



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality

Office of Long-Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: New Castle Health and Rehab Center

DATE SURVEY COMPLETED: January 14, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced Revisit and Complaint Survey to the Recertification and Complaint Survey ending December 13, 2025, was conducted by the State of Delaware Division of Health Care Quality, office of Long-Term Care Residents protection January 13, 2026, thru January 14, 2026. The facility census on the first day of the survey was one hundred sixteen (116). The sample size was nineteen (19) residents.</p> <p>Regulations for Skilled and Intermediate Care Nursing Facilities</p> <p>Scope</p> <p>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.</p> <p>The facility was found to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care as of December 26, 2025.</p> <p>No deficiencies were identified at the time of the survey.</p>		

[Handwritten Signature]

Provider's Signature

Title

NHA

Date

5/29/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085039	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER NEW CASTLE HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 32 BUENA VISTA DRIVE , NEW CASTLE, Delaware, 19720	
(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
E0000	Initial Comments An unannounced Revisit and Complaint Survey to the Recertification and Complaint Survey ending December 13, 2025, was conducted by the State of Delaware Division of Health Care Quality, office of Long-Term Care Residents protection January 13, 2026, thru January 14, 2026. The facility census on the first day of the survey was one hundred sixteen (116). The sample size was nineteen (19) residents. The facility was found to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care as of December 26, 2025.	E0000		02/04/2026
F0000	INITIAL COMMENTS An unannounced Revisit and Complaint Survey to the Recertification and Complaint Survey ending December 13, 2025, was conducted by the State of Delaware Division of Health Care Quality, office of Long-Term Care Residents protection January 13, 2026, thru January 14, 2026. The facility census on the first day of the survey was one hundred sixteen (116). The sample size was nineteen (19) residents. The facility was found to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care as of December 26, 2025.	F0000		02/04/2026

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 reverse for further 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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