

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 11/17/2025
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, it was determined that the facility failed to ensure food and beverages were stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 9/15/25 8:29 AM - The corners of numerous ceiling tiles in the dry food storage room had a variety of different sized black and gray circular areas, which appeared to be mold. 9/15/25 9:17 AM - The clear plastic tubing that connected the kitchen juice machine to the beverage dispenser contained several areas of a blackish gray substance that appeared to be mold. 9/23/25 2:45 PM - Findings were reviewed with E1 (NHA), E2 (Quality Manager) and E3 (DON) during the exit conference.</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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