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: Excelcare at Newark

DATE SURVEY COMPLETED: December 23, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from December 18, 2025, through December 23, 2025. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was eighty-eight (88). The survey sample totaled five (5) residents.	Cross reference CMS-2567-L F561, F580, F657,F684, and	01/26/2026
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**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.** **This requirement is not met as evidenced by:** Cross refer to the CMS-2567-L survey completed December 23, 2025: F561, F580, F657, F684 and F842.		

Provider's Signature [signature] Title DNA Date 1/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085025	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCELCARE AT NEWARK LLC	4949 OGLETOWN-STANTON ROAD , NEWARK, Delaware, 19713

(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
F0000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from December 18, 2025, through December 23, 2025. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was eighty-eight (88). The survey sample totaled five (5) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; BIMS - Brief Interview for Mental Status/assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions); 8-12: Moderately impaired (decisions poor; cues/supervision required); 13-15: Cognitively intact (decisions consistent/reasonable); BLS – Basic Life Support, provided to someone experiencing cardiac arrest, respiratory distress or an obstructed airway; COTA – Certified Occupational Therapy Assistant; CPR - Cardiopulmonary Resuscitation; DNR - Do not resuscitate; DON - Director of Nursing; EMS – Emergency Medical Services; Femur – thigh bone; FF - family friend; LPN – Licensed Practical Nurse; Nasal cannula – a device used to deliver supplemental oxygen through the nostrils; Non-rebreather mask – A device used to deliver high	F0000		02/13/2026

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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F0000	Continued from page 1 concentrations of oxygen to patients in emergency situations; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Pulse oximeter – a device used to measure the oxygenation saturation level in the blood; RN – Registered Nurse; SpO2 – Peripheral oxygen saturation, normal levels typically range from 95-100%; VPO - Vice President of Operations.	F0000		
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by:	F0561	1. R4 no longer resides in the facility. 2. All residents with conflicting BIMS scores who require consent signatures have the potential to be affected. All residents admitted within the past 30 days who remain in the facility will have their BIMS scores audited to ensure consistency with capacity determinations and to verify that consent forms were signed by the appropriate party. Any discrepancies identified will be corrected and documented as applicable 3. The RCA determined the facility did not have a guideline when there are two conflicting BIMS scores of varying cognition determining self determination. The facility will implement a guideline for conflicting BIMS scores. When one BIMS score is less than 12 and another is greater than or equal to 12, a third BIMS will be completed and an IDT note will document which BIMS is used for consent determination. Residents with a BIMS score less than 12 will have consents signed by the responsible party, while residents with a BIMS score of 12 or greater will sign their own consents.	01/26/2026

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F0561 SS = D	Continued from page 2 Based on interview and record review, it was determined that for one (R4) out of three residents reviewed for death, the facility failed to promote and facilitate R4's self determination with respect to signing multiple consents upon his admission to the facility. Findings include: Review of R4's clinical record revealed: 11/7/25 – R4 was admitted to the facility on Friday evening shift with a diagnosis that included, but was not limited to prostate cancer with metastasized (spread) to the bone and brain. R4's facesheet revealed that he was listed as the "Responsible Party." 11/10/25 (untimed) – A speech therapy evaluation and plan of treatment documented that R4's BIMS was a 14 out of 15, which represented that R4 had a normal cognitive function. 11/10/25 1:22 PM – A BIMS evaluation was performed by E16 (former social worker) that documented a score of 10 out of 15, which represented that R4 had a moderate cognitive impairment. 11/14/25 - The admission MDS assessment documented R4's BIMS score as a 10. Review of the following signed facility consents revealed that R4 did not sign them despite that R4 was evaluated and documented as cognitively intact: -CPR/DNR documentation form was signed on 11/18/25 by FF1 (friend), E10 (LPN/Charge Nurse) and E11 (NP). -Consent to treatment was signed on 11/18/25 by FF1; -Care Management Services consent form was signed on 11/18/25 by FF1; -Consent to treat/assignment of benefits and receipt of notice of privacy practices was signed on 11/18/25 by FF1; and -Consents to administer influenza vaccination,	F0561	Continued from page 2 The staff developer/designee started education on December 23, 2025 with the social worker, speech and language therapist, and licensed nurses on the new guidelines. Education will be completed on February 5, 2025 The NHA/designee will complete weekly auditing to monitor implementation and compliance with the guideline. 4. Audits will be conducted daily for four weeks, followed by weekly audits for four weeks and monthly audits for two months. Audit results will be reported to the monthly QAPI committee until 100% compliance is achieved and maintained for three months.	

