**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 Lewes LLC **DATE SURVEY COMPLETED:** February 18, 2026

| 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.<br><br>An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from February 9, 2026, through February 18, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was one hundred and fifty-six (156). The survey sample totaled sixty-seven (67) residents. | | |
| 3201 | **Regulations for Skilled and Intermediate Care 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.**<br><br>This requirement was not met as evidenced by:<br><br>Cross Refer to the CMS 2567 – L survey completed February 18, 2026: F568, F569, F580, F584, F585, F605, F627, F641, F657, F677, F690, F692, F695, F697, F698, F756, F757, F760, F790, F791, F812, F841, and F842. | | |

Provider's Signature OLUKANTI MARGARET ALAKE Title ADMINISTRATOR Date 3/13/2026

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/18/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EXCELCARE AT LEWES LLC | 301 OCEAN VIEW BLVD , LEWES, Delaware, 19958 |

| (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 |
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| E0000 | Initial Comments<br><br>In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from February 9, 2026 through February 18, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified. | E0000 | | 04/06/2026 |
| F0000 | INITIAL COMMENTS<br><br>An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from February 9, 2026 through February 18, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was one hundred and fifty-six (156). The survey sample totaled sixty-seven (67) residents.<br><br>Abbreviations/definitions used in this report are as follows:<br><br>AA - Activity Aide;<br><br>AD - Activity Director;<br><br>ADON - Assistant Director of Nursing;<br><br>BOM - Business office manager;<br><br>CMS - Center for Medicaid and Medicare Services;<br><br>DON - Director of Nursing;<br><br>MRR - Monthly Medication Review, a pharmacist review of resident's medication;<br><br>NP - Nurse Practitioner;<br><br>NHA - Nursing Home Administrator;<br><br>PRN- medications given as needed; | F0000 | | 04/06/2026 |

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<br>RN - Registered Nurse;<br><br>SSI - Supplemental Security Income;<br><br>AKI - acute kidney injury - a rapid decline in kidney function that disrupts the body's ability to maintain fluid, electrolyte and metabolic balance, and requires prompt medical evaluation and management;<br><br>Acute metabolic encephalopathy - is a serious condition characterized by sudden brain dysfunction due to systemic metabolic disturbances, leading to altered mental status and neurological symptoms;<br><br>BIMS - (Brief Interview for Mental Status) – assessment of the resident's mental status scoring from 0 to 15, zero indicating severe cognitive impairment and 15 indicating cognitively intact;<br><br>BUN - A blood test that measures the amount of nitrogen in your blood that comes from the waste product urea and measures how well the kidney is functioning;<br><br>Congestive heart failure (CHF) - is a chronic condition in which the heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen;<br><br>eGFR - is a blood test that measures how well the kidneys are filtering blood to assess kidney function.<br><br>Pyxis – an automated system that helps manage storage and tracking of medications;<br><br>Spondylopathy (cervical region) means there is a problem or disease affecting the bones, discs, or joints in the neck portion of the spine. It usually involves wear and tear, arthritis, or degeneration that can cause neck pain, stiffness, nerve irritation, or weakness. | F0000 | | 04/06/2026 |
| F0692<br>SS = G | Nutrition/Hydration Status Maintenance<br><br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration.<br><br>(Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- | F0692 | .<br><br>1)– Corrective Action<br><br>Resident R173 no longer resides in the facility and facility is unable to correct.<br><br>2) – Identification of Other Residents Potentially Affected | 04/06/2026 |

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| F0692 SS = G | Continued from page 2<br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, it was determined that for one (R173) out of two residents reviewed for hydration, the facility failed to ensure that R173 maintained proper hydration which resulted in harm, requiring hospitalization on 6/1/25 and 6/19/25 with diagnosis of acute kidney injury (AKI) and dehydration. Findings include:<br><br>The BUN (blood urea nitrogen) lab test measures the amount of urea nitrogen in the blood. The BUN is directly related to the metabolic function of the liver and the excretory function of the kidney ... BUN levels also may vary according to the state of hydration, with increased levels seen in dehydration and decreased levels seen in overhydration. Mosby's Diagnostic and Laboratory Test Reference 2023.<br><br>Review of R173's clinical record revealed:<br><br>4/25/25 - R173 was admitted to the facility with a diagnosis of acute lithium toxicity, AKI (acute kidney injury), acute metabolic encephalopathy and congestive heart failure (CHF).<br><br>4/28/25 - A care plan documented that R173 had potential for alteration in nutrition due to dementia and Parkinson's disease with the following interventions: assist at meals as needed, encourage oral fluids to promote adequate hydration, and monitor for the need of other nutrition interventions.<br><br>4/28/25 - A nutrition progress note documented a nutrition assessment which recommended R173's fluid intake should be 1943-2098 mL/day. The assessment further identified R173 was at risk for dehydration and malnutrition. The progress note further mentions lab tests obtained on 4/26/25 | F0692 | Continued from page 2<br>All residents with decreased oral intake have the potential to be affected.<br><br>A facility-wide audit will be conducted of residents who demonstrate a decline in oral fluid intake over a 48-hour period to monitor that appropriate clinical follow-up occurs. The review will include verification that feeding assistance is offered when indicated, the physician or physician extender is notified as appropriate, hydration interventions are implemented, and monitoring of intake and hydration status is initiated. Any identified concerns will be addressed at the time of discovery.<br><br>3) – Systemic Changes / Root Cause / Education<br><br>The root cause analysis identified an opportunity to strengthen recognition, communication, and documentation of residents experiencing decreased oral intake and potential hydration concerns.<br><br>Education began on February 27, 2026, when the Staff Developer/designee-initiated education for licensed nurses and CNAs regarding identification and management of residents with decreased PO intake. Education includes recognizing residents demonstrating decreased oral intake, offering feeding assistance when indicated, implementing hydration interventions, monitoring intake, and providing timely notification to the physician or physician extender when hydration concerns are identified.<br><br>A system change will include utilization of the PCC alert initiated on March 1st, 2026, for decreased PO intake to assist with timely identification of residents experiencing decreased intake. Residents identified with decreased PO intake will be reviewed during the daily morning clinical meeting to support timely intervention, implementation of hydration measures, and physician notification when indicated. The IDT team has been educated on the use of this alert and review process. The Dietician also received education about the new PCC alert for resident's decreased PO intake. The PCC has a built in notification that any 2 meals less than 50% is triggered on the alert notification.<br><br>Additionally, the Registered Dietician will review all new admissions within 72hours and will review residents identified with decreased PO intake within 72 hours or sooner if clinically indicated. The Registered Dietician will also complete ongoing review quarterly, annually and with any significant changes, including significant weight loss or gain, to evaluate nutritional and fluid requirements and | 04/06/2026 |

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| F0692 SS = G | Continued from page 3<br>which documented the following lab values: Sodium 140; BUN 29; creatinine 1.4; eGFR 53.<br><br>4/30/25 - An admission MDS documented that R173 required set up assistance of one staff for feeding and hydration and also documented that R173 was a BIMS of 1, indicating severely cognitively impaired.<br><br>The daily totals obtained from CNA Task flow sheet and MAR for R173's fluid intake:<br><br>5/1/25 - 1080 mL.<br><br>5/2/25 - 840 mL.<br><br>5/3/25 - 620 mL.<br><br>5/4/25 - 1080 mL.<br><br>5/5/25 - 1080 mL.<br><br>5/6/25 - 720 mL.<br><br>5/7/25 - 1680 mL.<br><br>5/7/25 - A Malnutrition Risk Assessment documented that R173 was at risk for malnutrition related to severe dementia and hand shake (tremors).<br><br>5/8/25 - 1920 mL.<br><br>5/9/25 - 1410 mL.<br><br>5/10/25 - A physician's order documented encourage increased fluid intake of 240 mL per shift.<br><br>5/10/25 - 720 mL.<br><br>5/11/25 - 840 mL.<br><br>5/12/25 - A nutrition progress note documented R173's average fluid intake was 330 mL/day and recommended to discontinue prescribed hydration pass related to R173's diagnosis of CHF. The assessment documented to encourage oral fluid intake and determined a new fluid goal was 1635 - 1766 mL/day.<br><br>The daily totals obtained from CNA Task flow sheet and MAR for R173's fluid intake:<br><br>5/12/25 - 960 mL.<br><br>5/13/25 - 1200 mL.<br><br>5/14/25 - 940 mL. | F0692 | Continued from page 3<br>ensure appropriate interventions are in place.<br><br>The DON/designee will conduct ongoing audits of residents identified with decreased PO intake to monitor that feeding assistance is offered when indicated, hydration interventions are implemented, intake monitoring is completed, the physician or physician extender is notified as appropriate, and hydration status is documented in the clinical record.<br><br>4) – Monitoring / Quality Assurance<br><br>The DON/designee will conduct audits of residents identified with decreased PO intake.<br><br>• Weeks 1–4: 100% of residents identified with decreased PO intake weekly until 100% compliance is accomplished.<br><br>• Weeks 5–8: 75% of residents identified with decreased PO intake weekly until 100% of compliance is accomplished.<br><br>• Weeks 9–12: 50% of residents identified with decreased PO intake bi-weekly until 100% of compliance is accomplished.<br><br>Audit findings will be reviewed in the monthly QA&A meeting until 100% compliance is achieved.<br><br>5) Responsible Person:<br><br>Director of Nursing/Designee | 04/06/2026 |

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| F0692 SS = G | Continued from page 4<br>5/15/25 - 1800 mL.<br>5/16/25 - 1200 mL.<br>5/17/25 - 720 mL.<br>5/18/25 - 1320 mL.<br>5/19/25 - 720 mL.<br>5/20/25 - 840 mL.<br>5/21/25 - 1000 mL.<br>5/22/25 - 1320 mL.<br>5/23/25 - 1200 mL.<br>5/24/25 - 1080 mL.<br>5/25/25 - 1080 mL.<br>5/26/25 - 1200 mL.<br>5/27/25 - 1080 mL.<br>5/28/25 - 960 mL.<br>5/29/25 - 930 mL.<br>5/30/25 - 1080 mL.<br>5/31/25 - 1080 mL.<br>6/1/25 - 360 mL.<br>6/1/25 11:00 AM - A transfer form documented that R173 was being sent to hospital post fall for evaluation.<br>6/1/25 - A hospital progress note documented that R173 presented to the emergency department related to frequent falls, hypotension, and confusion. R173 was admitted with diagnosis of AKI and dehydration, requiring further work up.<br>6/4/25 - R173 was readmitted to the facility.<br>6/10/25 - A nursing progress note documented R173 had "low oral intake and will discuss adding R173 to the assist to feeding list."<br>The facility lacked evidence of resident being added to the feeding list or the assessment regarding the need. | F0692 | | 04/06/2026 |

