

# **STATE SURVEY REPORT**

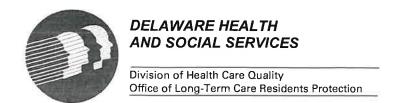
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NAME OF FACILITY: Milford Place - Enlivant AL

Provider's Signature

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
17.16	An unannounced Annual and Complaint visit was conducted at this facility from August 7, 2025, through August 12, 2025. The deficien-	3225.12 Dementia Training A. Corrective Action Taken: On 8/13/25, staff E9 and E14 com-	9/25/25
	cies 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.	pleted 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.	
	Abbreviations/definitions used in this report are as follows:	<ul> <li>Measures to Prevent Recurrence:</li> <li>A Dementia Training Tracking Log was created (effective 8/15/25). New hires</li> </ul>	
50 P	ED - Executive Director;  LPN - Licensed Practical Nurse;	must complete training within 30 days of hire; annual refresher scheduled	
	QuantiFeron – blood test for tuberculosis test	each January.  C. Root Cause Analysis Outcome:  Deficiency occurred due to lack of a	
	RA – Resident Assistant;	centralized tracking system for de- mentia-specific training, which led to	
	RWD – Resident Wellness Director;	oversight of E9 and E14's require- ments.	
	TST – two-step tuberculin skin test for tuber- culosis test	The Resident Wellness Director (RWD, RN licensed in DE) is designated to	
3225.5.0	Assisted Living Facilities	maintain the log.	
3225.5.0	General Requirements	Monitoring:     The Executive Director (ED) will review the training log monthly for six	
3225.5.12	An assisted living facility that provides direct healthcare services to person diagnosed as	months, with findings reported at QAPI meetings. Sustained compliance will be verified through continued	
s/s – D	having Alzheimer's disease or other forms of dementia shall provide dementia specific	quarterly reviews.	
	training each year to those healthcare pro- viders who must participate in continuing		
	education programs. The mandatory train-		
	ing must include: communicating with per-		
	sons diagnosed as having Alzheimer's dis-		
	ease other forms of dementia; the psycho-		
	logical, social, and physical needs of those		
4	persons; and safety measures which need to		



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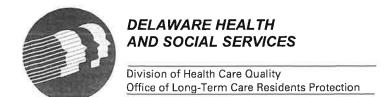
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	be taken with those persons. This paragraph shall not apply to persons certified to practice medicine under the Medical Practice Act, Chapter 17 of Title 24 of the Delaware Code.		9/25/25
	This requirement was not met as evidenced by:  Based on interview 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.		
3225.9.0	8/12/25 4:15 PM — Findings were reviewed with E1 (ED) and E2 (RWD) at the exit conference.  Infection Control		
3225.9.5	Requirement for Tuberculosis and immunization:	3225.9.5 Infection Control / TB Testing A. Corrective Action Taken: On 8/13/25, E9 completed a two-step	
3225.5.2	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 Commendation of the Commendati	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.	
_	ance with the recommendation of the Centers for Disease Control and Prevention of	C. Root Cause Analysis Outcome:	1

Title NHA BS Date 10/2/25



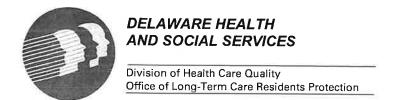
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DHSS - DHCQ 263 Chapman Road, Suite 200, Cambridge Bldg. Newark, Delaware 19702 (302) 421-7400

