STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085010	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milford Center	700 Marvel Road Milford, DE 19963

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, it was determined that for one (R7) out of two residents reviewed for Advance Directives, the facility failed to offer an opportunity to formulate an advance directive. Findings include:Review of R7's clinical record revealed:2/3/26 - R7 was admitted to the facility.2/6/26 11:31 AM - A BIM's assessment was completed for R7 with a score of 15 indicating R7 was cognitively intact.2/6/26 11:34 AM - An admission Social Services Assessment was completed and documented that R7 did not have an Advanced Directive (AD) in place and opportunity to complete AD was marked No. 3/2/26 10:26 AM - During an interview, R7 stated that he did not have an AD and the facility did not offer to assist with formulating one. 3/3/26 9:16 AM - During an interview, E7 (SW) stated that the expectation was to complete the assessment with the resident and if they do not have an AD to offer to assist enacting one. E7 confirmed based on the assessment for R7 that the right to formulate an AD was not offered.3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.

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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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, it was determined that for one (R8) out of five residents sampled for medication review, the facility failed to ensure that the resident was free from unnecessary meds. Findings include: Review of R8's clinical record revealed:7/12/23 - R8 was admitted to the facility.10/8/24 - A physician's order for R8 documented Trazodone 50 mg give 0.5 tablet by mouth at bedtime for insomnia. 1/10/25 - A physician's order for R8 documented Seroquel 12.5 mg give by mouth at bedtime for schizoaffective disorder.11/13/25 9:07 AM - A provider's progress note documented for R8 to initiate GDR of Seroquel. 11/13/25 8:00 PM - A physician's order for R8 documented Trazadone 50 mg give one tablet by mouth at bedtime for insomnia. 11/13/25 7:48 PM - An IDT progress note documented that R8, had no change in behaviors, no increase or change in medications in the last 30 days, and pharmacy recommendation to GDR: noted will attempt when resident [R8] is clinically stable. [R8] is currently on Seroquel and Trazodone 50 mg.3/4/26 11:43 AM - During an interview, E8 (CNA) stated that if a resident had insomnia, staff are expected to monitor them and maintain safety while the resident is awake and stated that CNA's do not document sleep patterns, including times, or frequency of awakenings.3/4/26 12:04 PM - During an interview, E9 (LPN) stated that staff are expected to monitor residents with insomnia and document any non-pharmacological interventions in the progress notes. E9 also stated that nurses should document how often a resident is awake during the night and duration of time the resident remains awake. 3/6/26 9:13 AM - During an interview, E14 (NP) stated that staff should monitor and document residents' sleep patterns and interventions, specifically residents taking medications to assist with sleep. E14 also stated that if residents have a change in patterns that the provider should be notified to address those changes. E14 confirmed that R8 was on a GDR of Seroquel and stated that typically when one medication is decreased, another medication may be increased to offset the decrease. E14 stated the reason was to decrease polypharmacy and overuse of psychotropic medications; however, in this case, E14 stated she was not sure the reason for the increase in the Trazodone. According to E14, R8 was stable on the combination of medication and did not have increased behaviors or concerns. The facility failed to monitor and document effectiveness of medications used for sleep and failed to document the rationale for increase of Trazodone for R8. 3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, it was determined that for one resident (R42) out of 37 residents in the investigative sample, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the resident's dental, vision, and hearing status. Findings include:Review of R42's clinical record revealed:8/21/25 - A facility Clinical admission Assessment included a dental assessment section with options to document dental status such as having natural teeth, dentures, or no natural teeth (edentulous). The assessment also included components to evaluate oral/dental status such as cavities, broken teeth, oral abnormalities, gum condition, and mouth pain. A review of the assessment revealed the oral/dental examination was documented as not assessed/no information.8/28/25 - The admission MDS assessment documented in Section B (Hearing, Speech, and Vision) that R42's hearing and vision were adequate. The assessment documented a BIMS score of 15, indicating the resident was cognitively intact. Section L (Oral/Dental Status) was coded as none of the above.11/28/25 - A quarterly MDS documented that R42 had adequate hearing, no hearing aid, adequate vision, and no corrective lenses. 2/26/26 - A quarterly MDS documented that R42 had adequate hearing, no hearing aid, adequate vision, and no corrective lenses. 