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| F0692 SS = G | Continued from page 5<br><br>The daily totals obtained from CNA Task flow sheet and MAR for R173's fluid intake:<br><br>6/11/25 – 1320 mL.<br><br>6/12/25 – 1040 mL.<br><br>6/13/25 1:00 AM - A physician's progress note documented that R173 was seen following two unwitnessed falls. The progress note lacked evidence of assessment of hydration status, fluid intake, or interventions to encourage hydration.<br><br>6/13/25 – 840 mL.<br><br>6/14/25 – 1200 mL.<br><br>6/15/25 – 720 mL.<br><br>6/16/25 – 780 mL.<br><br>6/16/25 - A progress note documented R173 was having lethargy.<br><br>6/17/25 – 1160 mL.<br><br>6/18/25 – 1140 mL.<br><br>6/18/25 - A progress note documented R173 was having increased confusion, agitation, restlessness, and continues with poor intake.<br><br>6/19/25 – 720 mL.<br><br>6/19/25 1:48 PM - A laboratory results report documented that R173 had the following lab values: BUN level of 62 mg/dL, creatinine 1.70 mg/dL, hemoglobin 7.6 g/dL and hematocrit 23.3.<br><br>6/19/25 2:35 PM - A progress note documented that lab results were called to provider and documented R173 would be seen by MD. The progress note documented R173 was noted to have increased shortness of breath, increased falls, and increased confusion/agitation/anxiety.<br><br>6/19/25 4:21 PM - A nursing progress note documented that R173 was sent to the hospital for further evaluation.<br><br>6/19/25 4:24 PM - A hospital progress note documented that R173 had lab values of BUN of 62 mg/dL and creatinine 1.7 mg/dL upon arrival to emergency department. The progress note further documented R173 was being admitted with diagnosis | F0692 | | 04/06/2026 |

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| F0692 SS = G | Continued from page 6<br>of AKI, hypotension, and anemia with a plan to fluid resuscitation via IV fluids and avoid nephrotoxic medications.<br><br>2/17/26 11:15 AM - During an interview, E16 (Dietician) stated resident's will have a nutrition evaluation at admission and quarterly thereafter and the dietician is expected to review intake, weights, labs and hydration status. E16 stated that additional fluids or supplements can be ordered if fluid goals are not being met and if resident is not consistently meeting goals the expectation is to discuss with the provider. E16 also stated that a resident having a diagnosis of AKI would be someone that would be closely monitored to prevent from reoccurring.<br><br>2/18/26 11:45 AM - During an interview, E13 (CNA) stated that if a resident is not drinking well the staff is expected to encourage fluids, monitor intake and notify the nurse if the resident is not meeting fluids goals during their shift.<br><br>2/18/26 12:00 PM - During an interview, E14 (LPN) stated that R173 was not a good drinker and staff would encourage him to drink. E14 stated that R173 would drink if staff would sit and encourage him to drink, but did say at times he would refuse to drink and push the cup away. E14 stated that R173 having poor intake was reported to the Nurse Manager and the process is for the Nurse Manager to report goals not met to the provider. E14 could not verify if the Nurse Manager reported R173 not meeting fluid goals was reported at that time and stated she did not see any progress notes documenting that.<br><br>2/18/26 12:15 PM - During an interview, E17 (Unit Manager) stated the expectation is for the provider to be notified if a resident is not meeting fluid goals and to be evaluated by the provider and dietician for interventions related to hydration.<br><br>Despite nursing documenting R173's decreased intake and change in mentation, the facility failed to increase monitoring, implement approaches to increase hydration and consult with the physician about decreased intake.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0692 | | 04/06/2026 |
| F0580 SS = D | Notify of Changes (Injury/Decline/Room, etc.)<br><br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes. | F0580 | 1) IMMEDIATE CORRECTIVE ACTION:<br><br>The facility notified the Attending Physician and NP of R3's refusal on 2/10/2026. | 04/06/2026 |

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| F0580<br>SS = D | Continued from page 7<br><br>(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-<br><br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br><br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br><br>(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<br><br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br><br>(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.<br><br>(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-<br><br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br><br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br><br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident<br><br>representative(s).<br><br>§483.10(g)(15)<br><br>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 | F0580 | Continued from page 7<br><br>2) IDENTIFICATION OF OTHER RESIDENTS:<br><br>All residents who refuse dialysis services have the potential to be affected.<br><br>A facility wide audit will be conducted of all residents receiving dialysis to monitor that refusals are documented appropriately, physicians are notified timely of any refusals and responsible parties are notified. Any identified variances will be corrected at the time of discovery.<br><br>3) SYSTEMIC CHANGES/ROOT CAUSE ANALYSIS:<br><br>The root cause analysis was identified as a breakdown in communication and documentation workflow related to physician notification when a resident attends dialysis appointment but refuses treatment at the dialysis center.<br><br>On February 27, the staff developer/designee-initiated education for licensed nurses on the standardized dialysis protocol and communication process. Education will reinforce the requirement to notify the provider and responsible party whenever a resident refuses critical treatment, such as dialysis prior to the end of the shift, and to document the refusal and notifications in the medical record.<br><br>Now, the D.O.N will review dialysis book for refusals in daily end of day meeting with unit managers. The unit managers/licensed nurse will contact Medical Provider for any refusals.<br><br>4) QUALITY ASSURANCE AND MONITORING:<br><br>The D.O.N./designee will conduct audits of residents receiving dialysis. The audit will include review of documentation of the refusal and timely Physician notification. Audits will be conducted twice weekly X 2 weeks, until 100% compliance is achieved. once a week for 2 weeks, monthly for 2 months and quarterly thereafter. The D.O.N. will present the audits findings to quality Assurance and Performance improvement (QAPI) Committee for review and evaluation with the purpose of identifying trends, ensuring sustained compliance, and determining whether additional performance improvement interventions are necessary. | 04/06/2026 |

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| F0580 SS = D | Continued from page 8<br>changes between its different locations under §483.15(c)(9).<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, it was determined that for one (R3) out of one resident reviewed for dialysis, the facility failed to ensure that the provider was consulted when R3 refused dialysis services. Findings include:<br><br>Review of R3's clinical record revealed:<br><br>12/18/25 - R3 was admitted to the facility.<br><br>12/26/25 - A physician's order documented R3 dialysis appointment Monday, Wednesday and Friday transport via stretcher.<br><br>2/9/26 11:30 AM - A progress note documented that R3 left for dialysis.<br><br>2/9/26 - A dialysis communication form documented that R3 attended dialysis but refused treatment and R3 was returned to facility without interventions.<br><br>2/12/26 1:01 PM - During an interview, E20 (LPN) stated dialysis center called the facility to notify them that R3 did not receive dialysis on 2/9/26. E20 stated she did not write a progress note documenting that R3 did not receive dialysis and stated the Nurse Manager was notified that R3 did not receive dialysis.<br><br>2/12/26 1:15 PM - During an interview, E17 (UM) stated that R3 went to dialysis on 2/9/26 and was not aware R3 did not receive dialysis.<br><br>2/12/26 1:30 PM - During an interview, E21 (NP) stated that neither the nurse nor the dialysis center notified her that R3 did not receive dialysis on 2/9/26 and that the expectation would be to notify her.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0580 | Continued from page 8<br><br>5) RESPONSIBLE PERSON:<br><br>Director of Nursing /Designee. | 04/06/2026 |
| F0585 SS = D | Grievances<br><br>CFR(s): 483.10(j)(1)-(4)<br><br>§483.10(j) Grievances.<br><br>§483.10(j)(1) The resident has the right to voice | F0585 | .<br><br>1) IMMEDIATE CORRECTIVE ACTION: | 04/06/2026 |

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| F0585 SS = D | Continued from page 9<br>grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.<br><br>§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.<br><br>§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.<br><br>§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:<br><br>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;<br><br>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; | F0585 | Continued from page 9<br><br>Resident #41 no longer resides in the Facility. Dentures were replaced prior to discharge. Facility was unable to correct and resolve the grievance from 5/14/25 to January 2026. The Administrator met with the resident's POA and reimbursed the cost for replacing the missing dentures prior to discharge.<br><br>2) IDENTIFICATION OF OTHER RESIDENTS POTENTIALLY AFFECTED:<br><br>The Facility respectfully states that all residents/family who have filed a grievance has the potential to be affected.<br><br>A facility wide audit of all grievances that have been filed over the past 30 days will be reviewed for timely resolution. Any identified variances will be addressed at the time of discovery.<br><br>3)SYSTEMIC CHANGES/ROOT CAUSE ANALYSIS<br><br>A root cause analysis determined that Social Services staff were unaware that dental services may proceed under a fee-for-service process without requiring Medicaid eligibility determination.<br><br>On February 27,2026, the Staff Developer/designee-initiated education for the Nursing Home Administrator, Director of Nursing, Director of Social Services and Social Services staff regarding the fee-for-service process for dental services. Education also included reinforcement of the Facility grievance process and the expectation that grievances are resolved within 5-7 days. Grievances will be reviewed during daily morning Q.A, meeting to support timely resolution. The Administrator (LNHA) is responsible for verifying that all grievances are addressed within the 5–7-day timeframe to ensure compliance with regulatory requirements.<br><br>4) QUALITY ASSURANCE AND MONITORING:<br><br>The Administrator/designee will conduct audits to monitor compliance that all grievances are resolved within 5-7 days. Audits will be conducted weekly x4 weeks until 100% compliance is achieved. | 04/06/2026 |

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| F0585 SS = D | Continued from page 10<br><br>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;<br><br>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;<br><br>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;<br><br>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and<br><br>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, it was determined that for one (R41) of one resident reviewed for grievances, the facility failed to ensure prompt resolution of a grievance regarding missing dentures. Findings include:<br><br>5/14/25 – A facility provided grievance form completed by E14 (LPN) documented that FM1 reported R41's top dentures were missing. E14 conducted a room sweep and documented that the 11:00 PM – 7:00 AM shift would complete a second room sweep. The concern was reported to the Director of Nursing.<br><br>5/14/25 – A grievance documented that E28 (Former Social Worker) was in receipt of the grievance and reported receiving an email from the Director of | F0585 | Continued from page 10<br><br>Then monthly X 2 months until 100% compliance is maintained and quarterly thereafter. Audit findings will be reported monthly to Quality Assurance Committee.<br><br>5)RESPONSIBLE PERSON: Administrator/Director of Social Services. | 04/06/2026 |

