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: Encore at Windsor Hills

DATE SURVEY COMPLETED: April 13, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced annual and complaint survey was conducted at this facility from April 7, 2026, through April 13, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was (forty-one) 41. The investigative sample totaled (fifteen) 15 residents. Abbreviations/definitions used in this report are as follows: ADON – Assistant Director of Nursing; DA – Dietary Aide; DON – Director of Nursing; ED – Executive Director; HSK – Housekeeper; MDSC – MDS Coordinator.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0 **3201.1.2**	**Scope** **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.**	**Corrective Action:** The facility acknowledges that there was past non-compliance related to mandatory pre-employment drug screening requirements, specifically the failure to include all required substances in the screening panel and failure to obtain results prior to employment for employees E8 and E9. This was identified during the survey completed on April 13, 2026. The facility recognizes this as a past deficiency and has taken immediate steps to prevent recurrence. As this was a past issue, the facility is unable to retroactively test all previously hired employees; however, measures have been implemented to ensure full compliance going forward.	4/27/2026

Provider's Signature Steven Gohay LNHA Title Executive Director Date 4/27/26

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DE Code Title 16 Health and Safety Chapter 11 Subchapter IV Criminal Background Checks; Mandatory Drug Screening; Long-Term Care Facilities § 1142. Mandatory drug screening. **S/S- E**	**This requirement was not met as evidenced by:** Cross refer to the CMS-2567-L survey completed April 13, 2026: F677 and F770. **(a) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screening.** **(b) All applicants must submit to mandatory drug screening, as specified by regulations promulgated by the Department.** **(c) The Department shall promulgate regulations, regarding the pre-employment testing of all applicants, for use of all of the following illegal drugs:** **(1) Marijuana/cannabis.** **(2) Cocaine.** **(3) Opiates.** **(4) Phencyclidine ("PCP").** **(5) Amphetamines.** **(6) Any other illegal drug specified by the Department under regulations promulgated under this section.** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for two (E8 and E9) out of five employees reviewed for pre-employment drug testing, the facility failed to have evidence of mandatory drug screening results. Findings include:	**Identification of Other Residents:** While no residents were directly harmed, all residents had the potential to be affected due to the facility's failure to follow state-mandated hiring protocols. The facility has reviewed its hiring practices and implemented controls to ensure all future hires meet state and federal compliance requirements. **System Changes:** The root cause of the deficiency was a gap in the facility's pre-employment screening process, specifically related to both panel selection and verification of completed results. For E9, the incorrect drug testing panel was selected, as it did not include marijuana, reflecting a lack of standardization and controls within the vendor ordering system that allowed non-compliant panels to be chosen; all non-compliant panels have since been removed from the system to prevent recurrence. For E8, although the correct panel was ordered, the testing vendor failed to test for all required substances, and the facility did not have a verification process in place to confirm the completeness of results prior to the employee's start date; moving forward, all drug screening results will be reviewed by Human Resources for completeness prior to any employee's start date. • The facility's Human Resources department has updated the pre-employment screening policy to require documentation of a complete drug panel that includes marijuana/cannabis, cocaine, opiates, phencyclidine	

Provider's Signature Steven Ybay LNHA Title Executive Director Date 4/27/26

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	3/9/26 – E9 (HSK) underwent employment drug screening that did not include marijuana. 3/20/26 – E8 (DA) underwent employment drug screening that did not include cocaine, opiates, phencyclidine or amphetamines. 3/26/26 – E9 and E8 started to work in the facility. 4/9/26 11:36 AM – During an interview, E1 (ED) confirmed that E9 had not been tested for marijuana before beginning employment at the facility. 4/10/26 1:15 PM – During an interview, E1 confirmed drug testing results were not received for E8 before beginning employment at the facility. 4/13/26 10:30 AM - Findings were reviewed with E1 and E2 (DON). 4/13/26 2:30 PM – Findings were reviewed with E1, E2, E3 (ADON) and E4 (MDSC) during the exit conference.	(PCP), amphetamines, and any other required substances prior to hire. • A compliance checklist is now in place and must be completed and signed off by the HR Director/designee prior to any new hire start date. • All HR personnel and hiring managers have been re-educated on Delaware's Title 16 drug screening requirements by the Executive Director/Nursing Home Administrator on 4/27/2026. **Success Evaluation:** The Human Resources Director/designee will be responsible for ensuring compliance. In absence of the Human Resources Director, the Executive Director/Nursing Home Administrator will be responsible for ensuring compliance. Going forward, audits of all new hire files will be conducted: • Weekly for 3 consecutive audit cycles to confirm that each new hire has a completed a compliant pre-employment drug screen, including all required substances. • Once 100% compliance is achieved for 3 weeks, audits will shift to bi-weekly for 3 additional cycles. • Thereafter, monthly audits will be conducted for 3 months to ensure sustained compliance. • All audit findings will be reviewed in Quality Assurance and Performance Improvement (QAPI) meetings, and any non-compliance will be addressed immediately.	

