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	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Milford Center	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on record review, interviews and review of other facility documentation as indicated, it was determined that for one (R1) out of three sampled residents the facility failed to ensure that grievances received by the facility included prompt efforts to resolve problems. In addition, the facility failed to ensure that a written decision was issued to the complainant. Findings include:Review of the facility's policy titled, OPS204 Grievance/Concern revised 10/15/24 indicated: Policy: . All patients and/or their representatives may voice grievances/concerns and recommendations for changes. Service location leadership will investigate, document, and follow up on all concerns and grievances registered by any patient or patient representative . The Administrator will serve as the Grievance Officer who is responsible for overseeing the grievance process. receiving and tracking grievances through to their conclusion . Purpose: To assure prompt receipt and resolution of patient or representative grievance/ concern . Process: 10. If the grievance/concern is unable to be resolved satisfactorily, refer the patient/representative to the Market President for assistance. Review of R1's clinical record revealed the following:10/28/29 - R1 was admitted to the facility with diagnoses including but not limited to congestive heart failure, atrial fibrillation, diabetes, chronic kidney disease, post right below knee amputation and a gangrene wound on the left toe. 11/11/25 9:16 AM - A nurse progress note documented that R1 was sent to the ER (Emergency Room) for treatment and evaluation due to change in respiratory status. R1 was found unresponsive with a fasting blood sugar of 30 mg /dl (milligram/deciliter).11/12/25 - A facility Grievance Form by E1 (NHA, Grievance Officer) documented that FM1 (Family Member) Expressed that [R1] with recent 911 to hospital will not be coming back due to care issues. Grievance investigation revealed . after review, moved to reportable . [R1] did not return . Resolution of Grievance - No. 11/12/25 - A written statement by E1 documented:On 11/12/25, [FM1] stopped me as I entered my office. She was carrying some personal items. She was upset that:- That staff had inquired about her husband who refused to identify himself and wanted personal items from the room.- On the night prior to R1 going out, [R1] had his cellphone on an open (R1 was engaged in a telephone call) and was calling out to someone asking for clinical help. The person (a female) stated that she was not his nurse but was doing something in the room.- Stated that R1 felt that the direction of staff and on - call physician was that if R1 went out to ER they would be sent back given the current vitals and treatment.- Staff had called and provided her with updates but when she called back to check it was hard to find staff to pick up the phone (during med - pass).- The ER staff reported that [facility] staff was ‘rude' during the process of sending [R1] out. [E1, NHA] stated that though not present during the send out we would review the clinical changes with our [P21, MD]. [E1] then took [FM1] to room with E8 [LPN/Wound Nurse], [E4, ADON], [E5. RN UM], and [E6, Quality Care Coordinator] where they were finishing up care plans. [E1] interrupted and asked if they would perform a clinical review of what happened, and the impromptu partial IDT (Interdisciplinary Team) meet to (continued on next page)

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	go over what could be reviewed at that time. [E1] told [FM1] that as we get closer to understanding the acute episode we can discuss further and that the impromptu meeting would show our commitment to process review, [FM1] left satisfied. The following day, despite the IDT stating [FM1] left (sic) [E1] left a VM (voice message) and then moved the grievance to reportable. 11/13/25 - A facility incident report submitted to the state agency documented, . [E7, DBO, Director of Business Office] had a conversation with [FM1] . in regard to [R1] not returning to the facility . expressed concerns about the care her father received while admitted to the facility . 