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| F0585 SS = D | Continued from page 11<br>Nursing requesting that E28 contact FM1. On 5/16/25 during that contact, FM1 was informed that if the resident was approved for Medicaid and no longer Medicaid-pending, Medicaid would replace the dentures. FM1 stated the resident had transferred from another facility and was already approved in Delaware. The family agreed to wait until E28 verified Medicaid status with the Business Office. A discussion with the Business Office was scheduled for 5/19/25.<br><br>5/19/25 through 7/28/25 – A record review did not reveal documented investigative findings, corrective actions, or grievance closure following the scheduled Business Office discussion.<br><br>7/28/25 at 11:49 AM – A facility provided email thread documented E15 (Social Worker) emailed the dentist requesting enrollment for R41 and indicated the resident needed to be fitted for dentures.<br><br>7/29/25 at 10:35 AM – The dentist responded requesting confirmation that E29 (Former Business Office Manager) was the resident's representative payee.<br><br>8/11/25 at 1:45 PM – The dentist notified E15 that R41 did not qualify for the dental program. FM1 was informed that the resident did not qualify due to lack of income required for program eligibility.<br><br>2/18/26 at 1:45 PM – During an interview, E15 reviewed the grievance documentation and confirmed the facility's grievance process includes receipt of the grievance, forwarding it to the appropriate unit or manager to search for the missing item, and, if not located, forwarding the matter to the Nursing Home Administrator. E15 was unable to explain the extended timeframe and stated uncertainty as to why a meeting with E29 was required before proceeding with denture replacement. E15 further stated the events that occurred during her absence.<br><br>2/18/26 at 1:53 PM – During a joint interview with E12 (Current Business Office Manager) and E15 it was revealed and confirmed by E12 that the facility could have obtained dental services on a fee-for-service basis and was not required to wait for Medicaid eligibility determination to proceed. E12 further confirmed the resident did not qualify for the dental program because program eligibility required income, which R41 did not have.<br><br>Record review indicated resolution of the denture replacement did not occur until January 2026, | F0585 | | 04/06/2026 |

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| F0585 SS = D | Continued from page 12<br>approximately eight months after the grievance was initiated.<br><br>The facility was unable to demonstrate a grievance was promptly resolved or managed in accordance with its stated grievance process.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON). | F0585 | | 04/06/2026 |
| F0605 SS = D | Right to be Free from Chemical Restraints<br><br>CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e)<br><br>§483.10(e) Respect and Dignity.<br><br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any . . . chemical restraints<br><br>imposed for purposes of discipline or convenience, and not required to treat the<br><br>resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br><br>The resident has the right to be free from abuse, neglect, misappropriation of<br><br>resident property, and exploitation as defined in this subpart. This includes but is<br><br>not limited to freedom from corporal punishment, involuntary seclusion and any<br><br>physical or chemical restraint not required to treat the resident's medical<br><br>symptoms.<br><br>§483.12(a) The facility must-. . .<br><br>§483.12(a)(2) Ensure that the resident is free from . . . chemical restraints<br><br>imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. | F0605 | ..<br><br>Step 1 – Immediate Corrective Action<br><br>Resident R11 PRN Ativan order was immediately reviewed. The physician was contacted, and the order was clarified to include duration and clinical indication. The order was revised to: Lorazepam 0.5 mg by mouth every 6 hours as needed for anxiety for 14 days, initiated on 3/01/2026.<br><br>Step 2 – Identification of Other Residents Potentially Affected<br><br>The Facility respectively states that all residents receiving PRN psychotropic medications have the potential to be affected.<br><br>A facility-wide audit will be conducted of residents receiving PRN psychotropic medications to verify that each order includes an appropriate indication and duration/stop date in accordance with regulatory requirements. Any identified orders lacking required parameters will be clarified with the physician.<br><br>Step 3 – Systemic Changes / Root Cause Analysis<br><br>A root cause analysis determined an opportunity to improve oversight of PRN psychotropic medication orders related to required stop dates, rationale for use, and monitoring.<br><br>Education began on February 27, 2026, by the Staff Developer/designee for licensed nurses regarding regulatory requirements for PRN psychotropic medications, including duration limits, documentation of clinical rationale, and required monitoring. DON/ADON will conduct ongoing review of all new PRN psychotropic medication orders during the daily morning meeting to monitor compliance. Additionally, the Consultant Pharmacist will provide ongoing monthly review and oversight | 04/06/2026 |

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

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| F0605<br>SS = D | Continued from page 13<br>. . . .<br><br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br><br>(i) Anti-psychotic;<br><br>(ii) Anti-depressant;<br><br>(iii) Anti-anxiety; and<br><br>(iv) Hypnotic.<br><br>§483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>§483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; | F0605 | Continued from page 13<br>of PRN psychotropic medications to monitor appropriate use and compliance.<br><br>The DON/designee will review new PRN psychotropic medication orders to monitor compliance with duration limits, clinical rationale, and required monitoring.<br><br>Step 4 – Monitoring / Quality Assurance<br><br>The DON/designee will conduct audits as follows:<br><br>• Week 1: Audit 100% of residents with PRN psychotropic medications until 100% compliance<br><br>• Week 2: Audit 75% of residents with PRN psychotropic medications until 100% compliance<br><br>• Week 3: Audit 50% of residents with PRN psychotropic medications until 100% compliance<br><br>• Week 4: Audit 25% of residents with PRN psychotropic medications until 100% compliance<br><br>Audit findings will be reviewed in the monthly QA&A meeting until 100% compliance is achieved.<br><br>Step 5 RESPONSIBLE PERSON:<br><br>Director of Nursing/designee. | 04/06/2026 |

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| F0605 SS = D | Continued from page 14<br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview it was determined that for one (R11) out of six residents reviewed for unnecessary medication review the facility failed to ensure that an ordered as needed psychotropic medication extended beyond 14 days had a documented rationale and duration. Findings include:<br><br>Cross refer F756<br><br>The facility policy on Psychotropic drug use last updated 5/1/25 indicated "PRN orders for psychotropic drugs are limited to fourteen days. Except if the attending physicians or prescribing practitioner believes that it is appropriate for the PRN order to be extended, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order."<br><br>Review of R11's clinical record revealed:<br><br>1/22/25 - R11 was admitted to the facility with multiple diagnoses including dementia, psychotic disturbance, mood disturbance, and anxiety.<br><br>10/15/25 - A significant change MDS assessment documented that R11 was cognitively impaired and receiving psychotropic medications. R11 exhibited physical behaviors 4 - 6 days in a seven-day period.<br><br>10/16/25 11:32 - A progress note in R11's clinical | F0605 | | 04/06/2026 |

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| F0605 SS = D | Continued from page 15<br>record documented, "Hospice nurse was in to visit. New [physicians] orders received from hospice for Lorazepam 6 hours PRN [for] anxiety/agitation. NP concurs with said orders hospice."<br><br>10/16/25 - A physician's order was written for R11 to receive Lorazepam 0.5 MG every six hours as needed for anxiety. This order was extended on 10/23/25. The clinical record lacked evidence of a rationale for the extension.<br><br>10/19/25 - An MRR for R11 documented "A duration must be specified for PRN psychoactive [psychotropic] medications. First order is limited to only fourteen days, but if the rationale documented by the prescriber to continue order...Please update Lorazepam per CMS regulations. Note: There is no exception to this regulation for hospice patients." The MRR lacked evidence of review by an attending provider E27 (LPN) signed the comments section.<br><br>10/23/25 - A physician's order was written for R11 to receive Lorazepam 0.5 MG every six hours as needed for anxiety. This order was discontinued on 11/6/25.<br><br>11/12/25 - A physician's order was written for R11 to receive Lorazepam 0.5 MG every six hours as needed for anxiety. This order was discontinued on 12/30/25.<br><br>12/10/25 - A quarterly MDS assessment documented that R11 was severely cognitively impaired and receiving psychotropic medications. R11 exhibited physical behaviors daily in a seven-day period.<br><br>12/29/25 - A physician's order was written for R11 to receive one Lorazepam 0.5 MG every six hours as needed for anxiety. The order was extended 1/2/26. The clinical record lacked evidence of a rationale for the extension.<br><br>1/2/26 - A physician's order was written for R11 to receive one Lorazepam 0.5 MG every six hours as needed for anxiety. This order was extended 1/22/26. The clinical record lacked evidence of a rationale for the extension.<br><br>1/14/26 - An MRR for R11 documented "A duration must be specified for PRN psychoactive [psychotropic] medications. First order is limited to only fourteen days, but if the rationale documented by the prescriber to continue order...Please update Lorazepam per CMS regulations. Note: There is no exception to this regulation for hospice patients." The MRR lacked evidence of review by an attending | F0605 | | 04/06/2026 |

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| F0605<br>SS = D | Continued from page 16<br>E4 (ADON) signed the comments section "This is not a first order for this patient.<br><br>1/22/26 - A physician's order was written for R11 to receive one Lorazepam 0.5 MG every six hours as needed for anxiety. This order is listed as "indefinite" with no indicated duration. The clinical record lacked evidence of a rationale for the extension.<br><br>1/22/26 - A psychiatric follow up note in R11's clinical record documented a rationale for extending provider 11's Lorazepam. The note did not contain a duration/end date.<br><br>2/13/26 11:19 AM - During an interview E22 (RN) stated that she was unaware of documented rationale to extend R11's order for Lorazepam or a duration. E22 stated the psychiatric team had discussed the residents continued anxious behavior.<br><br>2/13/26 11:52 AM - E1 (NHA) confirmed that the facility lacked evidence of rationale for extension of R11's Lorazepam except for the 1/22/26 psychiatric note.<br><br>2/13/26 2:10 PM - During an interview E4 (ADON) confirmed review of the 1/14/26 MRR and that it was not given to a provider because "the order was not new".<br><br>2/16/26 12:08 PM - During an interview E26 (NP) confirmed the finding, E26 reported that R11's Lorazepam was reordered without duration and rationale "because he's on hospice". E26 was unable to recall reviewing the MRR that addressed the extension of R11's Lorazepam.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0605 | | 04/06/2026 |
| F0627<br>SS = D | Inappropriate Discharge<br><br>CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv)<br><br>§483.15(c) Transfer and discharge-<br><br>§483.15(c)(1) Facility requirements-<br><br>§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-<br><br>(A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot | F0627 | .<br><br>.<br><br>Step 1 – Immediate Corrective Action<br><br>• Unable to correct from 8/1/2025-8/20/2025<br><br>Step 2 – Identification of Other Residents Potentially Affected<br><br>• All residents discharged from the facility requiring home health services have the potential to be | 04/06/2026 |