Provider's Signature Steven Hoban LNHA Title Executive Director Date 4/27/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085060	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WINDSOR HILLS	**1212 FOULK ROAD , WILMINGTON, Delaware, 19803**

(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 In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		
F0000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from April 7, 2026, through April 13, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 41. The investigative sample totaled 15 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; 8-12: Moderately impaired; 13-15: Cognitively intact; CNA - Certified Nursing Assistant; Dementia - A severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking and disorientation; DON - Director of Nursing; ED - Executive Director; FM - Family member;	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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F0000	Continued from page 1 MDS - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; MDSC - MDS Coordinator; Mood Disorder - Psychiatric condition characterized by abnormally depressed or elevated emotional states; Multiple Sclerosis - Nervous system disease that affects the brain and spinal cord; Paranoid Schizophrenia - A severe mental disorder characterized by grandiose delusions and hallucinations; RN - Registered Nurse; Trough Concentration - The lowest level of a drug in the bloodstream measured immediately before the next dose is administered.	F0000		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on interview and observation it was determined that for one (R21) out of one resident reviewed for Activities of Daily Living, the facility failed to ensure that R21 was offered a meal or assistance with eating. Findings include: 2/12/26 – R21 was admitted to the facility with diagnoses including paranoid schizophrenia and dementia. 2/18/26 – R21's admission MDS assessment documented a BIMS score of 3, indicating that R21 was severely cognitively impaired. The assessment also documented that R21 was dependent on staff to provide assistance with eating. 2/25/26 – R21's care plan documented, "[R23] is at nutrition/hydration risk related to significant weight loss prior to admission… Intervention/Tasks…Assist with meals for optimal intake…monitor oral intake of	F0677	Plan of Correction – F677 (ADL Care for Dependent Residents) Corrective Action: Corrective actions have been ensured by the Director of Nursing. Resident R21 was immediately assessed for nutritional status and meal intake, and interventions were implemented to ensure assistance with all meals per the care plan. All licensed nurses and certified nursing assistants (CNAs) were re-educated on providing ADL care, including timely meal assistance, proper positioning, and monitoring of intake. Education also included the requirement to ensure no resident requiring assistance with eating is left unattended during meal service. Staff responsible for the deficient practice received immediate re-training and competency validation. Identification of Other Residents: All residents requiring assistance with meals and/or eating have the potential to be affected by the alleged deficient practice. A facility-wide audit identified 9 residents who require extensive or total assistance with eating. A 100% audit of these residents was conducted for the	05/07/2026

