



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: Bay Terrace Rehab & Healthcare Ctr

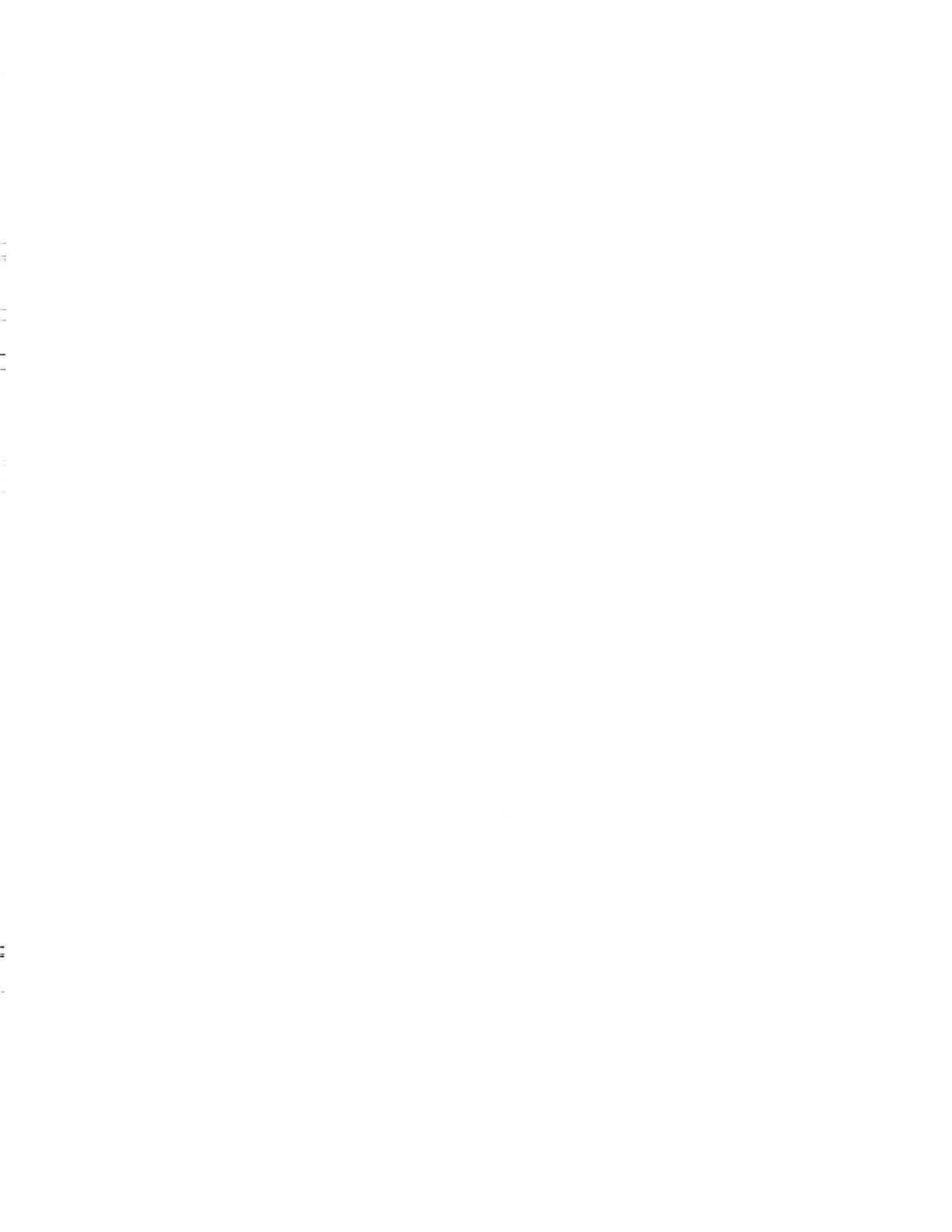
DATE SURVEY COMPLETED: February 24, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DE- FICIENCIES	COMPLE- TION 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 Complaint Survey was conducted at this facility from February 17, 2026, through February 24, 2026. The deficiencies contained in this report are based on observations, interviews, review of resident clinical records and review of other facility documents, as indicated. The facility census of the first day of the survey was seventy – three (73). The survey sample totaled three (3) residents.</p> <p>Regulations for Skilled and Intermediate Care 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>This requirement was not met as evidenced by:</p> <p>Cross Refer to the CMS 2567 – L survey completed February 24, 2026: F627</p>	<p>CROSS REFERENCED</p> <p>ePoc</p>	