3/2/26 8:59 AM - During observation and interview, R42 was asked if he had any dental concerns. R42 stated, I have told them I need to go to the dentist, and I don't have any teeth. During the interview, R42 frequently stated huh and was observed holding his hand to his left ear when questions were asked. Questions had to be repeated, and the interviewer had to raise their voice for R42 to hear and respond.3/9/26 12:02 PM - During an interview, E17 (MDS Coordinator) confirmed that R42 had been coded on the MDS as having no issues with hearing or vision. E17 reviewed the Physical Therapy (PT) and Occupational Therapy (OT) evaluations, which documented hearing loss. E17 stated the MDS assessments would need to be updated to reflect accurate information.3/9/26 12:10 PM - During an interview, E16 (Physical Therapist) stated the initial evaluation documented hearing loss in the left ear during the admission assessment. E16 stated this information is not routinely reported to nursing unless the deficit affects therapy participation.3/9/26 3:00 PM - The findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, it was determined that for one (R8) out of 37 residents in the investigative sample, the facility failed to develop a comprehensive care plan with measurable goals and person centered interventions. Findings include:Review of R8's clinical record revealed:7/12/23 - R8 was admitted to the facility. 4/10/25 - A care plan documented that R8 experiences sleep pattern disturbances as evidenced by insomnia with the following interventions: increase daytime activity, maintain bedtime preferred by resident, and provide an environment that is conducive to the resident's ability to get adequate sleep and maintain preferred sleep/wake schedule. The goal documented R8 will maintain a pattern of sleep sufficient to promote health and well-being throughout the review period. 3/4/26 12:04 PM - During an interview, E9 (LPN) stated that the expectation is for nurse's to document in progress notes any non-pharmacological interventions used to assist resident's who have insomnia and those interventions should be documented in the care plan. E9 also stated that care plans should have measurable goals and interventions should be person centered. 3/6/26 11:12 AM - During an interview, E2 (Director of Nursing) confirmed that the care plan was initiated but lacked person centered interventions related to R8's insomnia. 3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, it was determined that for one (R42) out of twenty-seven residents in the investigative sample, the facility failed to ensure services were provided in accordance with professional standards of quality by allowing a Licensed Practical Nurse (LPN) to complete admission assessments that are required to be completed by a Registered Nurse (RN) under the Delaware Board of Nursing scope of practice. Findings include:Delaware Board of Nursing RN, LPN, and NA/UAP Duties (2024) documented: admission assessments - RN. Once a care plan is established, the LPN may perform ongoing assessments.Review of R42's clinical record revealed:8/21/25 - R42 was admitted to the facility.8/21/25 12:00 PM - E11 (LPN) completed the Clinical admission Assessment, Braden Scale Assessment, and Lift Evaluation.The admission assessments for R42 were completed by an LPN rather than a RN, as required under the Delaware Board of Nursing scope of practice.3/9/26 11:20 AM - During an interview, E12 (RN) stated that the expectation was for a Registered Nurse to complete all admission assessments for new residents. E12 confirmed that E11, whose job title is Licensed Practical Nurse, completed the aforementioned assessments.3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on record review and interview, it was determined that for one (R42) out of one sampled resident reviewed for hearing/vision, it was determined that the facility failed to ensure that R42 received proper treatment and assistive device to maintain hearing and vision abilities. Findings include: Review of R42's clinical record revealed:8/21/25 - R42 was admitted to the facility.8/21/25 12:00 PM - A Clinical admission assessment documented that R42 was not using hearing aids to complete the assessment. Hearing ability and vision ability were not assessed, and the assessment documented no corrective lenses in use. 8/22/25 - A physical therapy evaluation documented that R42 had vision impairment and left ear hearing impairment. 8/22/25 - An occupation therapy evaluation documented that R42 had adequate vision with eye condition of cataracts and had minimal difficulty hearing. 8/28/25 - An admission MDS documented that R42 had adequate hearing, no hearing aid, adequate vision, and no corrective lenses. The MDS also documented R42 was a BIMs of 15 indicating cognitively intact.11/4/25 - A progress note documented that Director of Social Services met with [R42] to discuss ancillary services (podiatry, dental, vision and hearing). [R42] declined podiatry however wished to be referred to dental, hearing and vision. [Social Services] will notify clinical team.11/6/25 - A care plan for R42 documented that resident or responsible party accepts ancillary services (vision/hearing/dental/podiatry) as part of the ongoing care with the following interventions: encourage resident to verbalize concerns related to ancillary care, educate resident on benefits of ancillary services, and offer opportunities to revisit decision at care conference. 11/28/25 - A quarterly MDS documented that R42 had adequate hearing, no hearing aid, adequate vision, and no corrective lenses. 2/26/26 - A quarterly MDS documented that R42 had adequate hearing, no hearing aid, adequate vision, and no corrective lenses. 3/2/26 9:01 AM - During an interview and observation, R42 was unable to hear and asked interviewer to speak up during the interview or repeat what was said. 3/5/26 12:45 PM - During an interview, R42 stated that staff were aware he did not have glasses and that he did not have teeth. R42 stated, They talked about it at the meeting. They know about my glasses hearing and my teeth. R42 further stated he was using readers/ glasses but reported they were not helping him see clearly. During the interview, R42 frequently stated huh and was observed holding his hand to his left ear when questions were asked. Questions had to be repeated, and the interviewer had to raise their voice in order for R42 to respond. 