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F0561 SS = D	Continued from page 3 pneumococcal vaccination, respiratory syncytial virus (RSV) vaccination and Covid-19 vaccination were signed by E10 (LPN/Charge Nurse) on 11/18/25 with the following handwritten documentation: "verbal consent by [FF2, friend] family doesn't want vaccine". 12/22/25 11:55 AM – During an interview, E10 (LPN/Charge Nurse) stated that she did not complete R4's admission on Friday evening. E10 stated that the admitting nurse should have obtained the signed consents as part of the admission process. E10 stated that she was told to complete the consents because they were not done. E10 stated that FF1 (friend) was here all the time and was referred to as a "brother". E10 stated that she used the BIMS score that was documented 10, revealing that R4 was cognitively impaired. E10 stated that a resident with a BIMS score of 11 or lower cannot sign consents. When asked if she was aware of the BIMS score completed by the Speech Therapist (ST) on 11/10/25 that documented R4 as a 14/15, E10 stated that "nobody shared the speech therapy BIMS score." E10 also stated that she learned later on that FF1 was not R4's real brother. 12/23/25 9:25 AM – Finding was reviewed with E4 (VPO). The facility failed to promote and facilitate R4's self determination when obtaining multiple consents upon admission. 12/23/25 4:20 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON) and E4.	F0561		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status	F0580	1. R1 no longer resides in the facility. 2. • Any resident experiencing low oxygen saturation levels has the potential to be affected 3. • The root cause analysis determined there was a gap	01/26/2026

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F0580 SS = D	Continued from page 4 in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R1) out of three residents reviewed for change in condition, the facility failed to consult with R1's physician when R1 complained of shortness of breath and when oxygen therapy was initiated. Findings include:	F0580	Continued from page 4 between identification of a change in condition and notification to the MD/physician extender. The Staff Developer/ designee started re-educating with licensed nurses on 12/23/25 regarding the facility's notification expectations, including prompt of the MD/physician extender when a resident's oxygen saturation is 92% or below or outside of ordered parameters, with new or worsening shortness of breath, or when there is a need to initiate or increase oxygen therapy. Education will be completed 2/5/26. The DON, ADON, or designee will review daily respiratory change-in-condition events to ensure timely MD/physician extender notification and appropriate documentation. 4. • Audits will be conducted daily for four weeks, followed by weekly audits for four weeks and monthly audits for two months. Audit results will be reported to the monthly QAPI committee until 100% compliance is achieved and maintained for three months.	