Provider's Signature Adam K Martin

Title ADMINISTRATOR

Date 3/4/2026



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER BAY TERRACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 889 SOUTH LITTLE CREEK ROAD , DOVER, Delaware, 19901	
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F0000	<p>INITIAL COMMENTS</p> <p>An unannounced Complaint Survey was conducted at this facility from February 17, 2026, through February 24, 2026. The deficiencies contained in this report are based on observations, interviews, review of resident clinical records and review of other facility documents, as indicated. The facility census on the first day of the survey was seventy - three (73). The survey sample totaled three (3) residents.</p> <p>Abbreviations/Definitions:</p> <p>ADON - Assistant Director of Nursing;</p> <p>DME - Durable Medical Equipment;</p> <p>DON - Director of Nursing;</p> <p>DOR - Director of Rehabilitation;</p> <p>HHA - Home Health Agency;</p> <p>MDS - Minimum Data Set;</p> <p>NHA - Nursing Home Administrator;</p> <p>RN - Registered Nurse;</p> <p>SW - Social Worker;</p> <p>Carpel Tunnel- A problem in the wrist where a big nerve gets squeezed, causing numbness, tingling, or pain in the hand and fingers;</p> <p>Fasciotomy- A surgery where a doctor makes a cut in a tight layer of tissue in the arm or leg to release pressure and save the muscles and nerves;</p> <p>Cervical Stenosis- When the spaces in the neck part of the spine become too narrow and press on the spinal cord or nerves, which can cause pain, weakness, or numbness.</p>	F0000		
F0627 SS = J	<p>Inappropriate Discharge</p> <p>CFR(s):</p>	F0627	Findings	03/23/2026

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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F0627 SS = J	Continued from page 1 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation.	F0627	Continued from page 1 Plan of Correction Completion Date FTAG 627 SS=IJ A. The facility cannot retroactively correct the deficiency for Resident R2; R2 has been discharged. B. Residents discharged to the community could have the potential to be potentially affected. C. The root cause was determined to be due to failure to have a robust discharge care plan meeting with the Interdisciplinary team, with resident and resident representative. The procedure for Safe and Effective Discharge Planning and Discharge Audit Tool will be utilized. The Discharge planning IDT team was re-educated by Regional Social Services support consultant on the policy and procedure to ensure sufficient preparation and orientation to ensure a safe discharge. The Discharge planning IDT Team includes: NHA/Designee- responsible for oversight of overall discharge planning process Director of Nursing/Designee- responsible for medication reconciliation, wound care, other procedures as applicable, and respiratory needs Social Services/Case Management Designee- set up follow up appointments, community resources and meal resources, DMEs Therapy Director/Designee- DMEs needed, functional status and caregiver training as applicable The Discharge Audit Tool will be generated by the	

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F0627 SS = J	<p>Continued from page 2</p> <p>When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.</p> <p>(i)Documentation in the resident's medical record must include:</p> <p>(A) The basis for the transfer per paragraph (c)(1)(i) of this section.</p> <p>(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).</p> <p>(ii)The documentation required by paragraph (c)(2)(i) of this section must be made by-</p> <p>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and</p> <p>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.</p> <p>§483.15(c)(7) Orientation for transfer or discharge.</p> <p>A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand.</p> <p>§483.15(e)(1) Permitting residents to return to facility.</p> <p>A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following.</p> <p>(i)A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident-</p>	F0627	<p>Continued from page 2</p> <p>NHA/Designee, which will be initiated at least 5 days prior to the anticipated discharge. NHA/Designee will review to verify discharge needs were completed prior to discharge utilizing the Safe Discharge Verification Checklist.</p> <p>Twice a week, residents scheduled for discharge within the next week will be reviewed by the IDT team using the Discharge Audit Tool to ensure a safe discharge is in place. Additional IDT team discussion will be conducted on an as-needed basis.</p> <p>Weekly, during utilization review, NHA/designee will oversee discharge planning to ensure preparation and services are in place prior to discharge.</p> <p>D. Daily audit by NHA/Designee will be conducted to ensure discharge planning and preparation is in place to ensure safe discharge x 5 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4 until a 100% compliance is sustained, then monthly x 3 months.</p> <p>Audit findings will be reported to QA committee monthly x 3 months.</p>	