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| EXCELCARE AT LEWES LLC | 301 OCEAN VIEW BLVD , LEWES, Delaware, 19958 |

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| F0627 SS = D | Continued from page 17<br>be met in the facility;<br><br>(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;<br><br>(C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;<br><br>(D)The health of individuals in the facility would otherwise be endangered;<br><br>(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<br><br>(F)The facility ceases to operate.<br><br>§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.<br><br>§483.15(c)(2) Documentation.<br><br>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.<br><br>(i)Documentation in the resident's medical record must include:<br><br>(A) The basis for the transfer per paragraph (c)(1)(i) of this section. | F0627 | Continued from page 17<br>affected.<br><br>• A facility-wide audit will be conducted of residents discharged within the past 14 days to monitor that home health needs were identified timely and referrals were initiated prior to discharge. Any identified concerns will be corrected at the time of discovery.<br><br>Step 3 – Systemic Changes / Root Cause Analysis<br><br>The root cause analysis determined that the facility lacked a consistent process to verify that discharge planning steps, including home health referrals, were completed in accordance with the facility's discharge planning policy.<br><br>Education began on February 27, 2026, when the Staff Developer/designee-initiated re-education of Social Workers on the facility's discharge planning policy, including initiating discharge planning at the time of admission, identifying potential home health needs early in the resident's stay, and coordinating with interdisciplinary team members regarding home health referrals. The education is incorporated into Social Services new hire orientation for ongoing understanding of safe discharge planning expectations and responsibilities.<br><br>Social Services Director or Social Services Assistant will review discharge planning documentation during the daily morning meeting for residents with anticipated discharges within the upcoming week to monitor that home health referrals are initiated prior to discharge. In the absence of the Social Services Director, the Social Services Assistant will be responsible for completing this review to ensure continuity of process. In addition to our step-by-step process, upcoming discharges are discussed in Utilization Review where upcoming discharges are discussed with the IDT Team. Discharges are also flagged in the PCC, electronic medical record to alert the IDT team. Items to be discussed in daily morning Q.A are home care referrals, and any specialized equipment needed at home and family education. The IDT Team are Nursing, Social Services, MDS coordinator, Therapy, Dietician, Unit Managers. Nursing and Therapy department are part of the Discharge planning process to verify that appropriate home health and Therapy are in place.<br><br>The Social Worker Director /designee will conduct | 04/06/2026 |

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| F0627 SS = D | Continued from page 18<br><br>(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).<br><br>(ii)The documentation required by paragraph (c)(2)(i) of this section must be made by-<br><br>(A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and<br><br>(B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.<br><br>§483.15(c)(7) Orientation for transfer or discharge.<br><br>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.<br><br>§483.15(e)(1) Permitting residents to return to facility.<br><br>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.<br><br>(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-<br><br>(A) Requires the services provided by the facility; and<br><br>(B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services<br><br>(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.<br><br>§483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is | F0627 | Continued from page 18<br>routine audits to monitor compliance with the facility's discharge planning policy, including timely initiation of discharge planning and home health referrals prior to discharge.<br><br>Step 4 – Monitoring / Quality Assurance<br><br>The Social worker/designee audit schedule will as follows:<br><br>• 5 audits per week of discharged residents x 4 weeks until 100% compliance is achieved.<br><br>• 3 audits per week of discharged residents x 4 weeks until 100% compliance is achieved<br><br>• 2 audits per week of discharged residents x 4 weeks until 100% compliance is achieved.<br><br>Audit results will be reviewed through the QAPI process. Monitoring will continue until 100% compliance is achieved.<br><br>Step 5-RESPONSIBLE PERSON:<br><br>NHA/Director of Social Services/Designee | 04/06/2026 |

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| F0627 SS = D | Continued from page 19<br>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.<br><br>§483.21(c)(1) Discharge Planning Process<br><br>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-<br><br>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.<br><br>(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.<br><br>(iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.<br><br>(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.<br><br>(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.<br><br>(vi) Address the resident's goals of care and treatment preferences.<br><br>(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.<br><br>(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. | F0627 | | 04/06/2026 |

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| F0627 SS = D | Continued from page 20<br><br>(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.<br><br>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.<br><br>(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.<br><br>(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.<br><br>§483.21(c)(2) Discharge Summary<br><br>When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:<br><br>(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.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interviews, record review and review of | F0627 | | 04/06/2026 |

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| F0627 SS = D | Continued from page 21<br>other facility documentation it was determined that for one (R174) out of three residents sampled for discharge, the facility failed to ensure a referral for home health care services was completed prior to discharge. R174 was discharged to home on 8/12/25. R174's home health services did not begin until 8/20/25 eight days after discharge from the facility. Findings include:<br><br>A facility policy titled "Notice Requirements before Transfer/Discharge" dated 5/1/25 documented "The facility will provide sufficient preparation and orientation to residents to ensure an orderly transfer or discharge from the facility."<br><br>A review of R174's clinical record revealed:<br><br>7/28/25 – R174 was admitted to the facility with the following diagnoses: aortic valve replacement, aortic regurgitation, and congestive heart failure.<br><br>8/11/25 – A review of R174's discharge summary documented, "Discharge summary and post-discharge plan for home health aide, home health RN/LPN, occupational and physical therapy."<br><br>8/12/25 – R174 was discharged to home with a family member.<br><br>9/30/25 9:40 AM – A review of a complaint to the Division documented, "[R174] was discharged to a family member's home without a home health care agency referral." Further review of the complaint documented that R174 had been in the home for one week and had not received any physical or occupational therapy and had not received a wellness check from a nurse.<br><br>2/16/26 11:00 AM – During an interview, E15 (SW) reported, "I would need to check if a referral was made for [R174]."<br><br>2/16/26 12:17 PM – During an interview, E15 confirmed R174's referral for home health and therapy services was not requested until 8/15/25. E15 then stated, "[R174's] referral for home health care was opened for recommended services on 8/20/25."<br><br>2/16/26 1:48 PM – During an interview, E35 (DT) reported, "[R174] already had therapy equipment at home." E35 confirmed and stated, "Physical therapy and occupational therapy were recommended for [R174]." E35 then reported, "Typically, recommendations are communicated to social services to set up home care." | F0627 | | 04/06/2026 |

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| F0627 SS = D | Continued from page 22<br><br>2/18/26 3:40 PM – Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON). | F0627 | | 04/06/2026 |
| F0641 SS = D | Accuracy of Assessments<br><br>CFR(s): 483.20(g)(h)(i)(j)<br><br>§483.20(g) Accuracy of Assessments.<br><br>The assessment must accurately reflect the resident's status.<br><br>§483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.<br><br>§483.20(i) Certification.<br><br>§483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.<br><br>§483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.<br><br>§483.20(j) Penalty for Falsification.<br><br>§483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-<br><br>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or<br><br>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.<br><br>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interviews, it was determined for three (R6, R17 and R43) out of sixty-seven sampled residents, the facility failed to ensure the MDS was accurate. Findings include:<br><br>1.Review of R6's clinical record revealed: | F0641 | .<br><br>Tag F641 – Accuracy of Assessments<br><br>Step 1 – Corrective Action for Residents Identified<br><br>The MDS assessments for residents R6, R17, and R143 were corrected on 3/9/26.<br><br>Step 2 – Identification of Other Residents Potentially Affected<br><br>Residents admitted from the hospital with active diagnoses, or current residents who receive new diagnoses requiring coding on the MDS, have the potential to be affected.<br><br>A targeted review will be conducted of residents admitted from the hospital and residents with new diagnoses within the past 14 days to monitor accurate MDS coding related to infection of the foot due to fungal infection. Any discrepancies identified will be corrected at the time of discovery.<br><br>Step 3 – Systemic Changes / Root Cause Analysis<br><br>A root cause analysis determined an opportunity to strengthen oversight and education related to MDS coding for infection of the foot due to fungal infection.<br><br>Education began on February 27, 2026, when the VP of Clinical Reimbursement/designee-initiated education for the MDS Coordinator and licensed nurses regarding MDS coding related to infection of the foot due to fungal infection. The MDS Coordinator/designee will audit residents admitted from the hospital and current residents with new diagnoses to monitor accurate coding of infection of the foot related to fungal infection.<br><br>Step 4 – Monitoring / Quality Assurance Plan<br><br>The accuracy of assessment audit schedule will be as follows:<br><br>• All new admissions and newly diagnosed residents weekly x 4 weeks until 100% compliance is achieved.<br><br>• 50% of new admissions and newly diagnosed | 04/06/2026 |

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| F0641 SS = D | Continued from page 23<br><br>12/16/25 - R6 was admitted to the facility.<br><br>12/20/25 - An MDS assessment documented that R6 had an infection of the foot.<br><br>2/18/26 9:30 AM - During an interview, E33 (MDS Coordinator) and E34 (MDS Coordinator) confirmed that R6 was marked for an infection of the foot on the MDS assessment and stated they are coded with infection of the foot related to a fungal infection documented by the podiatrist.<br><br>2. Review of R17's clinical record revealed:<br><br>1/8/26 - R17 was admitted to the facility.<br><br>1/15/26 - An MDS assessment documented that R17 had an infection of the foot.<br><br>2/18/26 9:30 AM - During an interview, E33 (MDS Coordinator) and E34 (MDS Coordinator) confirmed that R17 was marked for an infection of the foot on the MDS assessment and stated they are coded with infection of the foot related to a fungal infection documented by the podiatrist.<br><br>3. Review of R143's clinical record revealed:<br><br>9/21/25 - R143 was admitted to the facility.<br><br>11/11/25 - A quarterly MDS assessment documented that R143 had an infection of the foot.<br><br>2/18/26 9:30 AM - During an interview, E33 (MDS Coordinator) and E34 (MDS Coordinator) confirmed that R143 was marked for an infection of the foot on the MDS assessment and stated they are coded with infection of the foot related to a fungal infection documented by the podiatrist.<br><br>The facility failed to ensure the MDS was accurate for R6, R17 and R143.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0641 | Continued from page 23<br>residents x 2 weeks until 100% compliance is achieved.<br><br>• 25% of new admissions and newly diagnosed residents x 2 weeks until 100% compliance is achieved.<br><br>Audit results will be reviewed through the QAPI Committee until 100% compliance is achieved.<br><br>Step 5-RESPONSIBLE PERSON:<br><br>MDS Coordinator/Designee | 04/06/2026 |
| F0657 SS = D | Care Plan Timing and Revision<br><br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br><br>§483.21(b)(2) A comprehensive care plan must be- | F0657 | .<br><br>1)IMMEDIATE CORRECTIVE ACTION:<br><br>R2 had his care plan conference completed on | 04/06/2026 |