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F0580 SS = D	Continued from page 5 Cross refer F684 11/13/25 – R1 was admitted to the facility with diagnoses including a right femur fracture. 11/23/25 2:52 PM - E8 (COTA) documented in R1's clinical record, "[R1] presents with labored breathing, oxygen saturation of 89%...session shortened…[R1] unable to participate…". R1's clinical record lacked evidence that the medical provider was consulted of this new onset of respiratory distress. 11/25/25 5:51 AM – A review of EMS documentation revealed a 911 call was made requesting emergency assistance for R1 at the facility. 11/25/25 7:04 AM – An EMS Prehospital Care Report documented, "…Nursing staff relayed at around 3am [sic] [R1] began complaining of SOB [shortness of breath]…they [nursing staff] placed [R1] on 5 lpm [liters per minute] of oxygen via NRB [non-rebreather mask]…". 12/19/25 8:00 AM – During an interview, E7 (LPN) stated, "I answered the call bell. [R1]'s roommate said that [R1] can't breathe. I saw [R1] and she didn't look well. [R1] said she couldn't breathe. [R1] was at 88%. I put her on O2 [oxygen] at 2 liters…It was between 3:00 and 4:00 AM. It was before my break...". The facility lacked evidence of documentation of consultation with R1's medical provider when she complained of shortness of breath, had a low oxygenation saturation level and was started on oxygen therapy. 12/19/25 11:17 AM – During an interview (E8) stated, "I remember [R1] did not do therapy that day [11/23/25]. I asked why she couldn't do therapy. [R1] told me she couldn't do therapy because of her breathing. I checked her vitals and put them in my note. I told the nurse whose cart was immediately outside of [R1]'s room…". The facility lacked evidence that R1's physician was consulted when R1 complained of shortness of breath when it was reported to nursing staff on 11/23/25. 12/23/25 11:58 AM – Findings were confirmed with E1, E2, and E3. 12/23/25 4:20 PM - Findings were reviewed during the exit conference with E1, E2, E3 and E4.	F0580		

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F0580 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R4) out of three residents reviewed for death, the facility failed to ensure all the required IDT (interdisciplinary team) members contributed to the 11/14/25 care plan conference. Findings include: Review of R4's clinical record revealed: 11/14/25 10:58 AM – The facility's unsigned and incompleted Care Conference Summary documented that "Therapy discussed the resident's progress… Discharge planning was discussed… Nursing went over the resident's care…". Under Section D. IDT participants	F0580 F0657	1. R4 no longer resides in the facility 2. Any resident that has a conference schedule has the potential to be affected. 3. Residents due for quarterly/annual/new admissions care plans are reviewed in the weekly High Risk Meeting attended by the physician. The RCA was determined to be that facility lacked a physician signature sheet that reflected the physician's participation and input to the resident's care plan meeting. The facility has now implemented a physician signature sheet reflecting input into the care plan. The Staff Educator began education on 12/23/25 the physician, DON, ADON and Unit Managers on the new signature sheet. Completion date of education will be 2/9/25 The DON/designee will DON/Designee will audit weekly audit for completion of the physician signature sheet. 4. The adults will be conducted, Weekly x 4 weeks then biweekly for 2 months and then monthly x 2 months. Results will be reviewed in monthly QAPI meeting until 100% compliance is achieved for 2 months.	01/26/2026

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F0657 SS = D	Continued from page 7 who contributed to plan of care lacked evidence of that a specific Physician/Nurse Practitioner/Physician Assistant contributed and how they contributed. 12/22/25 10:30 AM – During an interview, E12 (SSD) stated that the only facility participants that attended R4's care plan conference was E12 from social services, [name of E10, LPN/Charge Nurse] and an unidentified therapy person. E12 stated that E15 (dietician) provided input ahead of the conference as she would not be present. E12 also stated that R4 had two individuals with him (FF1 and FF2). 12/22/25 11:55 AM – During an interview, E10 (LPN/Charge Nurse) stated that the Provider (Physician/NP) did not participate in R4's care plan conference or Provider input. E10 stated that if there are concerns by the resident during the conference, they would be shared with the Provider after the care conference. 12/23/25 9:25 AM – Finding was reviewed with E4 (VPO). The facility failed to ensure all required IDT members contributed to R4's care plan conference. 12/23/25 4:20 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON) and E4.	F0657		
F0684 SS = SQC-J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and other documentation as indicated, it was determined that for one (R1) out of three residents reviewed for change in condition, the facility failed to ensure that the proper assessments, interventions, and timely	F0684	1. • R1 no longer resides in the facility. 2. • Any resident experiencing low oxygen saturation and/or shortness of breath has the potential to be affected. 3. The Staff Developer/designee provided education to all licensed nurses on 12/23/25 regarding recognition of decreased oxygen saturation and signs of shortness of breath, completion of focused respiratory assessments,	01/26/2026

