direct healthcare services to person 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 other forms of dementia; the psychological, social, and physical needs of those persons; and safety measures which need to**		

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	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. This requirement was not met as evidenced by: Based on interview and review of facility provided documents, it was determined that the facility failed to provide specific dementia training for (E9 and E14) out of six sampled employees. Findings include: 7/24/23 – E14 (RA) was hired. The facility lacked evidence of annual dementia training. 6/15/25 – E9 (RA) was hired. The facility lacked evidence of dementia training. 8/8/25 10:15 AM – E2 (RWD) confirmed the facility lacked evidence of dementia training for E9 and E14. 8/12/25 4:15 PM – Findings were reviewed with E1 (ED) and E2 (RWD) at the exit conference.		9/25/25
3225.9.0 **3225.9.5** **3225.5.2**	**Infection Control** **Requirement for Tuberculosis and immunization:** **Minimum requirements for pre-employment require all employees to have a baseline two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendation of the Centers for Disease Control and Prevention of**	**3225.9.5 Infection Control / TB Testing** **A. Corrective Action Taken:** • On 8/13/25, E9 completed a two-step TST test; documentation filed. • On 8/14/25, RWD audited personnel files; all other staff compliant. **B. Measures to Prevent Recurrence:** • Effective 8/14/25, new hires must provide evidence of baseline two-step TST or IGRA before hire. Staff may not be scheduled without clearance. **C. Root Cause Analysis Outcome:**	

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	the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendation of the Center for Disease Control for the appropriate risk category. This requirement is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for one (E9) out of seven sampled employees for tuberculosis testing, the facility lacked evidence of a two-step tuberculin test having been completed before employment. Findings include: 6/16/25 – E9 was hired. There was a lack of evidence provided by the facility that a TST, IGRA, or QuantiFeron test was performed. 8/8/25 10:15 AM - During an interview with E2 DON, it was confirmed that there was a lack of facility documentation to show that TST, IGRA, or QuantiFeron was completed by new employees. 8/12/25 4:15 PM – Findings were reviewed with E1 (ED) and E2 (RWD) at the exit conference.	• The deficiency occurred due to inconsistent HR verification and lack of checklist validation prior to hire. • The HR Coordinator will verify TB testing before hire; if unavailable, the RWD (RN) will assume responsibility. **D. Monitoring:** • ED will review the TB Screening Compliance Checklist monthly for six months to ensure no new hire begins without completed TB documentation.	9/25/25
3225.18.0	**Emergency Preparedness**		
3225.18.2	**Regular fire drills shall be held at least quarterly on each shift. Written records shall be kept of attendance at such drills.** **This requirement is not met as evidenced by:** Based on observations and interviews it was determined that the facility failed to include	**3225.18.2 Emergency Preparedness / Fire Drills** **A. Corrective Action Taken:** • On 8/15/25, fire drills were completed for evening and overnight shifts. • A Fire Drill Calendar covering all shifts for the next 12 months was implemented. **B. Measures to Prevent Recurrence:**	

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	all-hazards in their emergency plans. Findings include: 8/12/25 – Documents received by email at approximately 12:34 PM from E2 (DON) revealed that the facility failed to meet the minimum requirement of quarterly fire drills held on each shift. Records available for review dated between May 29, 2025, to February 19, 2025. The four fire drill reports received were conducted between 9:48 AM to 2:30 PM. No other fire drill reports were received. 8/12/25 4:15 PM – Findings were reviewed with E1 (ED) and E2 (RWD) at the exit conference.	• Attendance records will be logged in the Emergency Preparedness Binder. **C. Root Cause Analysis Outcome:** • Deficiency occurred due to lack of structured scheduling for drills across all shifts. • The Maintenance Director is assigned responsibility for ensuring drills are conducted quarterly per shift. **D. Monitoring:** • The ED will review fire drill records monthly for one year to confirm drills occur on all shifts. Results reviewed at QAPI monthly.	9/25/25
3225.19.0	**Records and Reports**		
3225.19.6	**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 directed by the Division.**	**3225.19.7.2 Reportable Incidents (Falls with Transfer)**	
3225.19.7	**Reportable incidents include:**	**A. Corrective Action Taken:** • On 8/13/25, the missing incident involving R2 was reported to DHCQ. • On 8/14/25, the RWD audited 30 days of incident reports and submitted any missed reports. • On 8/15/25, nursing staff were re-educated on Reportable Incident Policy.	
3225.7.7.2 **S/S - D**	**Injury from a fall which results in transfer to an acute care facility for treatment or evaluation of which requires periodic reassessment of the resident's clinical status by facility professional staff for up to 48 hours.** **This requirement was not met as evidenced by:** Based on interview, record review and review of facility provided documents, it was determined for one (R2) out of three residents sampled for falls the facility failed to report R2's fall with injury. R2 attained a laceration to the head with bleeding and was	**B. Measures to Prevent Recurrence:** • Effective immediately, all falls with injury requiring transfer will be reported within 8 hours per state code. **C. Root Cause Analysis Outcome:** • Deficiency occurred due to staff's lack of clarity regarding which falls required mandatory reporting. • The ED (Licensed Assisted Living Administrator) will oversee timely and accurate reporting. Education provided by the RWD (RN).	