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F0677 SS = D	Continued from page 2 food and fluid…". 4/9/26 8:39 AM – R21 was observed laying in bed sleeping. 4/9/26 9:34 AM – R21 was observed laying in bed sleeping. 4/9/26 9:47 AM – E6 (CNA) was observed entering R21's room. 4/9/26 10:00 AM – During an interview, FM1, R21's family member, stated, "[R21] should be up and dressed by now. I want to take her downstairs for the music activity that starts at 10:30 [am].". 4/9/26 10:07 AM – E6 was observed bringing R21 out of her room. During an interview, E6 stated, "I'm assigned to the second floor, I just came to the third floor to assist [R21]." 4/9/26 10:15 AM – FM1 was observed pushing R21 in a wheelchair down the hallway. 4/9/26 10:36 AM – R21's breakfast tray with a covered and untouched plate of food was observed sitting on a third floor dining room table. 4/9/26 10:40 AM – During an interview, E5 (RN) stated, "[R21]'s assigned CNA [E7, Agency] went home. Another CNA was called to come in". 4/9/26 12:22 PM – During an interview FM1 stated, "I took [R21] downstairs to the music activity." The Surveyor asked, "Did [R21] eat breakfast downstairs or did anyone ask if [R21] ate breakfast?" FM1 stated, "No. It's time for lunch now anyway. I'm going to get her tray and I'll help [R23] eat in her room.". 4/13/26 10:30 AM - Finding was reviewed with E1 (ED) and E2 (DON). 4/13/26 2:30 PM – Findings were reviewed with E1, E2, E3 (ADON) and E4 (MDSC) during the exit conference.	F0677	Continued from page 2 past 30 days to ensure meals were offered, assistance was provided, and intake was documented according to the care plan. Any identified concerns were immediately corrected, including staff re-education, care plan updates, and implementation of additional supervision during meal times. System Changes: The root cause of the concern was identified as a failure in staffing communication and supervision, resulting in lack of coverage for residents requiring assistance with eating when assigned staff were unavailable. To prevent recurrence, the facility has implemented the following system changes: Structured Staffing Coverage Process: A real-time staffing assignment protocol has been implemented requiring that when a staff member calls off or leaves early, the charge nurse (Licensed Nurse – RN/LPN) must immediately reassign responsibilities to available staff prior to leaving the unit unattended. Nursing Administration Oversight: The Director of Nursing (DON), Assistant Director of Nursing (ADON), or House Supervisor (RN/LPN) will oversee and guide all staff reassignments during shift changes or unexpected staffing variations. This includes prioritizing residents who require assistance with meals and/or eating to ensure uninterrupted care. Supervisory Rounding: Licensed nursing staff (RN/LPN) will conduct rounds during each meal to ensure all dependent residents are receiving assistance per care plan. Responsible Party for Ongoing Compliance: The Director of Nursing (RN) and/or Designee (RN/LPN Unit Manager or House Supervisor) will be responsible for ongoing monitoring to ensure the deficient practice does not recur beyond this Plan of	05/07/2026

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F0677 SS = D		F0677	Continued from page 3 Correction. Success Evaluation: The facility currently has 9 residents who require assistance with meals and/or eating. The Director of Nursing (RN)/Designee (RN/LPN) will conduct 100% audits of all identified residents requiring assistance with eating during every meal (breakfast, lunch, and dinner) to ensure compliance with care plans. Audit Frequency: Audits will be conducted daily (all three meals) until 100% compliance is achieved for 7 consecutive days. Then weekly until 100% compliance is achieved for 3 consecutive evaluations. Then every other week until 100% compliance is achieved for 3 additional consecutive evaluations. Then monthly thereafter to ensure sustained compliance. Audit Elements Include: Verification resident was offered a meal Verification assistance was provided per care plan Observation of staff assisting residents during meals Documentation of meal intake The goal for all audits is 100% compliance. All audit results will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee, and immediate corrective action will be taken for any identified concerns to ensure continued compliance and resident safety.	05/07/2026

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F0770 SS = D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R23) out of one resident reviewed for laboratory services, the facility failed to provide timely laboratory services. Findings include: Review of R23's clinical record revealed: 11/15/21 – R23 was admitted to the facility with diagnoses including multiple sclerosis and mood disorder. 3/16/23 – A physicians order entered in R23's clinical record documented, "…Divalproex Sodium Give 1 capsule by mouth two times a day for mood disorder.". 7/24/24 – A physician's order entered in R23's clinical record documented, "Monitor a Valproic Acid trough concentration in the next lab day and Q6months [every six months] starting on the 28th for 1 day(s) for Valproic level monitoring". 7/28/25 – R23's clinical record lacked evidence that the valproic acid levels were monitored as ordered. 12/5/25 – A Pharmacy Consultation Report for R23 documented, "[R23] receives Divalproex Sodium but does not have a trough concentration documented in the medical record…please monitor a valproic acid trough on the next convenient lab day…every 6 months thereafter…". The report also contained a handwritten physician note documenting, "Valproic trough today 1/5/2026…". 1/5/26 – A physician's order entered in R23's clinical record documented, "Valproic acid trough one time…Start Date 01/05/2025 1400 [2:00 PM].". 1/29/26 – A laboratory results report for R23 documented, "…Time/Date Collected 01/29/26 14:20	F0770	Plan of Correction – F770 (Laboratory Services) Corrective Action: Corrective actions have been ensured by the Director of Nursing. For Resident R23: The new valproic acid trough laboratory order was obtained on 01/28/2026 The valproic acid trough level was collected and received on 01/29/2026 The physician was notified of the laboratory results on 01/30/2026, and results were reviewed with no new orders / with new orders implemented as indicated. All licensed nursing staff were re-educated on the importance of timely laboratory services, including obtaining labs as ordered, tracking lab orders, and ensuring results are received, reviewed, and documented in the medical record. Education was completed on 4/27/2026 by Tirus Macharia, RN, Director of Nursing. Identification of Other Residents: All residents with active laboratory orders have the potential to be affected by the alleged deficient practice. A facility-wide audit of all laboratory orders for the past 30 days was conducted to ensure that labs were obtained as ordered, results were received timely, and documented in the medical record. Any discrepancies identified were immediately addressed, including obtaining missing labs and notifying the physician as appropriate. System Changes The root cause of the deficient practice was identified as a failure in the tracking and follow-up process for laboratory orders. To prevent recurrence, the facility has implemented the following: Laboratory Tracking Process:	05/07/2026