12/2/25 9:30 AM - During a telephone interview, FM1 stated that she went to the facility and talked to the management last month (November 2025). FM1 stated that she had discussed her concerns regarding [R1's] care to the nursing team who in turn told her that an investigation will be done. FM1 further stated that, I have not heard back from them. 12/2/25 11:00 AM - A follow up review of R1's grievance form revealed a lack of a written decision issued to [FM1, complainant].12/2/25 11:10 AM - In an interview, E1 stated that the Grievance filed by FM1 was not resolved because, [R1] did not return to the facility, and I left a voice message for [FM1] but she did not return the call so I talked to [E3, Clinical Lead] about it and we decided to move it as a state reportable incident.12/2/25 2:00 PM - When asked regarding FM1's unresolved grievance, E3 stated that she met with the Market President and discussed the grievance concerns, investigations concluded and the grievance was closed. It was escalated to a reportable event. E3 further stated that, [E1] reached out to [FM1] via phone, left a voice mail in regards to the results of the investigation, but to my knowledge, [FM1] did not return [E1's] phone call. [FM1] was provided [E5's, RN UM] personal cell phone number for any future questions or concerns. [FM1] never called [E3] at any point. The facility failed to ensure that a written decision was issued to the FM1, the complainant.12/3/25 4:05 PM - Findings were reviewed with E1, E2 (DON), E3 (Clinical Lead) and E15 (Regulatory Nurse) during the Exit Conference.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, it was determined that for one (R1) out of three residents sampled for care plan review, the facility failed to revise the person - centered care plan interventions to address R1's refusal to obtain his daily weights. Findings include:Cross Refer F842Review of R1's clinical records revealed:10/28/25 - R1 was admitted to the facility with diagnoses including CHF (congestive heart failure).10/29/25 - R1 had a physician's order to notify provider if R1 gains more than two lbs. (pounds) in one day, or five lbs. in a week related to CHF. 10/28/25 (revised 11/4/25) - A care plan was developed for R1's risk for decreased ability to perform ADLs (Activities of Daily Living) . resistive to daily morning weights for CHF. 11/3/25 - R1's admission MDS (Minimum Data Set) assessment revealed that R1 had an intact cognition with a BIM score of 15. R1 required substantial to maximal assistance of one staff person with bed mobility including lying to sitting on side of the bed. R1 also required moderate assistance of one staff person with sit to stand or chair -to - chair transfer, using the wheelchair for mobility. 12/2/25 - Review of R1's October and November 2025 TARs (Treatment Administration Record) revealed a lack of evidence that R1's daily weights were obtained on October 28, 29 and 31, 2025 and from November 2 through 11, 2025. 12/2/25 - A review of R1's Weight Summary from 10/28/25 through 11/11/25 revealed that R1's weights were only obtained two times on 10/30/25 (255 lbs. with use of wheelchair) and 11/1/25 (258.2 lbs. with use of mechanical lift). 12/2//25 - Review R1's nurse progress notes from 10/29/25 through 11/11/25 revealed the following documentation: 10/29/25 7:15 AM - [R1] refused the weight this morning stated (sic) 'I don't trust the lift'.11/2/25 6:40 AM - [R1] told this writer, 'The 7-3 shift took the weight yesterday and it was 258, I should go with that number, (sic) educated [R1] it's a daily weight but he refused.11/3/25 6:57 AM - [R1] refused the weight this morning, stated 'I don't feel the weight this morning' (sic) educated [R1] but still refused.11/6/25 6:58 AM - [R1] refused the weight this morning (sic) stated 'I don't feel it'. 11/8/25 6:17 AM - In the morning stated, 'I don't trust the Hoyer lift or the chair' (sic) educated [R1] they are all accurate but still he refused.12/3/25 8:00 AM - During an interview, E9 (LPN) stated that she was the night nurse and E9 confirmed that R1 had always refused to get his weights taken using the Hoyer lift machine. E9 further stated, [R1] was thinking that the Hoyer lift machine's weighing scale calibration was not accurate. I told the day shift nurse about his weight refusals. Although the facility identified R1's refusals to obtain his weight, the facility failed to ensure that R1's person centered care plan interventions were included to address his refusals to obtain his weight. In addition, the facility failed to address the issue of R1 refusing to get weighed using the Hoyer lift weighing scale. 12/3/25 4:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (Clinical Lead) and E15 (Regulatory Nurse) during the Exit Conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, it was determined that the facility failed to maintain a complete and accurate record for one (R1) of three sampled residents. Findings include:Cross Refer F657Review of R1's clinical record revealed:12/2/25 - Review of R1's October and November 2025 TARs (Treatment Administration Record) revealed a lack of evidence that R1's daily weights were obtained and completed on October 28, 29 and 31, 2025 and from November 2 through 11, 2025. 12/3/25 10:00 AM - During an interview, E3 (Clinical Lead) confirmed the incomplete documentation. 12/3/25 4:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (Clinical Lead) and E15 (Regulatory Nurse) during the Exit Conference.