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F0684 SS = SQC-J	Continued from page 8 notifications to the medical provider were done when R1 was observed with changes in her clinical status. R1, a resident who previously did not require oxygen, complained of shortness of breath to nursing staff between 3:00 AM and 4:00 AM on 11/25/25. The facility lacked evidence that R1's vital signs or respiratory status were monitored, and that the provider was consulted during this time. R1 was transferred to the hospital approximately two hours later. R1 was unresponsive when she arrived at the emergency room and later expired at the hospital. Due to this failure, an Immediate Jeopardy (IJ) was called on 12/23/25 at 12:00 PM, with an abatement date of 12/23/25 at 4:15 PM. Findings include: Cross refer F580 A review of R1's clinical record revealed: 11/13/25 – R1 was admitted to the facility with diagnoses including a right femur fracture. 11/23/25 2:52 PM – E8 (COTA) documented in R1's clinical record, "[R1] presents with labored breathing, oxygen saturation of 89%...session shortened…[R1] unable to participate…". 11/24/25 9:16 PM – A Daily Skilled Charting note entered by E9 (LPN) documented, "…O2 sats [saturation] 93% Date: 11/23/2025 22:10 [10:10 PM]...". R1's documented oxygen saturation level, obtained approximately twenty-four hours earlier, was not a current reading. 11/25/25 5:47 AM – A facility document that listed messages that were sent to R1's provider documented E5 (RN) left a message stating, "[R1] is having a hard time breathing [sic] wants to go to the hospital…". 11/25/25 5:51 AM – A review of EMS documentation revealed a 911 call was made requesting emergency assistance for R1 at the facility. 11/25/25 6:25 AM – A review of hospital documentation revealed R1 arrived at the emergency room. 11/25/25 7:04 AM – An ED (Emergency Department) Physician Record documented, "[R1] presents to the emergency department unresponsive…". 11/25/25 7:10 AM – An EMS Prehospital Care Report narrative documented, "…[R1] contact delayed due to no one answering the doorbell…Nursing staff relayed at	F0684	Continued from page 8 and appropriate oxygen management, as well as timely notification to the physician. Education included proper use, monitoring, and escalation of oxygen therapy, including administration via nasal cannula and nonrebreather mask, with required reassessment following initiation or adjustment of oxygen. Now the Staff Developer/designee will conduct return-demonstration validation of oxygen administration and monitoring. All return-demonstration competencies will be completed by 1/26/25. The Staff Developer re-educated on 12/23/25 with licensed nurses on documentation requirements, including completion of a full set of vital signs, oxygen saturation monitoring, resident response to interventions, ongoing reassessment and timely notification to the physician. Education was completed on 12/23/25. The DON, ADON, or designee will review daily respiratory change-in-condition events to ensure appropriate assessment, oxygen management, and accurate documentation. 4. • Audits will be conducted daily for four weeks, followed by weekly audits for four weeks and monthly audits for two months. Audit results will be reported to the monthly QAPI committee until 100% compliance is achieved and maintained for three months	