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F0627 SS = J	<p>Continued from page 3</p> <p>(A) Requires the services provided by the facility; and</p> <p>(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services</p> <p>(ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.</p> <p>§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.</p> <p>§483.21(c)(1) Discharge Planning Process</p> <p>The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-</p> <p>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.</p> <p>(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.</p> <p>(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.</p> <p>(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.</p>	F0627		

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F0627 SS = J	<p>Continued from page 4</p> <p>(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.</p> <p>(vi) Address the resident's goals of care and treatment preferences.</p> <p>(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.</p> <p>(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.</p> <p>(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.</p> <p>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.</p> <p>(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.</p> <p>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.</p> <p>§483.21(c)(2) Discharge Summary</p> <p>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not</p>	F0627		

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F0627 SS = J	<p>Continued from page 5 limited to, the following:</p> <p>(iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on interviews, record review, and review of other documentation as indicated, it was determined that for one (R2) out of three residents sampled for discharge, the facility failed to ensure durable medical equipment and home health services were in place prior to R2's discharge. R2 was discharged from the facility on 2/9/26 at 6:00 PM and transported home via medical transport services and assisted up the stairs to a three-story residence by transport, where no caregiver support was in the home. On 2/11/26, R2 was found in the home by the home health agency nurse in unsafe conditions. The facility's failure to confirm home health services and the availability of caregiver support to perform required care and assistance placed R2 in a situation with the potential for serious harm or injury. An immediate jeopardy (IJ) was identified starting on 2/9/26. Based on the facility's investigation, documented response, completion of in-service training, and staff interviews, the facility's date of abatement for the Immediate Jeopardy was determined to be 2/20/26. Findings include:</p> <p>A facility policy titled "Transfer and Discharge (including AMA)" dated 9/2025 documented "A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility in a form or manner that the resident can understand."</p> <p>Review of R2's clinical record revealed:</p> <p>1/16/26 – R2 was admitted to the facility with diagnoses including spinal stenosis, cervical disc disorder, muscle weakness, carpal tunnel syndrome and a recent post-fasciotomy to the right arm.</p>	F0627		

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F0627 SS = J	<p>Continued from page 6</p> <p>1/22/26 – A review of a five-day admission MDS assessment documented R2 was cognitively intact with a BIMS of 14/15.</p> <p>2/9/26 2:21 PM – A progress note titled "Late Entry" for 2/11/26 authored by E3 (SW) documented "[R2] will have a safe discharge home with services and supports in place to assist with continuity of care, person-centered goals and psychosocial well-being. Further review of the progress note revealed referrals for home health care, skilled nursing services and DME equipment were made. Additionally, the progress note documented "family members were in attendance at the discharge care plan." R2's clinical record lacked evidence of confirmation by the facility that services were in place prior to R2's discharge from the facility.</p> <p>2/9/26 7:43 PM – A progress note documented "The resident has been discharged from the facility. Discharge paperwork was reviewed with the resident and the resident verbalized understanding. No further concerns were received the d/c (sic) paperwork was signed and a copy handed to the resident. Medications were called to the pharmacy and will be delivered at the resident's house. The resident left the unit with medical transportation at 6:00 PM with his personal belongings and received evening meds from the floor nurse."</p> <p>2/11/26 8:43 AM – A progress note titled "Late Entry" authored by E3 documented "5:13 PM, [E5 (HHA RN)] called to update E3 on the status of staffing resident with HHA (Home Health Aide). [E5] has been in touch with the VA (Veterans Administration) who is currently working on authorization for HHA (Home Health Agency Services). [E5] shared that he forgot to mention to [E3] that VA service required PCP (Primary Care Physician) script (sic). [E5] confirmed a nurse will visit [R2] tonight 2/11/26."</p> <p>2/11/26 2:40 PM – A review of a progress note for R2 revealed "the facility reached out to [R2] to discuss discharge concerns. [R2] informed the facility the hospital bed had not been delivered until the morning of 2/10/26 and that therapy, RN and HHA had not shown up as of time of the call and had not heard anything from the VA. In addition, the progress note documented "[E3] to follow up with [R2] after outreach to providers."</p> <p>2/17/26 2:23 PM – During an interview, E3 reported "[R2's] significant other and stepchildren were</p>	F0627		