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| F0657 SS = D | Continued from page 24<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br><br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(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.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.<br><br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, it was determined that for four (R2, R9, R22, R41 and R46) out of forty-nine sampled residents the facility failed to revise the residents care plans to reflect their individualized needs. Additionally, it was determined that for R2 the facility failed to ensure that the resident and the resident representative were involved in developing the care plan. Findings include:<br><br>1. Review of R2's clinical record revealed:<br><br>11/15/24 – R2 was admitted to the facility.<br><br>11/4/25 – A Brief Interview for Mental Status (BIMS) evaluation documented R2 with a score of 15 out of 15, showing an intact cognitive status.<br><br>2/9/26 9:27 AM – During an interview, R2 stated that he did not recall having quarterly care plan meetings since his admission.<br><br>2/10/26 – A review of R2's electronic chart documented a care conference meeting on 11/29/24, | F0657 | Continued from page 24<br>02/16/2026, and care plans were reviewed and updated as indicated. The facility is unable to retroactively correct the absence of a care plan conference from 03/29/2024 through 02/26/2026.<br><br>R9's care plan was updated to reflect refusal of a palm guard and that a rolled washcloth or gauze may be used as an alternative.<br><br>R22's self-care deficit care plan was updated to reflect that she is dependent with bathing.<br><br>R41 is unable to be corrected.<br><br>R46 care plan was revised on 2/12/26 to include new behavior of potential for resident-to-resident.<br><br>2) – Identification of Other Residents Potentially Affected<br><br>All residents with self-care deficits, residents utilizing palm guards, and residents who return from hospitalization have the potential to be affected.<br><br>A facility-wide audit will be conducted of all residents who returned from the hospital within the past 30 days to verify that care plan conference schedules are reset upon return and that required care plan conferences are scheduled timely. The facility will conduct ongoing reviews of all residents returning from the hospital to ensure care plan conference schedules are reset and conferences are scheduled in accordance with regulatory timeframes.<br><br>A whole-house audit will be conducted to monitor that self-care deficit care plans reflect that resident functional status is fluid and may vary from day to day, and that care plan language supports promoting the resident's highest practicable level of functioning. Any discrepancies identified will be corrected at the time of discovery.<br><br>A facility-wide audit will be conducted of residents utilizing palm guards to monitor that care plans reflect device use, resident refusals when applicable, and acceptable alternatives such as a rolled washcloth or gauze. Any discrepancies identified will be corrected at the time of discovery.<br><br>3) Systemic Changes/Root Cause Analysis:<br><br>The root cause analysis identified that self-care deficit care plans did not consistently reflect that a resident's functional status is fluid and may vary from day to day, or that care is adjusted based on the resident's changing functional status. | 04/06/2026 |

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| F0657 SS = D | Continued from page 25<br>where R2 was present and no further meetings afterwards. Furthermore, the electronic chart for R2 documented a care plan completed on 3/10/25, 5/21/25 and 12/2/25.<br><br>2/16/26 8:50 AM – During an interview, E15 (SW) confirmed that R2's last care conference meeting was 11/29/24 and that there were no care conference meetings in 2025.<br><br>There was a lack of evidence that R2 was involved in developing a care plan for 3/10/25, 5/21/25 and 12/2/25.<br><br>2. Review of R9's clinical record revealed:<br><br>3/17/23 - A physician's order was written for R9 to wear a right palm protector at all times, as tolerated, may use rolled gauze [wash cloth] if replacement unavailable.<br><br>12/8/25 - Reviews to R9's care plan for potential for further contractures related to impaired mobility and existing contractures was completed, the palm guard/replacement was listed as an intervention. The care plan lacked evidence of any potential refusals from R9 to wear the palm guard or a replacement such as a rolled washcloth or gauze.<br><br>2/9/26 10:00 AM - R9 was observed without a palm guard or replacement. R9 answered "no" when offered a palm guard/replacement. E19 (LPN) stated "he usually refuses".<br><br>2/11/26 12:10 PM - R9 was observed without a palm guard or replacement.<br><br>2/16/26 1:13 PM - R9 was observed without a palm guard or replacement. R9 answered "no" when offered a palm guard/replacement.<br><br>2/16/26 1:17 PM - During an interview E18(CNA) confirmed that R9's palm guard/replacement was not in place and stated, "I haven't seen the palm guard recently, but we use a washcloth then, he takes it out or sometimes says no".<br><br>2/16/26 1:25 PM - During an interview E23 (LPN) stated "he gets the washcloth I have not seen the palm guard he takes them out". E22(RN) then immediately confirmed that R9's care plan for a palm guard should have been updated to reflect the residents' potential refusals. | F0657 | Continued from page 25<br>Additionally, Social Services lacked a standardized process to monitor care plan conferences scheduled timely following a resident's return from hospitalization.<br><br>Education began on February 27, 2026, when the Staff Educator/designee re-educated licensed nurses and the interdisciplinary team on individualized self-care deficit care planning, documentation of palm guard refusals and alternatives, and timely care plan updates following changes in resident status.<br><br>The facility recognizes that self-care deficits can be fluid and may vary from day to day, as reflected in CNA task documentation. Care is provided and adjusted to promote each resident's highest practicable level of functioning, recognizing that a resident's functional status may fluctuate daily. Care plans will be updated to reflect this by incorporating language addressing self-care deficits that encourage independence in activities of daily living while providing assistance as needed.<br><br>A standardized process has been implemented requiring the Social Services Director or Social Services Assistant to reset the care plan conference schedule within 24 hours or the next business day for all residents returning from hospitalization. This process will be ongoing to ensure timely scheduling and compliance. The PCC will alert all IDT of the new admission. Once a new admission or readmission is announced, either in morning meeting or group communication that the Admission arrived in the building, the care plan conference will be scheduled.<br><br>The Director of Nursing (DON)/designee will conduct ongoing audits to verify that self-care deficit care plans reflect that a resident's functional status is fluid and may vary from day to day and that care is adjusted based on the resident's changing functional status that promotes highest level of function. Audits will also monitor that residents utilizing palm guards have care plans reflecting device use, refusals when applicable, and appropriate alternatives, and that all residents returning from hospitalization have care plan conference schedules reset within 24 hours or the next business day.<br><br>4) Quality Assurance and Monitoring:<br><br>The DON/designee will conduct audits to verify that self-care deficit care plans accurately reflect the resident's current ADL status and align with CNA | 04/06/2026 |

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| F0657 SS = D | Continued from page 26<br>3. Review of R22's clinical record revealed:<br><br>9/16/25 - A quarterly MDS assessment documented that R22 was cognitively impaired and dependent for bathing.<br><br>12/15/25 Annual MDS assessment documented that R22 was cognitively impaired and dependent for bathing.<br><br>12/29/25 - A review of R22's care plan for self-care deficit was completed. The care plan documented that R22 required set up assistance for bathing.<br><br>12/15/25 Annual MDS assessment documented that R22 was cognitively impaired and dependent for bathing.<br><br>2/12/26 2:28 PM - During an interview E24(CNA) confirmed that R22 was dependent for bathing and occasionally refuses care. E24 stated, "She needs me to pretty much do everything now for her now. She hasn't been able to without help in a while.<br><br>2/12/26 2:28 PM - During an interview E3 (DON) confirmed the finding and stated she would revise R22's care plan to include the R22's dependence for bathing.<br><br>4. Review of R41's clinical record revealed:<br><br>11/3/25 - A quarterly MDS assessment documented that R41 was cognitively impaired and dependent for bathing.<br><br>11/17/25 - R41's care plan for self-care deficit was reviewed by the facility and indicated that R41 required one person to assist them with bathing. The care plan lacked documentation of R41's dependance for bathing.<br><br>2/18/26 12:19 PM - During an interview E4 (ADON) confirmed the facility failed to ensure that R41's self-care deficit care plan was revised to reflect residents' dependence for bathing.<br><br>5. Review of R46's clinical record revealed:<br><br>10/27/25 R46's behavior care plan for safety hazard to others as evidenced by resident is combative during care, attempts to hit staff with bed remote and call bell was created.<br><br>1/13/26 - A quarterly MDS assessment documented that R46 was cognitively impaired and had physical behaviors four to six times in a seven-day period. | F0657 | Continued from page 26<br>ADL documentation and nursing assessments, that residents utilizing palm guards have care plans reflecting device use, refusals when applicable, and appropriate alternatives, and that residents returning from hospitalization have care plan conference schedules reset within 24 hours or next<br><br>4) – Monitoring / Weaning Schedule<br><br>Audit schedule:<br><br>• 5 residents weekly x 4 weeks until 100% compliance is achieved.<br><br>• 3 residents weekly x 4 weeks until 100% compliance is achieved<br><br>• 2 residents weekly x 4 weeks until 100% compliance is achieved.<br><br>Audit findings will be reviewed through the QAPI process until 100% compliance is achieved. | 04/06/2026 |

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| F0657 SS = D | Continued from page 27<br><br>1/13/26 - An incident report was submitted to the State Agency that alleged R46 aggressed another resident during an altercation when R46 swung a television remote and hit another resident.<br><br>1/19/26 - A five day follow up to the previous incident report was submitted that documented, "care plans were reviewed".<br><br>2/12/26 - Review of R46's behavior care plans lacked evidence of revision to include R46's new behavior of an attempt to hit residents.<br><br>2/12/26 1:37 PM - During an interview E3 (DON) confirmed that the facility failed to revise R46's behavioral care plan to include the new potential for resident-to-resident altercations.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON). | F0657 | | 04/06/2026 |
| F0677 SS = D | ADL Care Provided for Dependent Residents<br><br>CFR(s): 483.24(a)(2)<br><br>§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;<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview, and record review, it was determined that for one (R131) out of one resident reviewed for ADL (Activities of Daily Living), the facility failed to provide ADL care for dependent residents. Findings include<br><br>Review of R131's clinical record revealed:<br><br>3/12/25 - R131 was admitted to the facility with a diagnosis of stroke infarction, affecting the right side.<br><br>12/3/25 - A quarterly MDS assessment documented that R131 was dependent on staff for bathing and dressing.<br><br>12/15/25 - A review of R131's care plan for ADL's documented that the resident is dependent for ADL care. The care plan did not include a refusal of nail care.<br><br>2/9/26 9:00 AM – An observation revealed that | F0677 | ) – Immediate Corrective Action<br><br>Resident R131's fingernails were immediately cleaned and trimmed.<br><br>2)– Identification of Other Residents Potentially Affected<br><br>All residents who are dependent for nail care have the potential to be affected.<br><br>A facility-wide audit will be conducted of residents who are dependent on nail care. Residents' fingernails will be reviewed for cleanliness and appropriate length. Any resident identified with grooming needs will receive immediate intervention.<br><br>3) – Systemic Changes / Root Cause Analysis<br><br>The root cause analysis identified that documentation of nail care was not included as a task within the POC task system.<br><br>Education began on February 27, 2026, when the Staff Developer/designee-initiated re-education of Certified Nursing Assistants on monitoring nail length and cleanliness during routine care, providing timely nail care within their scope of practice, and reporting concerns requiring nurse evaluation to the nurse. This education is incorporated into C.N.A new hire orientation to ensure ongoing understanding of expectations. Nail care will now be documented as a POC task. | 04/06/2026 |