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	STATEMENT OF DEFICIENCIES	ADMINISTRATOR'S PLAN FOR	Completion
SECTION	SPECIFIC DEFICIENCIES	CORRECTION OF DEFICIENCIES WITH	Date
		ANTICIPATED DATES TO BE CORRECTED	
	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	<ul> <li>The deficiency occurred due to inconsistent HR verification and lack of checklist validation prior to hire.</li> <li>The HR Coordinator will verify TB testing before hire; if unavailable, the RWD (RN) will assume responsibility.</li> <li>D. Monitoring:         <ul> <li>ED will review the TB Screening Compliance Checklist monthly for six months to ensure no new hire begins without completed TB documentation.</li> </ul> </li> </ul>	9/25/28
	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.  Emergency Preparedness		
3225.18.0	Lineigency Frepareuriess		
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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NAME OF FACILITY: Milford Place - Enlivant AL DATE SURVEY COMPLETED: August 12, 2025 STATEMENT OF DEFICIENCIES ADMINISTRATOR'S PLAN FOR Completion SECTION SPECIFIC DEFICIENCIES CORRECTION OF DEFICIENCIES WITH Date ANTICIPATED DATES TO BE CORRECTED all-hazards in their emergency plans. Findings Attendance records will be logged in include: the Emergency Preparedness Binder. C. Root Cause Analysis Outcome: 8/12/25 - Documents received by email at Deficiency occurred due to lack of approximately 12:34 PM from E2 (DON) restructured scheduling for drills across vealed that the facility failed to meet the minall shifts. imum requirement of quarterly fire drills held The Maintenance Director is assigned on each shift. Records available for review responsibility for ensuring drills are conducted quarterly per shift. dated between May 29, 2025, to February 19. D. Monitoring: 2025. The four fire drill reports received were The ED will review fire drill records conducted between 9:48 AM to 2:30 PM. No monthly for one year to confirm drills other fire drill reports were received. occur on all shifts. Results reviewed at 8/12/25 4:15 PM - Findings were reviewed QAPI monthly. with E1 (ED) and E2 (RWD) at the exit conference. 3225.19.0 **Records and Reports** Reportable Incidents shall be reported im-3225.19.6 mediately, which shall be within 8 hours of 3225.19.7.2 Reportable Incidents (Falls with the occurrence of the incident, to the Divi-Transfer) sion. The method of reporting shall be di-A. Corrective Action Taken: rected by the Division. On 8/13/25, the missing incident involving R2 was reported to DHCQ. 3225.19.7 Reportable incidents include: On 8/14/25, the RWD audited 30 days Injury from a fall which results in transfer to of incident reports and submitted any 3225.7.7.2 missed reports. an acute care facility for treatment or evalu-On 8/15/25, nursing staff were re-ed-**S/S-D** ation of which requires periodic reassessucated on Reportable Incident Policy. ment of the resident's clinical status by facil-**B.** Measures to Prevent Recurrence: ity professional staff for up to 48 hours. Effective immediately, all falls with injury requiring transfer will be reported This requirement was not met as evidenced within 8 hours per state code. by: C. Root Cause Analysis Outcome: Based on interview, record review and re-Deficiency occurred due to staff's lack view of facility provided documents, it was of clarity regarding which falls required mandatory reporting. determined for one (R2) out of three residents sampled for falls the facility failed to re-The ED (Licensed Assisted Living Administrator) will oversee timely and port R2's fall with injury. R2 attained a laceraccurate reporting. Education proation to the head with bleeding and was

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vided by the RWD (RN).

Date 10/2/25

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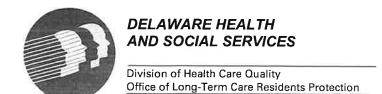
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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	transferred to the hospital for evaluation and treatment. Findings include:  6/30/23 – 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.	D. Monitoring:	9/25/28
	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.		
Title 16	1191. Mandatory drug screening.		
Health and Safety Subchapter IX.	(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	Title 16, Subchapter IX – Drug Testing A. Corrective Action Taken: On 8/13/25, E9 completed a new drug	
Drug Test- ing PPECC	drug screen, as specified by regulations promulgated by the Department.	screen including all six substances (Marijuana, Cocaine, Opiates, PCP, Amphetamines, Other). Results were	
	(c)The Department shall promulgate regulations regarding the pre-employment screening of all applicants for use of all of the following illegal drugs.	<ul> <li>negative and placed in file.</li> <li>On 8/14/25, HR audited all employee drug screen files; all other results compliant.</li> </ul>	
	(1) Marijuana/Cannabis.	B. Measures to Prevent Recurrence:	
	(2) Cocaine.	may begin work until full drug screen	
	(3) Opiates.	results are on file, including mariju- ana. A Drug Screening Checklist was	

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added to onboarding.

Date 10 2 25



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DATE SURVEY COMPLETED: August 12, 2025 STATEMENT OF DEFICIENCIES ADMINISTRATOR'S PLAN FOR Completion CORRECTION OF DEFICIENCIES WITH **SPECIFIC DEFICIENCIES** Date ANTICIPATED DATES TO BE CORRECTED (4) Phencyclidine ('PCP"). C. Root Cause Analysis Outcome:

(5) Amphetamines.

SECTION

- (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.

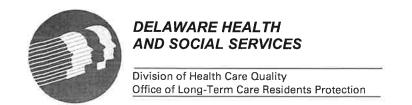
- Deficiency occurred due to incomplete review of external lab panel by HR prior to hire.
- HR Coordinator will verify compliance; if unavailable, the ED (Licensed Administrator) will serve as backup reviewer.

#### D. Monitoring:

ED will review the Drug Screening Checklist monthly for six months to confirm pre-employment drug testing is complete.

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		DATE SORVET 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
	8/12/25 4:15 PM – Findings were reviewed		0/2/2/
	with E1 (ED) and E2 (RWD) at the exit confer-		9/25/25
	ence.		
	5.755		