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F0627 SS = J	<p>Continued from page 7 visiting on the day of the resident's baseline care plan and reported they would be there to support [R2]."</p> <p>2/19/25 9:25 AM – A telephone interview with the DME provider confirmed the hospital bed was ordered for R2 on 2/6/26 was not delivered until 2/10/26.</p> <p>2/19/26 9:39 AM – A telephone interview with R2 revealed that the resident returned to the hospital. R2 stated, "I live in a three-story home. I don't think that was fair the way they sent me home. I needed a caretaker. Nobody was home when I got there. I can't use my hands. I had to call my sister-in-law to help me get washed up and fix a meal so I had something to eat that night, and she moved some furniture around to make room for the bed that didn't come until the next day, but she couldn't stay long." R2 then stated, "The nurse was supposed to be at my house but was not there until a couple of days after I was home."</p> <p>2/19/26 10:02 AM – During a phone interview FM1 (Significant Other) stated, "[R2] lives alone, no one lives with [R2]." FM1 then stated, "I have my own health issues I'm dealing with, I can't take care of [R2]. [R2] arrived home alone, nobody was with [R2]."</p> <p>2/19/26 10:37 AM – A telephone interview with E5 revealed a referral was received for R2 2/6/26. E5 then stated, "The nurse is in the home within 48 hours of discharge."</p> <p>2/19/26 12:05 PM – During an interview E4 (DOR) stated, "I do believe that [R2] needed more assistance based on [R2's] difficulty with fine motor skills."</p> <p>2/19/26 1:13 PM – During an interview, E3 was asked, "Did you inform the agency what date services for [R2] needed to start?" E3 stated, "No I always give them a discharge date, and they contact the resident to set up the date." E3 then stated, "I was assuming [R2] was going to get a call from the agency and the VA." E3 confirmed, "I did not call to confirm the delivery of the hospital bed prior to [R2's] discharge."</p> <p>2/19/26 1:51 PM – During an interview E1 (NHA) reported contacting "[E5] to inquire about [R2] not getting services." E1 then stated, "E5 reported the agency received a call from someone that [R2] didn't need their level of care." E1 then stated, "I was under the impression that FM1 and the son were going to be at home with [R2] and that the agency would be providing [R2] support through the VA."</p> <p>2/19/26 2:06 PM – During a telephone interview E7</p>	F0627		