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| F0677 SS = D | Continued from page 28<br>R131's left and right hands had long fingernails, and there was black debris under the fingernails of his right hand.<br><br>2/10/26 10:00 AM - An observation revealed that R131's left and right hands had long fingernails, and there was black debris under the fingernails of his right hand.<br><br>2/11/26 12:51 PM - During an interview, E10 (CNA) stated that when she gives a bath, she washes the resident and does hair and nails. R131's bath days are Mondays and Thursdays.<br><br>2/11/26-1:00 PM - During an interview, E5 (UM) confirmed that the 3:00 PM to 11:00 PM shift documented that R131 received his bath, R131's left and right hands had long fingernails and that his fingernails on the right hand had black debris underneath.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0677 | Continued from page 28<br>Licensed nurses will observe nail hygiene during daily rounds, review care plans for grooming assistance needs, and reinforce expectations during shift report.<br><br>The DON/designee will conduct audits of residents requiring assistance with ADLs to monitor nail care for cleanliness and appropriate length.<br><br>4) – Monitoring / Quality Assurance<br><br>The audit schedule will be as follows:<br><br>Weeks 1–2: Audit 100% of resident's dependent on nail care until 100% compliance is achieved.<br><br>Weeks 3–4: Audit 50% of residents' dependent on nail care until 100% compliance is achieved<br><br>Month 2: Audit 25% of residents' dependent on nail care until 100% compliance is achieved.<br><br>Audit findings will be reviewed through the QAPI process until 100% compliance is achieved.<br><br>5) Responsible Person:<br><br>Director of Nursing/Designee. | 04/06/2026 |
| F0690 SS = D | Bowel/Bladder Incontinence, Catheter, UTI<br><br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br><br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br><br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br><br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as | F0690 | .<br><br>.<br><br>.<br><br>1) – Corrective Action for Identified Resident<br><br>R56 was evaluated by a urologist on 12/31/25 and received a recommendation to follow up with the urologist on a PRN basis.<br><br>2) – Identification of Other Residents Potentially Affected<br><br>All residents who return from an Emergency Department (ED) visit with recommendations for specialist follow-up have the potential to be affected.<br><br>A facility-wide audit will be conducted of residents who have had ED visits within the past 30 days to monitor that referrals are initiated, and appointments are scheduled and documented. Any identified issues will be corrected at the time of discovery. | 04/06/2026 |

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| F0690 SS = D | Continued from page 29<br>possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br><br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review for one (R56) out of two residents reviewed for catheter use, the facility failed to refer R56 to urology timely while having an ongoing urinary catheter issue. Findings include:<br><br>Review of R56's clinical record revealed:<br><br>10/24/23 - R56 was admitted to the facility.<br><br>11/6/23 - A care plan documented R56 had a foley catheter related to neurogenic bladder with the following interventions: resident had a 18F with a 30 mL balloon, position catheter bag and tubing below level of the bladder; monitor intake and output per facility policy; monitor for signs and symptoms of discomfort on urination and frequency; monitor for signs and symptoms of UTI and report to physician; monitor and document for pain or discomfort related to catheter.<br><br>2/25/25 - A progress note documented R56 returned from an appointment and foley catheter was found to be out, with balloon intact. The progress note documented that foley catheter insertion was attempted and unsuccessful at this time, due to resistance. The provider was notified and recommendation to leave foley catheter out and bladder scan every 8 hours for residual urine.<br><br>2/26/25 - A progress note documented that foley catheter re-insertion was successful.<br><br>3/1/25 - A progress note documented that R56 had large amount of bleeding and blood clots noted from penis. The on-call provider was notified and labs and urine culture ordered. | F0690 | Continued from page 29<br><br>3)– Systemic Changes / Root Cause Analysis<br><br>The root cause analysis identified an opportunity to improve consistency in reviewing specialist recommendations following ED visits.<br><br>Education began on February 27, 2026, regarding review of ED discharge documentation and initiation of specialist referrals. The Unit Clerk will review emergency department (ED) discharge paperwork within 24 hours or the next business day and will update appointments in PCC to ensure visibility and follow-up by the interdisciplinary team. The R.N admitting the patient and Unit manager will also review the ED discharge paperwork to ensure that recommendations are followed. The process will be ongoing to ensure compliance.<br><br>The DON/designee will conduct audits of residents returning from the Emergency Department to monitor that specialist referrals are initiated, appointments are scheduled, and documentation is completed.<br><br>4)– Monitoring / Audit Schedule<br><br>The audit schedule will be as follows:<br><br>• All ED return audits per week x 4 weeks until 100% compliance is achieved.<br><br>• 75% ED return audits per week x 4 weeks until 100% compliance is achieved.<br><br>• 50% return audits per week x 4 weeks until 100% compliance is achieved.<br><br>Audit results will be reviewed through the QAPI process until 100% compliance is achieved.<br><br>5)-Responsible Person:<br><br>Director of Nursing/Designee | 04/06/2026 |

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| F0690 SS = D | Continued from page 30<br>3/2/25 6:03 AM - A progress note documented that R56 presented with excessive bleeding and clots around urinary catheter and was sent to hospital for evaluation.<br><br>3/2/25 9:51 AM - A diagnostic report for CT results documented "the tip of the catheter is seen in the penile urethra with distended balloon just proximal to the tip."<br><br>3/2/25 3:54 PM - A progress note documented that R56 returned from hospital.<br><br>3/5/25 12:00 AM - A physician's progress documented that R56 was recently seen and examined by urology with foley catheter change. The diagnoses, assessment, and plan section documented that R56 will follow up with urology.<br><br>11/3/25 10:31 AM - A visit summary report documented that R56 was seen by urology.<br><br>2/18/2026 9:35 AM - During an interview, E30 (LPN) stated that R56 was difficult to replace the urinary catheter and recalls staff having ongoing difficulty changing. E30 stated that R56 was recommended to follow up with urology and have catheter changes done with them due to the increased difficulty.<br><br>2/18/2026 10:03 AM - During an interview, E31 (LPN) stated that R56 had multiple catheters dislodged in the year 2025 and stated that R56 was difficult catheter to change. E31 stated that R56's catheter would leak often and would require staff to change it. E31 stated the expectation would be for staff nurses to attempt to change the catheter and if unsuccessful they would be referred out.<br><br>2/18/2026 12:11 PM - During an interview, E14 (LPN) stated the expectation is to get residents scheduled with outside providers as soon as possible. E14 confirmed that R56 did not see urology until 11/3/25.<br><br>The facility failed to refer R56 to an outside provider timely.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0690 | | 04/06/2026 |
| F0695 SS = D | Respiratory/Tracheostomy Care and Suctioning<br><br>CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy | F0695 | Tag F695 – Respiratory / Oxygen Therapy<br><br>1) –Immediate Corrective Action:<br><br>Resident # 183 nebulizer mask and oxygen tubing | 04/06/2026 |

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| F0695 SS = D | Continued from page 31<br>care and tracheal suctioning.<br><br>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and record review it was determined that for one (R183) out one resident sampled for respiratory care, the facility failed to provide professional standards of practice. Findings include:<br><br>A review of R183's clinical record revealed:<br><br>1/31/26 – R183 was admitted to the facility with diagnoses of chronic obstructive pulmonary disease and chronic respiratory failure.<br><br>2/7/26 - An initial MDS documented that R183 was moderately impaired BIMS 11.<br><br>2/10/26 – A physician's order for R183 documented place nebulizer face mask after each use in a plastic bag.<br><br>2/15/26 – A review of the treatment administration record lacked evidence of an order directing that the mask and tubing be stored in a protective plastic bag when not in use.<br><br>2/9/26 at 11:35 AM – An observation revealed that R183's oxygen tubing was on the floor, and not in a protective plastic bag. The nebulizer face mask was on the bedside table and not in a protective plastic bag.<br><br>2/10/26 at 9:00 AM – An observation revealed that R183's oxygen tubing was on the floor and not in a protective plastic bag. The nebulizer face mask was on the bedside table and not in a protective plastic bag.<br><br>2/10/26 AM 10:30 AM – During an interview, E5 (LPN) confirmed that oxygen tubing and a nebulizer face mask are required to be stored in a protective plastic bag when not in use. E5 immediately placed the oxygen tubing and mini neb into a protective plastic bag.<br><br>2/18/26 3:40 PM - Findings were reviewed during | F0695 | Continued from page 31<br>nebulizer mask and oxygen were immediately discarded and replaced with a new one placed in a plastic bag.<br><br>2) – Identification of Other Residents Potentially Affected:<br><br>All residents receiving oxygen therapy have the potential to be affected.<br><br>A facility-wide audit will be conducted of residents currently receiving oxygen therapy or to verify physician orders include direction for oxygen mask and tubing to be stored in a protective plastic bag when not in use and that tubing and masks are observed to be stored properly. Orders will be obtained as indicated.<br><br>3) – Systemic Changes / Root Cause Analysis<br><br>On February 27, 2026, the Staff Developer/designee-initiated education for licensed nurses regarding respiratory therapy management, including the expectation that oxygen masks and tubing are stored in a protective plastic bag when not in use in accordance with the respiratory order set.<br><br>The DON/designee will conduct ongoing audits to monitor physician orders for proper storage of oxygen tubing and masks and to verify that tubing and masks are stored appropriately when not in use.<br><br>4) – Quality Assurance and Monitoring Audits:<br><br>The audit schedule will be<br><br>Weeks 1–2: Audit 100% of residents receiving oxygen therapy or respiratory treatments until 100% compliance is achieved.<br><br>Weeks 3–4: Audit 50% of residents receiving oxygen therapy or respiratory treatments until 100% compliance is achieved.<br><br>Months 2–3: Audit 10 residents monthly receiving oxygen therapy or respiratory treatments until 100% compliance is achieved.<br><br>Audit findings will be reviewed in the monthly QA&A meeting until 100% compliance is achieved.<br><br>5) Responsible Person: | 04/06/2026 |