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F0770 SS = D	Continued from page 5 [2:20 PM]...Test Name Valproic Acid...". R23's clinical record lacked evidence of valproic acid trough level was laboratory tested as ordered. 4/9/26 2:45 PM – During an interview, E2 (DON) stated, "[R23]'s July 2025 six month valproic acid trough lab results could not be found." 4/13/26 10:30 AM - Findings were reviewed with E1 (ED) and E2. 4/13/26 2:30 PM – Findings were reviewed with E1, E2, E3 (ADON) and E4 (MDSC) during the exit conference.	F0770	Continued from page 5 A laboratory tracking log has been implemented to monitor all laboratory orders from initiation through completion, receipt of results, and physician review. The process will be overseen by the Night Supervisor (Licensed Nurse – RN/LPN), who is responsible for daily review and reconciliation of all laboratory orders. Verification of Night Supervisor Review: The Night Supervisor will document completion of the daily lab reconciliation on a designated lab tracking log. The log will include identification of any outstanding or incomplete lab orders. If issues are identified, the Night Supervisor will report them to the Director of Nursing or Designee. The Unit Manager/Director of Nursing is responsible for ensuring follow-through and resolution of all identified issues. Staffing and Assignment Continuity: If staffing changes occur or if another nurse assumes the role of Night Supervisor, the assignment will be reassigned by the Director of Nursing/Staffing Coordinator. All individuals functioning in the Night Supervisor role (including weekday and weekend staff) will be notified of responsibilities through shift report, written assignment sheets, and ongoing education. The expectation for lab reconciliation will remain consistent regardless of staff assignment. Policy Reinforcement: Policies requiring timely follow-up on all laboratory orders have been reinforced through staff education and ongoing supervision. This includes: Immediate follow-up with laboratory vendors when	05/07/2026

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F0770 SS = D		F0770	Continued from page 6 results are not received within expected timeframes. Documentation of all follow-up actions in the medical record. Escalation to the Director of Nursing if delays occur. Success Evaluation Audit Process: All laboratory orders will be identified for review through the laboratory tracking log, physician order review, and electronic medical record (EMR) reports. This process ensures that any incomplete, missing, or incorrectly entered lab orders are identified promptly. To address the concern identified in the deficient practice, the facility has implemented a double-check system during daily reconciliation to ensure that all lab orders are complete, correctly entered, and carried through to completion. Monitoring Plan: The Director of Nursing/Designee will conduct 100% audits of all laboratory orders to ensure: Labs are obtained as ordered Results are received timely Physician notification is completed Documentation is accurate and complete Audits will be conducted: Weekly until 100% compliance is achieved for 3 consecutive evaluations Every other week until 100% compliance is achieved for 3 additional evaluations	05/07/2026

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

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	085060	A. BUILDING B. WING	04/13/2026

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F0770 SS = D		F0770	Continued from page 7 Monthly thereafter for a period of 3 months The goal for all audits is 100% compliance. Audit results will be reviewed by the Quality Assurance Performance Improvement (QAPI) Committee to ensure sustained compliance. Any identified concerns will be addressed immediately with additional corrective action.	05/07/2026