3/9/26 10:30 AM - During an interview and observation, R42 stated he was willing to go to appointments if they would acquire hearing aids and glasses he would go to the appointments. During this interview, an observation of R42 holding the phone close to his face and the volume turned up so R42 could hear the video he was watching. 3/9/26 10:35 AM - During an interview, E18 (CNA) stated that if a resident had a change in vision or hearing staff should report it to the nurse so it can be evaluated. 3/9/26 10:40 AM - During an interview, E10 (LPN) stated that if a resident had a change in vision or hearing the nurse would add them to the provider to be seen list to have them evaluated for the change. E10 confirmed that nurses do not typically assess vision and hearing on the quarterly assessments and once the provider sees the resident nursing will monitor until they are referred to the appropriate specialist.3/9/26 11:20 AM - During an interview, E12 (RN) stated that the IDT team will discuss any residents that need services related to vision and hearing and once determined services are required the SW (social worker) will then call and set up appointments. 3/9/26 11:34 AM - During an interview, E7 (SW) stated the expectation is for the SW to make the appointments for outside services once the IDT determines its needed for the resident. E7 stated he was not sure if R42 was receiving services but would find out. 3/9/26 12:10 PM - During an interview, E16 (Physical Therapist) confirmed that R42 had a hearing deficit in the left ear and that it was identified on his initial PT/OT screening. E16 further stated that PT does not notify nursing of the deficit unless it affects the resident receiving therapy services. The facility failed to identify R42's vision and hearing deficit, routinely assess and evaluate, and refer for necessary services related to vision and hearing. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, it was determined that for one (R64) out of two residents reviewed for pressure injury, the facility failed to follow a physician's order for dressing change. Findings include:A review of R64's clinical record revealed:2/19/26 - R64 was admitted to the facility with diagnoses including displaced fracture of the left femur, acute kidney failure, and diabetes.2/26/26 - An initial MDS assessment documented R64 was cognitively intact and had one unstageable pressure injury present on admission.2/27/26 - A physician's order documented to apply skin prep to the right heel blister, then apply a foam dressing twice daily.February 2026 - A review of R64's Treatment Administration Record (TAR) revealed the right heel treatment order had been entered as an ancillary order and did not appear on the TAR. As a result, there was no designated area for nursing staff to document completion of the ordered treatment.3/5/26 10:30 AM - During wound rounds, observation of R64's right heel revealed the foam dressing was dated 3/2/26, indicating the dressing had not been changed twice daily as ordered.3/5/26 10:30 AM - During an interview, E4 (LPN) confirmed the foam dressing was dated 3/2/26, indicating the dressing had not been changed twice daily. E4 immediately changed the dressing.3/5/26 10:45 AM - During an interview, E5 (RN) confirmed the treatment order had been incorrectly entered as an ancillary order rather than on the TAR, resulting in no designated location for nursing staff to document completion of the dressing changes.3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Leader) during the exit conference.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review it was determined that for two (R6 and R72) out of five residents reviewed for unnecessary medications, the facility failed to ensure a clinical rationale was documented for not completing a gradual dose reduction (GDR) of an anti-psychotic medication and failed to respond to a Medication Regimen Review (MRR) pharmacy recommendation promptly. Findings include: A policy titled Medication Monitoring: Medication Regimen Review and Reporting last updated 1/2024 documented . 8. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols. 1.Review of R6's clinical record revealed:3/1/24 - R6 was admitted to the facility.7/18/25 - A physician's order for R6 documented Abilify (antipsychotic) 15 mg by mouth daily for the treatment of schizophrenia. 1/2/26 - A Medication Regimen Review (MRR) documented R6's Abilify to consider a trial dose reduction to 10 mg daily. The provider documented that a GDR (gradual dose reduction) is not indicated due to: dose reduction attempt at this time would risk decompensation of patient and See physician's progress note for rationale. 2/9/26 - A physician's progress note documented Gradual dose reduction of patient's antipsychotic medication was not recommended or ordered during this visit. The providers progress note lacked documentation of a clinical rationale explaining why a GDR was not attempted.3/3/26 3:30 PM - During an interview, E2 (DON) and E5 (Clinical Lead) confirmed the providers progress note lacked a rationale explaining why a GDR was not attempted. 2. Review of R72's clinical record revealed:5/2/22 - R72 was admitted to the facility.5/31/25 - A physician's order for R72 documented Depakote Sprinkles 125 mg give two capsules by mouth two times a day for increased agitation. 