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| F0695 SS = D | Continued from page 32<br>the exit conference with E1 (NHA), E2 (ROD), and E3 (DON). | F0695 | Continued from page 32<br>Director of Nursing/ Designee. | 04/06/2026 |
| F0697 SS = D | Pain Management<br><br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br><br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, it was determined that for one (R141) out of one resident reviewed for pain, the facility failed to provide pain management according to professional standards of practice Findings include:<br><br>Review of R141's clinical record revealed:<br><br>5/25/25 – R141 was admitted to the facility with a diagnosis of spondylopathy cervical region and muscle weakness.<br><br>11/25/26 - A quarterly MDS assessment documented that R141was alert and oriented. Additionally, the MDS documented that R141 had pain.<br><br>12/8/25 - A baseline care plan was initiated for potential for pain and actual for spinal stenosis of the cervical region, mobility impairment, spondylopathy, and chronic pain syndrome.<br><br>1/28/26 – A progress note revealed R141 had a surgical cervical fusion.<br><br>2/2/26 - A physician's order for oxycodone 5 mg, take 2 tablets by mouth as needed for pain for 14 days. The order was discontinued 2/16/26.<br><br>2/16/26 - A physician's order was reissued for Oxycodone 2 tablets 5mg by mouth for chronic pain as needed for pain.<br><br>2/16/26 4:40 AM - A review of R141's MAR (Medication Administration Record) revealed oxycodone 5mg, take 2 tablets by mouth, was not given.<br><br>2/16/26 7:10 AM – A progress note documented E3 (DON) was called to R141's room, R141 was | F0697 | .<br><br>Pain Medication Renewal & Monitoring<br><br>1) – Immediate Corrective Action for Identified Resident:<br><br>• Resident R141 had her oxycodone order reviewed, renewed as indicated, and administered per physician order. Her oxycodone was reviewed on 2/17/26. Order stated Oxycodone 5mg every 4 hrs. and as needed for Pain for 14 days. It was renewed again on 2/27/26 for another 14 days and on 3/12/26 was renewed as oxycodone 5mg q4 and prn for pain management ongoing.<br><br>2) – Identification of Other Residents Potentially Affected<br><br>• The Facility respectfully states that all residents receiving pain medications that require renewal orders have the potential to be affected.<br><br>• A facility-wide audit will be conducted of all residents currently prescribed narcotic pain medications to determine the presence of an active physician order, upcoming expiration or renewal date, any concerns will be corrected, including obtaining renewal orders, notifying the physician/NP, and monitoring medication availability to prevent interruption in administration.<br><br>3) – Systemic Changes / Root Cause Analysis:<br><br>• Root cause analysis identified the absence of a standardized process to review residents prescribed narcotic pain medications for upcoming renewal dates and to proactively notify the physician/NP to prevent lapses in orders or administration.<br><br>• A weekly pain medication review process will be implemented to identify orders approaching expiration. The Unit Manager/designee will review active narcotic pain medication orders to monitor timely renewal prior to expiration. The Director of Nursing/licensed Nurse will run a weekly narcotic ordering report in PCC. Orders with end dates will be reviewed and the licensed nurse will contact the medical provider as needed to obtain renewal or new orders to ensure continuity of care and compliance.<br><br>• On February 27, 2026, the Staff | 04/06/2026 |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| EXCELCARE AT LEWES LLC | 301 OCEAN VIEW BLVD , LEWES, Delaware, 19958 |

| (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 |
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| F0697 SS = D | Continued from page 33<br>complaining of neck pain, and the pain level was 7 of 0-10 pain scale. The nurse practitioner was made aware, and a new order was received to give Oxycodone 2 tabs 5 mg by mouth.<br><br>2/16/26 9:45 AM -During an interview, R141 stated experiencing significant pain throughout the night and specifically requested her prescribed oxycodone for pain and was told by E7 (RN) they did not have it.<br><br>2/17/26 4:40 AM - A late entry progress note by E7 (RN) documented not given. E7 called the provider for an order for Oxycodone 5mg 2 tabs by mouth so they can pull the medication out of the Pyxix but was unsuccessful.<br><br>2/17/26 9:32 AM – An interview with E7 confirmed the prescription expired for R141's oxycodone on 2/16/26 and failed to get a new order to use back-up pain medication at the facility to treat R141's pain.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0697 | Continued from page 33<br>Developer/designee-initiated education for all licensed nurses regarding oversight of narcotic pain medication orders and renewal monitoring. Education included reviewing physician order parameters, identifying medications with expiration or renewal requirements, timely physician/NP notification for renewal, monitoring medication availability, and ensuring accurate documentation in the EMR.<br><br>• The DON/designee will conduct audits of residents receiving narcotic pain medications to verify active renewal orders, timely provider notification, and ongoing monitoring of pain management interventions.<br><br>4) – Quality Assurance Monitoring Audit Schedule:<br><br>The audit schedule will be:<br><br>• 5 narcotic pain medication audits per week x 4 weeks until 100% compliance is achieved.<br><br>• 3 narcotic pain medication audits per week x 4 weeks until 100% compliance is achieved.<br><br>• 2 narcotic pain medication audits per week x 4 weeks until 100% compliance is achieved.<br><br>Audit findings will be reviewed through the monthly QA&A Committee until 100% compliance is achieved.<br><br>5) Responsible Person:<br><br>Director of Nursing/Designee | 04/06/2026 |
| F0698 SS = D | Dialysis<br><br>CFR(s): 483.25(l)<br><br>§483.25(l) Dialysis.<br><br>The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, interview and review of other facility documentation, it was determined that for one (R3) out of one sampled residents reviewed for dialysis, the facility failed to monitor R3's dialysis catheter and failed to complete R3's before (pre) and after (post) dialysis assessments. Findings | F0698 | F698 Plan of Correction<br><br>Plan of Correction<br><br>1) – Immediate Corrective Action for Resident R3<br><br>Resident R3 had pre-dialysis and post-dialysis nursing assessments completed on February 25, 2026, including assessment of the dialysis catheter.<br><br>2 – Identification of Other Residents Potentially Affected<br><br>The Facility respectively states that all residents receiving dialysis services have the potential to be | 04/06/2026 |

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| F0698 SS = D | Continued from page 34<br>include:<br><br>Review of R3's clinical record revealed:<br><br>12/18/25 - R3 was admitted to the facility.<br><br>12/19/25 - A care plan documented "R3 needs dialysis related to renal failure with the following interventions: encourage resident to go for scheduled dialysis appointments; monitor/document/report any sign and symptoms of infection to the access site: redness, swelling, warmth or drainage; monitor/document/report signs and symptoms of renal insufficiency: change in level of consciousness, changes in skin turgor, change in heart or lung sounds; monitor/document/report signs and symptoms of the following: bleeding, hemorrhage, bacteremia or septic shock."<br><br>12/25/25 - An admission MDS documented that R3 was receiving hemodialysis and dependent for ADL's.<br><br>12/26/25 - A physician's order documented R3 dialysis appointment Monday, Wednesday and Friday transport via stretcher.<br><br>2/12/26 - A review of physician's order lacked evidence of an order to assess R3's dialysis catheter.<br><br>2/12/26 1:01 PM - During an interview, E20 (LPN) stated the expectation is for the nurse to complete a pre and post dialysis assessment on R3, including assessment of the dialysis catheter. E20 confirmed pre and post assessments should be completed and documented in a progress note in the medical record.<br><br>2/12/26 - A review of the progress notes and assessments in R3's medical record lacked evidence of pre and post dialysis assessments. A review of the dialysis assessment revealed an assessment of the dialysis port or catheter is included.<br><br>2/12/26 1:15 PM - During an interview, E17 (UM) confirmed the expectation is to assess R3 before and after dialysis and the progress notes lacked evidence of those assessments being completed.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0698 | Continued from page 34<br>affected.<br><br>A house-wide audit will be conducted of all current dialysis residents to monitor that pre-dialysis and post-dialysis assessments are completed, including assessment of the dialysis port or catheter. Any identified concerns will be corrected at the time of discovery.<br><br>3 – Systemic Changes / Root Cause Analysis<br><br>Root Cause Analysis (RCA):<br><br>The RCA determines the facility has an opportunity to improve consistency in completing and documenting pre- and post-dialysis assessments within PCC and to strengthen staff understanding of the required assessment elements and their location within the EMR.<br><br>• The Staff Developer/designee will re-educate all licensed nurses on the required components of pre- and post-dialysis assessments, including assessment of the dialysis port or catheter and documentation in the electronic medical record. The nursing comprehensive dialysis assessment documentation is now part of the facility's new nurse orientation.<br><br>The licensed Nurse will review the resident's communication book from Dialysis to keep informed of any changes and follow up recommendation.<br><br>• The DON/designee will conduct focused audits of dialysis documentation to monitor ongoing compliance with completion of pre- and post-dialysis assessments, including assessment of the dialysis port or catheter.<br><br>4)–Quality Assurance and Monitoring / Audit Schedule<br><br>The audit schedule will be:<br><br>• 3 audits per week for 4 weeks until 100% compliance is achieved.<br><br>• 2 audits per week for 4 weeks until 100% compliance is achieved.<br><br>• 1 audit per week for 4 weeks until 100% compliance is achieved.<br><br>Audit findings will be reviewed in the monthly QA&A meeting until 100% compliance is achieved. | 04/06/2026 |

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| F0698 SS = D | | F0698 | Continued from page 35<br>5) Responsible Person:<br><br>Director of Nursing/Designee. | 04/06/2026 |
| F0756 SS = D | Drug Regimen Review, Report Irregular, Act On<br><br>CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br><br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br><br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br><br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br><br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, it was | F0756 | .<br><br>F756 Plan of Correction (POC)<br><br>1) –Immediate Corrective Action:<br><br>Residents R11, R14, and R15 had the identified irregularities reviewed and signed off by the attending physician/physician extender for the current, most clinically relevant month of February. The Facility did not retrospectively review prior months.<br><br>2) – Identification of Other Residents Potentially Affected<br><br>The facility respectfully states that all residents have the potential to be affected.<br><br>A facility-wide audit will be conducted of Medication Management Reviews (MMRs) completed over the past 30 days to verify that all irregularities identified during the MMR process, including both nursing-identified and physician-identified irregularities, are reviewed by the attending physician/physician. Any identified concerns will be addressed and corrected as indicated.<br><br>3) – Systemic Changes / Root Cause Analysis<br><br>Root Cause Analysis (RCA):<br><br>The root cause analysis determines that during the Medication Management Review (MMR) process, the facility obtained physician/physician extender signature on physician recommendations; however, nursing irregularities identified during the MMR were not consistently included for provider review and sign-off.<br><br>The facility revises the MMR process to require the physician/physician extender to review and sign off on all MMR irregularities, including both nursing-identified and physician-identified findings, to ensure complete clinical oversight and timely follow-up.<br><br>The Staff Developer/designee-initiated education on February 27, 2026, on re-educating, Unit managers, licensed nurses on the revised MMR workflow, | 04/06/2026 |