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	transferred to the hospital for evaluation and treatment. Findings include: 6/30/23 – R2 was admitted to the facility. 6/12/25 9:15 PM – A review of a facility form "first responder worksheet documented R2 had an unwitnessed fall and injury. R2 fell in room hit her head was (sic) bleeding." R2 was transported to the hospital. 6/12/25 9:53 PM – R2 arrived at the hospital and was treated for a scalp laceration and required four staples from the fall. 8/11/25 10:00 AM – An interview with E2 (RWD) confirmed the facility did not report R2's fall with injury. E2 stated, "I will get the report done today." 8/12/25 4:15 PM – Findings were reviewed with E1 (ED) and E2 (RWD) at the exit conference.	**D. Monitoring:** • ED will review incident logs monthly for six months to verify timely reporting. Logs will track incident type, reporting time, and submission confirmation.	9/25/25
Title 16 Health and Safety **Subchapter IX. Drug Testing PPECC**	**1191. Mandatory drug screening.** **(a) An employer may not employ any applicant without first obtaining the results of that applicant's mandatory drug screening.** **(b) All applicants must submit to mandatory drug screen, as specified by regulations promulgated by the Department.** **(c)The Department shall promulgate regulations regarding the pre-employment screening of all applicants for use of all of the following illegal drugs.** **(1) Marijuana/Cannabis.** **(2) Cocaine.** **(3) Opiates.**	**Title 16, Subchapter IX – Drug Testing** **A. Corrective Action Taken:** • On 8/13/25, E9 completed a new drug screen including all six substances (Marijuana, Cocaine, Opiates, PCP, Amphetamines, Other). Results were negative and placed in file. • On 8/14/25, HR audited all employee drug screen files; all other results compliant. **B. Measures to Prevent Recurrence:** • Effective immediately, no employee may begin work until full drug screen results are on file, including marijuana. A Drug Screening Checklist was added to onboarding.	

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	(4) Phencyclidine ('PCP"). **(5) Amphetamines.** **(6) Any other illegal drug specified by the Department, under regulations promulgated under section.** **(d) The employer must provide confirmation of the drug screen in the manner prescribed by the Department's regulations.** **(e) Any employer who fails to comply with the requirements of this section is subject to a civil penalty of not less than 1,000 nor more than $5,000 for each violation.** **This requirement is not met as evidenced by:** Based on the interview and record review, it was determined that for one (E9) out of seven sampled employees for drug screening, the facility failed to complete required pre-employment drug screening. Findings include: 8/7/25 11:00 AM - A desk review of the facility's employee drug test results submitted by E2 (DON), it was determined that for one (E9) out of seven employees sampled did not have marijuana/cannabis included in their pre-employment drug screen testing regimen: 6/16/25 - E9 (resident assistant) was hired. No evidence of marijuana drug test. 8/8/2025 10:15 AM - During an interview with E2 DON, it was confirmed that there was a lack of facility documentation to show confirmation of drug screening for employees.	**C. Root Cause Analysis Outcome:** • Deficiency occurred due to incomplete review of external lab panel by HR prior to hire. • HR Coordinator will verify compliance; if unavailable, the ED (Licensed Administrator) will serve as backup reviewer. **D. Monitoring:** • ED will review the Drug Screening Checklist monthly for six months to confirm pre-employment drug testing is complete.	9/25/25

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	8/12/25 4:15 PM – Findings were reviewed with E1 (ED) and E2 (RWD) at the exit conference.		9/25/25

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