



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Health Care Quality  
Office of Long Term Care Residents Protection

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

**STATE SURVEY REPORT**

NAME OF FACILITY: Wilmington Nursing and Rehabilitation

DATE SURVEY COMPLETED: January 31, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>An unannounced third Follow-Up Survey to the Annual, Complaint and Emergency Preparedness Survey ending July 31, 2023, an Extended Survey ending August 10, 2023, the first Follow-Up Survey ending November 7, 2023, and the second Follow-Up Survey ending January 8, 2024, was conducted at this facility from January 29, 2024 through January 31, 2024. The facility census on the first day of the survey was 92. The sample totaled 6 residents. No deficient practice was identified.</p> <p><b>Regulations for Skilled and Intermediate Care Nursing Facilities</b></p> <p><b>Scope</b></p> <p><b>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</b></p> <p>No deficiencies were identified at the time of the survey.</p>	

Provider's Signature

Title

NHA

Date

3/5/24

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/27/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085028</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>01/31/2024</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WILMINGTON NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 FOULK ROAD</b> <b>WILMINGTON, DE 19803</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	INITIAL COMMENTS  An unannounced third Follow-Up Survey to the Annual, Complaint and Emergency Prepared-ness Survey ending July 31, 2023, an Extended Survey ending August 10, 2023, the first Follow-Up Survey ending November 7, 2023, and the second Follow-Up Survey ending January 8, 2024, was conducted at this facility from January 29, 2024 through January 31, 2024. The facility census on the first day of the survey was 92. The sample totaled 6 residents. The facility was found to have regained substantial compliance with 42CFR Part 483, Subpart B, Requirements for Long Term Care Facilities as of January 31, 2024.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  Electronically Signed	TITLE	(X6) DATE  02/07/2024
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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.