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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
F0684 SS = SQC-J	Continued from page 9 around 3am [sic] [R1] began complaining of SOB [shortness of breath]…they [nursing staff] placed [R1] on 5 lpm (liters per minute) of oxygen via NRB [non-rebreather mask]…[R1]'s [oxygen] saturation was in the 60's and had improved to the 80's…EMS placed [R1] on 15 lpm…En route, [R1] began declining and BLS administered [sic]…". 11/25/25 7:30 AM – E5 documented in R1's clinical record, "[R1] c/o [complained] of SOB, [R1] put on oxygen, still remained low 65% at 5 liters. Applied non-rebreather and went up to 90%. [R1] insisted on going to the hospital…[R1] sent to ER…sp02 [sic] 90%." 12/19/25 8:00 AM – During an interview, E5 stated, "I was on break at 4:00 am. E7 [LPN] told me to check on [R1]. [E7] said [R1] can't breathe. [E7] put [R1] on oxygen. [E6, RN Supervisor] and I went in after my break. [R1] was okay, she was on NC (nasal cannula) 2 liters. [R1] said she was hungry. [R1] ate a snack, and I went to start med pass. [R1] again said she couldn't breathe. We titrated [oxygen] up to 3 liters and it [R1's oxygenation level] went up to 92%. The Surveyor asked, "What time did this occur?" E5 stated, "I don't remember the exact time." E5 then stated, "[R1] went down to 65% on 3 liters. [E6] put [R1] on a non-rebreather at 6 liters. The Surveyor asked, "What time was [R1] put on the non-rebreather?" E5 stated, "I can't recall the exact time. I called the provider when [R1] went down again. After that I called 911." The Surveyor asked, "Did you take [R1]'s vitals or do an assessment?" E5 stated, "I took her vitals around 4:30 am. I assessed [R1]'s lungs and they sounded diminished. I kept checking her pulse ox [pulse oximeter]". The Surveyor asked, "Were the assessment and pulse ox readings documented?" E5 stated, "I did not document it." 12/19/25 10:26 AM – During an interview, E7 stated, "I answered the call bell. [R1]'s roommate said that [R1] can't breathe. I saw [R1] and she didn't look well. [R1] said she couldn't breathe. [R1] was at 88%. I put her on O2 [oxygen] at 2 liters. [R1] went up to 92%. I told her nurse [E5]. It was between 3:00 and 4:00 AM. It was before my break." The Surveyor asked, "Were any vitals or oxygen saturation readings documented?" E7 stated, "I did not document them." The facility lacked evidence of documentation of R1's vital signs even though she complained of difficulty breathing and exhibited signs of respiratory distress. 12/19/25 11:17 AM – During an interview, E8 stated, "I remember [R1] did not do therapy that day [11/23/25]. I	F0684		

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F0684 SS = SQC-J	Continued from page 10 asked why she couldn't do therapy. [R1] told me she couldn't do therapy because of her breathing. I checked her vitals and put them in my note. I told the nurse whose cart was immediately outside of [R1]'s room. The nurse took [R1]'s pulse ox again." R1's clinical record lacked evidence of nursing documentation of R1's shortness of breath, inability to participate in therapy, any interventions that were implemented or notification to the medical provider on this date. 12/22/25 11:00 AM – An undated facility document entitled, "Nursing Competencies Identified Through Facility Assessment" provided to the Surveyor stated, "...the facility has identified the following...to ensure safe and effective care delivery...vital signs monitoring and nursing assessment...recognition and timely reporting of changes in resident condition...oxygen therapy and respiratory treatments...emergency response and clinical escalation...". 12/22/25 1:50 PM – During an interview, E10 (LPN) stated, "We are not trained on oxygen use, if someone is in respiratory distress, I would put them on nasal cannula at 2 liters. If they are under 92%, I will inform the provider." 12/22/25 2:25 PM – During an interview, E13 (Staff Development Coordinator) stated, "If any vitals are below baseline, the provider should be called. If anyone cannot be maintained at 92% on NC (nasal cannula) 2 liters, I would call 911. If a non-rebreather is being used, 911 should already be in route. The nurses are trained to document the times vitals are taken and when the provider was called in their progress note." The Surveyor asked, "When was the last in-service training for nurses held?" E13 stated, "It was held on 11/13/25." The Surveyor asked, "Did the training include how to use a non-rebreather mask?" E13 stated, "Yes, O2 [oxygen] therapy was discussed. A non-rebreather should be used with 10-15 liters of oxygen." The Surveyor the asked, "Are the areas of vital signs monitoring, nursing assessment and emergency response addressed in this training?" E13 stated, "Yes." 12/23/25 7:15 AM – During an interview, E6 stated, "The nurse [E5] called me, and I went in [R1's] room. [R1] already had oxygen on. [R1] was comfortable. [E5] called me again saying [R1] was having shortness of breath. [E5] put the non-rebreather on [R1]. The Surveyor asked, "Do you remember the approximate time this occurred?" E6 stated, "I don't remember. The	F0684		

