

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2025
NAME OF PROVIDER OR SUPPLIER Milford Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Marvel Road Milford, DE 19963	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review and review of other facility documentation it was determined that for one (R1) out of three residents reviewed for accidents and supervision the facility failed to provide adequate supervision and assistive devices to prevent elopement. This put R1 in immediate jeopardy and at risk of a serious adverse outcome. R1 was able to elope from the facility on 6/13/25 through an unsecured sliding door in the conference room. R1 wandered across a busy roadway approximately 0.6 miles away from the facility and was found asleep on the grass. R1 was missing for 1 hour and 23 minutes. An immediate jeopardy (IJ) was identified starting on 6/13/25. Due to the facility ' s corrective measures following the incident, this is being cited as immediate jeopardy, past non-compliance with an abatement date of 6/17/25. Findings include:</p> <p>A policy titled Elopement of Patient last reviewed by the facility on 6/12/25 documented Patients/Residents (hereinafter patient) will be evaluated for elopement risk upon admission, readmission, quarterly, and with change in condition as part of the clinical assessment process. Those determined to be at risk will receive appropriate interventions to reduce the risk and minimize injury Elopement is defined as any situation in which a patient leaves the premises or a safe area without the facility ' s knowledge and supervision, if necessary</p> <p>Review of R1 ' s clinical record revealed:</p> <p>1/2/20 - R1 was admitted to the facility with diagnoses including but not limited to paranoid schizophrenia, sick sinus syndrome, cardiac pacemaker and anxiety.</p> <p>3/17/20 - Review of R1 ' s care plan documented [R1] attempts to leave the building without an escort [R1] will have 3 or less episodes weekly of attempt (sic) to leave the building without an escort Additionally, [R1 ' s] elopement care plan was revised on 4/16/25 and on the date that [R1] eloped from the facility 6/13/25</p> <p>12/3/24 3:00 PM - A physicians order documented the Wander Guard/Wander Elopement Device due to poor safety awareness every shift check placement of the device and in supplemental documentation document the location</p> <p>3/19/25 - A quarterly MDS revealed R1 ' s cognition was moderately impaired.</p> <p>4/21/25 - Review of R1 ' s facility elopement risk assessment documented Wandering behavior, a pattern or goal - directed: Yes</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility investigation documented the following timeline for R1 ' s elopement on 6/13/25:</p> <p>6/12/25 11:53 PM - E3 (LPN) checked R1 ' s wander guard.</p> <p>6/13/25 3:00 AM - E4 (CNA) provided water and a snack to R1.</p> <p>4:00 AM - R1 was at the nurses' station and E3 provided orange juice and a snack to the resident. R1 then self-propelled back to his room.</p> <p>5:40 AM - R1 was noticed to be missing and additionally:</p> <ul style="list-style-type: none"> -R1 ' s wheelchair was in front of the conference room door the sliding door in the conference room was open -R1 was not seen and the elopement protocol was initiated -A whole house room to room check determined all residents were accounted for -R1 was the only resident missing -When the search for R1 was started a face sheet of R1 was printed to provide to all staff and that R1 had a wander guard order. -R1 was searched for outside of the facility by staff as well <p>6:00 AM - E2 (DON) was notified by staff.</p> <p>6:10 AM - DON called E1 (NHA) to notify.</p> <p>6:15 AM - Police were notified. The facility continued to search for R1.</p> <p>6:57 AM - E5 (CNA) driving to work saw someone resembling a resident sleeping on the grass at a home on Old Shawnee Road and [NAME] Boulevard.</p> <p>7:00 AM - E5 arrived at work and was notified R1 was missing.</p> <p>7:03 AM - E5 and E6 (RCA) drove back to the location where R1 was lying in the grass. R1 was asked to enter the car to travel back to the facility. R1 returned to the facility with both staff.</p> <p>7:30 AM - A head to toe assessment was performed on R1 and the on-call NP was notified. Neurological checks were initiated for the next 24 hours. In addition, R1 was placed on 1:1 supervision until all the sliding doors in the conference room were secured.</p> <p>7:36 AM - Staff attempted to contact emergency contact #1 left message.</p> <p>8:08 AM - Staff attempted to contact emergency contact #2 left message.</p> <p>8:18 AM - Staff contacted emergency contact # 3 and notified him of the elopement.</p> <p>(continued on next page)</p>

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