12/2/25 - A Medication Regimen Review (MRR) documented for provider to evaluate and consider dose reduction on the following psychotropic medications: duloxetine (antidepressant), Depakote (anticonvulsant) and Seroquel (antipsychotic). The provider (E15, MD) documented that R72 was stable clinically and to attempt GDR (Gradual Dose Reduction) on Depakote. E15 signed the document on 1/7/26. The provider signed the GDR form 36 days after the pharmacy recommendation was completed.1/2/26 - A physician's order for R72 documented Depakote Sprinkles 125 mg give one capsule by mouth two times a day for agitation.The provider changed the order 41 days after the pharmacy recommendation was completed. 3/6/26 11:12 AM - During an interview, E2 (DON) stated the expectation is for MRR recommendations to be addressed as soon as possible and within 30 days. E2 stated the process was the pharmacy sends the recommendations by email to her, then they are printed, and then the provider reviews them. E2 stated that E15 was not prompt in completing recommendations and that recommendations were not always resolved within the expected 30-day timeframe. E2 confirmed that R72's medication was not reduced until 41 days after the pharmacy recommendation. 3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, it was determined that for two residents (R24 and R42) out of two residents reviewed for dental services, the facility failed to assist residents in obtaining routine dental services. Findings include:1. Review of R24's clinical record revealed:11/15/25 - The admission MDS assessment documented a BIMS score of 15 and in Section L0200 (Oral/Dental Status) coded D, indicating broken teeth or cavities.A care plan created in November 2025 documented a focus area stating: Resident/Responsible Party accepts ancillary services (vision/hearing/dental) as part of ongoing care. Interventions included encouraging the resident to verbalize concerns related to ancillary care, educating the resident on the benefits of ancillary services, and the nurse initiating a response to address areas of concern.3/2/26 12:01 PM - During observation and interview, R24 was observed to be missing multiple teeth, including the middle top three teeth, and had only one tooth remaining on the bottom. R24 stated that a tooth fell out on Friday while eating a cheeseburger and reported that he sometimes has pain. R24 stated that he told E10 (LPN) on Friday when the tooth fell out.3/4/26 2:30 PM - During an interview, E10 (LPN) stated that when residents are assessed for dental needs or request dental services, they are placed on the dental list in a dental binder. E10 showed the surveyor a dental binder that contained a list of residents to be seen by the dental provider and residents scheduled for dental services. R24 was not listed on either list. E10 stated he did not recall R24 reporting that a tooth had fallen out or mentioning any concerns.3/6/26 - A review of the unit dental book revealed that R24 was added to the list for an appointment after surveyor inquiry.2. Review of R42's clinical record revealed:8/21/25 - A facility Clinical admission Assessment revealed a dental assessment section with options to document dental status including: has own teeth, has dentures, or has no natural teeth (edentulous). The assessment also included components to evaluate oral/dental status including cavities, broken teeth, oral abnormalities, gum condition, and mouth pain. Review of the assessment revealed the oral/dental examination was documented as not assessed/no information.8/28/25 - The admission MDS assessment documented a BIMS score of 15, indicating the resident was cognitively intact. Section L0200 (Oral/Dental Status) was coded as none of the above.11/4/25 2:32 PM - A progress note by E13 (Former Social Services Director) documented: Met with [R42] to discuss ancillary services (podiatry, dental, vision, and hearing). [R42] declined podiatry; however, wished to be referred to dental, hearing, and vision. [Social Services] will notify the clinical team.There was no evidence in the clinical record that a referral for dental services was initiated.A care plan last revised 2/25/26 revealed a focus area titled Resident/Responsible Party accepts ancillary services (vision/hearing/dental) as part of their ongoing care, initiated 11/6/25. Interventions included encouraging the resident to verbalize concerns related to ancillary services, educating the resident on the benefits of ancillary services, and offering opportunities to revisit decisions at care conferences. The care plan did not include resident-specific interventions addressing the resident's edentulous status, monitoring of oral health, or referral for dental services.3/2/26 8:59 AM - During observation and interview, R42 was asked if he had any dental concerns. Observation revealed R42 was missing both upper and lower teeth. R42 stated, I have told them I need to go to the dentist, and I don't have any teeth.3/4/26 - During an interview, E10 (Licensed Practical Nurse) stated that the process for a resident to be seen by the dentist is for the resident to notify staff of a problem or request to see a dentist, after which the resident is placed on the list in the dental book. Review of the dental book revealed that R42 was not listed for dental services.3/9/26 - During an interview, E2 (DON) confirmed that R42 was not listed for dental services and had not been referred for dental evaluation despite the resident requesting dental services.As a result, the facility failed to ensure residents received assistance in obtaining routine dental services to maintain oral health and comfort.3/9/26 3:00 PM - Findings were reviewed with E2 (DON) and E5 (Clinical Lead) during the exit conference.