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F0684 SS = SQC-J	Continued from page 11 Surveyor asked, "Do you remember [R1]'s oxygen saturation level at the time or how much oxygen [R1] was given?" E6, "I cannot remember what oxygen level [R1] was on. We did not have time to document the vitals." 12/23/25 12:00 PM – An Immediate Jeopardy (IJ) was called due to the facility's failure to adequately assess R1's change in condition, timely consult the provider, and to promptly request emergency medical assistance when R1 began complaining of not being able to breathe and had low oxygen saturation readings. The facility also failed to maintain oxygen delivery to R1 at an appropriate level until emergency medical assistance arrived. 12/23/25 4:15 PM – The facility's abatement plan for the Immediate Jeopardy included: Licensed nursing staff were re-educated on: a) recognition of respiratory distress, respiratory assessments, including vital signs and oxygen saturation b) initiation and monitoring of oxygen therapy c) timely provider notification All residents were immediately screened by licensed nursing staff for respiratory distress. Residents identified with respiratory distress were assessed and interventions were implemented. The facility failed to ensure that R1 was assessed and appropriate interventions were implemented, including emergency care and services, when she complained of difficulty breathing and was noted with obvious respiratory distress. 12/23/25 4:20 PM – Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), and E4 (VPO).	F0684		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public.	F0842	1. R4 no longer resides in the facility. 2.	01/26/2026

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F0842 SS = D	Continued from page 12 (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for-	F0842	Continued from page 12 Any resident admitted to the facility has the potential to be affected. The facility conducted a 30-day look-back of all current residents to identify any incomplete required admission agreements. Any identified incomplete signatures were obtained. Missing signatures will be obtained when possible. 3. The root cause analysis (RCA) determined that the facility lacked standardized guidelines for completing admission agreements. The facility implemented the following guidelines: Admissions will complete and document repeat outreach and the method attempted (phone/voicemail/email/text/letter, as applicable) on the following schedule: (1) within 1–3 business days, (2) within 5–7 business days, and (3) within 10–14 business days. If the form remains unsigned after these attempts, the concern will be escalated to the Administrator/designee, and weekly follow-up will continue until the signature is obtained or refusal/non-response is documented. The Staff Developer/designee began education with the Admissions Director on 12/23/25 regarding documentation and expectations for admission agreement and consent signatures. Education will be completed by 1/26/25. The NHA/designee will audit admission/consent signatures and adherence to the new process. 4. Audits will be conducted weekly for four (4) weeks, then biweekly for four (4) weeks, then monthly for three (3) months, with findings reported to QAPI and immediate corrective action taken as indicated.	

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F0842 SS = D	Continued from page 13 (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R4) out of one resident reviewed for death, the facility failed to ensure R4 had a completed and signed resident agreement upon admission to the facility. Findings include: Review of R4's clinical record revealed: 11/7/25 – R4 was admitted to the facility on Friday evening shift with a diagnosis that included, but was not limited to prostate cancer with metastases to the bone and brain. R4's facesheet revealed that he was listed as the "Responsible Party." 12/2/25 9:40 PM – A nursing note documented that R4 passed away in the facility. Review of R4's 11/7/25 DE (Delaware) Admission Packet	F0842		

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F0842 SS = D	Continued from page 14 revealed that it was unsigned and incomplete. A written statement by E14 (Admission Director) revealed, "On November 10th patient [R4] was asleep when trying to do the admission agreement; went back in the afternoon and was still sleeping. On November 11th patient refused due to being tired. Facesheet from the hospital had 2 people listed as siblings that we did not find out they were NOT family members until the brother came in the day he [R4] passed away. Agreement... was in progress until the day patient passed away." 12/23/25 9:25 AM – Finding was reviewed with E4 (VPO). The facility failed to ensure R4's medical record included a completed and signed DE Admission Packet, a legal document that clearly communicated the resident's rights, facility's policies and described the healthcare services to be provided to the resident. 12/23/25 4:20 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON) and E4.	F0842		