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F0627 SS = J	<p>Continued from page 8</p> <p>stated, "The referral for [R2] was received on 2/6/26 with a discharge date of 2/9/26 and start of care was requested for 2/11/26." In addition, E7 stated, "I was called about the condition of [R2] I advised [E6] to call APS (Adult Protective Services). E7 then reported receiving a call on 2/10/26 from a family member of [R2], and they reported the facility said [R2] would have twenty-four-hour care." E7 then reported I can't say how the facility translated the care to the family, but I told them "We do not do private duty, and that [E5] had already reached out to the VA for additional support services." E7 reported R2 agreed to go back to the hospital.</p> <p>2/20/26 9:12 AM – During a telephone interview E6 (HHA RN) reported arriving to R2's home between 7:40 PM – 7:50 PM on 2/11/26. E6 stated, "[R2] was sitting on the couch wearing an undershirt, a pull-up brief, and socks. [R2] reported not eating in two days, and that a friend had come by and brought a cheeseburger, and that was all [R2] had eaten." E6 reported that the cheeseburger was half-eaten. E6 then stated, "[R2] said there was no food in the house, and if there was [R2] said, 'I couldn't get up to fix it.'" In addition, E6 stated, "[R2] said I can't open my medications, and I can't open bottles." E6 reported assisting R2 to use the urinal to urinate, and that [R2] could not grip anything with the right hand and [R2] didn't have the fine motor skills to open a bottle. E6 reported contacting E7 (Agency Director) and explained the unsafe conditions that R2 was found in. E6 then spoke to R2 and explained why R2 should not be home alone, and asked R2 to call 911. E6 reported waiting with R2 until emergency medical transport arrived to take the resident to the hospital for further evaluation.</p> <p>2/20/26 10:11 AM – During another telephone interview FM1 stated, "On the day [R2] was being discharged my son who lives in Chesapeake, Virginia brought me to the nursing home to give [R2] his house keys when [R2] got home the transport people helped him into the house. I did not go to [R2's] house my son drove me back to my house and then got in the car and drove back to Chesapeake, Virginia and no, my son did not go to [R2's] house."</p> <p>2/20/26 2:20 PM - An immediate jeopardy was identified.</p> <p>2/20/26 - 2/24/26 - Through interviews and record reviews, the Surveyor confirmed the facility had regained compliance on 2/20/26.</p> <p>2/20/26 - The facility identified residents affected or likely to be affected by an inappropriate discharge</p>	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/24/2026
NAME OF PROVIDER OR SUPPLIER BAY TERRACE REHABILITATION AND HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 889 SOUTH LITTLE CREEK ROAD , DOVER, Delaware, 19901	
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F0627 SS = J	<p>Continued from page 9 from the facility.</p> <p>Audits of discharge documentation related to home health services, appropriate caregiver/family support, and any necessary services to meet residents' care needs for the last 7 days were reviewed by the NHA in order to determine if any residents were affected.</p> <p>All discharges planned within the next 72 hours were reviewed by the Administrator, DON, Director of Social Services, and the Director of Rehabilitation to ensure home health services, appropriate care/giver/family support, and necessary services to meet the resident's care needs are in place before discharge.</p> <p>Actions to Prevent Occurrence/Reoccurrence: The facility took the following actions to prevent an adverse outcome from recurring.</p> <p>Root cause analysis was determined to be failure to have a robust discharge care plan meeting with the Interdisciplinary team, with the resident and resident representative.</p> <p>The procedure for safe and effective discharge planning was reviewed with the IDT.</p> <p>Discharge planning IDT will be re-educated on the policy and procedure to ensure sufficient preparation and orientation to ensure a safe discharge.</p> <p>Residents who are scheduled to be discharged within 14 days will be reviewed to ensure appropriate discharge planning is in place.</p> <p>Residents who are scheduled to be discharged in the next 14 days will be reviewed to ensure support for ADLs is in place, durable medical equipment is available prior to or on the discharge date, medications are available upon discharge, and identified needs/support are available.</p> <p>Two times a week, residents who are scheduled for discharge will be reviewed to ensure safe discharge is in place. Any issues identified will be addressed accordingly.</p> <p>Weekly, during utilization review, NHA/Designee will oversee discharge planning to ensure preparation and services are in place prior to discharge.</p> <p>2/20/26 – The facility's response initiated for R2's inappropriate discharge to home included audits, educational in-services to the IDT team and staff</p>	F0627		

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F0627 SS = J	Continued from page 10 interviews with E1 (NHA), E2 (DON), E3, (SW), E4 (DOR), E8 (ADON) and E9 (RNAC) confirmed education received for a residents discharge from the facility to the community and or other facility transfers, the facility's date of abatement for the immediate jeopardy was determined on 2/20/26. 2/24/26 2:15 PM -Findings were reviewed with E1 (NHA), E2(DON), and E8 (ADON) at the exit conference.	F0627		

