



**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 and Healthcare Center

DATE SURVEY COMPLETED: April 10, 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 complaint survey was conducted at this facility from April 9, 2026, through April 10, 2026. The facility census on the first day of the survey was (seventy-two) 72. The sample totaled (three) 3 residents.</p> <p><b>Regulations for Skilled and Intermediate Care Nursing Facilities</b></p> <p><b>Scope</b></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><b>This requirement is met as evidenced by:</b></p> <p>No deficiencies were identified during the survey.</p>	<p>CROSS REFERENCE</p> <p>EPOC</p>	

Provider's Signature Adam K Martin

Title ADMINISTRATOR

Date 4/15/2026

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  04/10/2026
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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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(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	<p>INITIAL COMMENTS</p> <p>An unannounced complaint survey was conducted at this facility from April 9, 2026, through April 10, 2026. The facility census on the first day of the survey was (seventy-two) 72. The sample totaled (three) 3 residents. No deficient practice was identified.</p>	F0000		

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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