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| F0756 SS = D | Continued from page 36<br>determined that for three (R11, R14 and R15) out of six residents reviewed for unnecessary medication review, the facility failed to ensure for the medication regimen review (MRR) that irregularities identified were reviewed by the attending/designee. Findings include:<br><br>A facility policy titled, "Pharmacy Services – Drug Regimen Review," dated 5/1/25, documented, "... the pharmacist will report any irregularities to the attending physician, the facility's medical director and the director of nursing ... The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it ...".<br><br>1. Review of R15's clinical record revealed:<br><br>8/26/25 – R15 was admitted to the facility with a diagnosis including, but not limited to, hypothyroidism.<br><br>12/8/25 – A medication regimen review for R15 documented that charting omissions are noted for levothyroxine for 11/21/25. A nursing comment documented, "Omitted? Not sure why," and was signed by E27 (UM).<br><br>There was a lack of an attending or designee signature on the aforementioned medication regimen review document.<br><br>2/16/26 2:44 PM – During an interview, E26 (NP) stated that when the MRR is submitted to the facility, some of the recommendations can be added by the nurses. However, if the medication or frequency changes, they give it to the provider. The UM or DON gets the medication review and then gives it to us, the provider, to review. The surveyor noted the following irregularity: Charting omissions are noted for levothyroxine on 11/21/25. E26 stated that she would need to know that information.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON).<br><br>2. Review of R11's clinical record revealed:<br><br>6/20/25 - An MRR completed for R11 identified an irregularity. The MRR lacked evidence of review from an attending E27 (LPN) signed the comments section. | F0756 | Continued from page 36<br>including documentation expectations, escalation for provider review, and verification that provider sign-off is obtained for all MMR irregularities. The process is incorporated into new orientation for unit managers and administrative nursing staff to ensure ongoing understanding and compliance.<br><br>The DON/designee will conduct audits to verify that nursing irregularities are included for provider review, provider sign-off is present for all irregularities, and follow-up actions are documented as applicable.<br><br>4)–Monitoring / Quality Assurance (Audit Schedule)<br><br>The audit schedule will be:<br><br>• Month 1: Audit 100% of MMRs completed until 100% compliance is achieved.<br><br>• Month 2: Audit 75% of MMRs completed until 100% compliance is achieved.<br><br>• Month 3: Audit 50% of MMRs completed until 100% compliance is achieved.<br><br>Audit findings will be reviewed in the monthly QA&A meeting until 100% compliance is achieved.<br><br>5) Responsible Person: Director of Nursing/Designee | 04/06/2026 |

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| | 085034 | A. BUILDING<br>B. WING | 02/18/2026 |

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| F0756<br>SS = D | Continued from page 37<br><br>9/14/25 - An MRR completed for R11 identified an irregularity. The MRR lacked evidence of review from an attending E27 (LPN) signed the comments section.<br><br>10/19/25 - An MRR completed for R11 identified an irregularity. The MRR lacked evidence of review from an attending E27 (LPN) signed the comments section.<br><br>12/7/25 - An MRR completed for R11 identified an irregularity. The MRR lacked evidence of review from an attending E27 (LPN) signed the comments section.<br><br>1/14/26 - An MRR completed for R11 identified an irregularity. The MRR lacked evidence of review from an attending E4 (ADON) signed the comments section.<br><br>2/13/26 2:10 PM - During an interview with E4 (ADON) it was confirmed that all MRR's with irregularities were not reviewed by providers.<br><br>3. Review of R14's clinical record revealed:<br><br>4/6/25 - An MRR completed for R14 identified and irregularity. The MRR lacked evidence of review from an attending E4 (ADON) signed the comments section.<br><br>6/8/25 - An MRR completed for R14 identified an irregularity. The MRR lacked evidence of review from an attending E4 (ADON) signed the comments section.<br><br>10/16/25 - An MRR completed for R14 identified an irregularity. The MRR lacked evidence of review from an attending.<br><br>11/9/25 - An MRR completed for R14 identified an irregularity. The MRR lacked evidence of review from an attending E27 (LPN) signed the comments section.<br><br>12/7/25 - An MRR completed for R14 identified an irregularity. The MRR lacked evidence of review from an attending E27 (LPN) signed the comments section. | F0756 | | 04/06/2026 |

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| F0756 SS = D | Continued from page 38<br><br>2/16/26 12:10 PM - During an interview E26 (NP) confirmed the findings, E26 reported that providers do not review all MRR's with documented irregularities, providers review irregularities after a referral from the nurses.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0756 | | 04/06/2026 |
| F0757 SS = D | Drug Regimen is Free from Unnecessary Drugs<br><br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview it was determined that for one (R11) out of six residents reviewed for unnecessary medication review the facility failed to ensure that the resident was free from unnecessary medications. Findings include:<br><br>Review of R11's clinical record revealed: 9/23/25 - A physician's order was written for R11 to receive Metoprolol, a blood pressure medication one time a | F0757 | ) – Immediate Corrective Action:<br><br>R11's Metoprolol was discontinued on 2/9/2026<br><br>2 – Identification of Other Residents Potentially Affected<br><br>The Facility respectfully states that all residents receiving antihypertensive medications with parameters have the potential to be affected.<br><br>A whole-house audit will be conducted of residents currently prescribed antihypertensive medications with parameters, to monitor patterns of held doses and ensure physician/physician extender review as indicated. Any identified concerns will be addressed at the time of discovery.<br><br>3) – Systemic Changes / Root Cause Analysis:<br><br>A root cause analysis determines there is an opportunity to improve oversight of antihypertensive medications that are frequently held, such as Metoprolol, to ensure patterns of held doses are evaluated for continued clinical indication.<br><br>Education began February 27, 2026, by the Staff Developer/designee with all licensed nurses regarding regulatory requirements for unnecessary medications, including documentation and reporting of held medications.<br><br>A standardized process will be implemented requiring the DON/designee to review medication administration records at least monthly, through the Medication Management Review (MMR) process to identify patterns of held antihypertensive medications. Reviews will occur monthly or more frequently as needed, and findings will be reported to the physician/physician extender as indicated. Identified patterns will also be reviewed in the High-Risk meeting with the attending physician/physician extender as appropriate. This process will be on-going to monitor compliance and | 04/06/2026 |

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| F0757 SS = D | Continued from page 39<br>day for hypertension, hold for systolic blood pressure greater than 130 or heart rate less than sixty. October 2025 - Review of R11's MAR revealed that nineteen out of thirty-one doses of Metoprolol were not given to R11 because of lower systolic blood pressure or heart rate. November 2025 - Review of R11's MAR revealed that twenty-five out of thirty doses of Metoprolol were not given to R11 because of lower systolic blood pressure or heart rate. December 2025 - Review of R11's MAR revealed that eleven out of thirty-one doses of Metoprolol were not given to R11 because of lower systolic blood pressure or heart rate. January 2026 - Review of R11's MAR revealed that nine out of thirty-one doses of Metoprolol were not given to R11 because of lower systolic blood pressure or heart rate. 2/9/26 - A physician's order was written to discontinue R11's Metoprolol. 2/16/26 12:08 PM - During an interview E26 (NP) confirmed the finding, E26 reported, "I discontinued the medication in February because with low blood pressure it was no longer appropriate." E26 was not made aware of the frequency that R11's Metoprolol was held and stated, "If I would have been notified of the holds, I would have discontinued it at that time." 2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON). | F0757 | Continued from page 39<br>appropriate clinical oversight.<br><br>The DON/designee will conduct routine audits of residents prescribed antihypertensive medications with parameters to verify appropriate clinical indication, review of held dose patterns, and that the physician/physician extender was notified as indicated.<br><br>4) –Quality Assurance Monitoring /Audit Schedule<br><br>The audit schedule will be:<br><br>• Weekly audits for four weeks until 100% compliance is achieved.<br><br>• Monthly audits for two months until 100% compliance is achieved.<br><br>Audit findings will be reviewed in the monthly QA&A meeting until 100% compliance is achieved.<br><br>5) Responsible Person:<br><br>Director of Nursing/Designee<br><br>.. | 04/06/2026 |
| F0760 SS = D | Residents are Free of Significant Med Errors<br><br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br><br>§483.45(f)(2) Residents are free of any significant medication errors.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review, interview and review of physician orders it was determined that for one (R11) out of six residents' sampled for unnecessary medication review the facility failed to ensure that R11's blood pressure medication was held when vital signs were below ordered parameters. Findings include:<br><br>The facility policy on medication administration last updated 5/1/25 indicated, "Medications are administered as prescribed in accordance with good nursing principles and practices."<br><br>Review of R11's clinical record revealed:<br><br>9/22/25 - A physicians' order was written for R11 | F0760 | .<br><br>F760 – Plan of Correction (Free of Significant Medication Errors)<br><br>1) – Immediate Corrective Action<br><br>R11's Metoprolol was discontinued on 2/9/2026<br><br>2) – Identification of Other Residents Potentially Affected<br><br>The Facility respectfully states that all residents receiving antihypertensive medications such as Metoprolol have the potential to be affected.<br><br>A whole-house audit will be conducted of residents currently prescribed antihypertensive medications such as Metoprolol, including a retrospective review of residents who received these medications within to monitor that medications are administered within ordered parameters. Any identified concerns will be addressed at the time of discovery.<br><br>3) – Systemic Changes / Root Cause Analysis | 04/06/2026 |

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| EXCELCARE AT LEWES LLC | 301 OCEAN VIEW BLVD , LEWES, Delaware, 19958 |

| (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 |
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| F0760 SS = D | Continued from page 40<br>to receive metoprolol daily for blood pressure; hold for systolic blood pressure (SBP) less than 130 or hear rate (HR) less than 60.<br><br>October 2025 - R11 was administered metoprolol with below ordered parameters on the following dates:<br><br>10/7 with a SBP of 118<br><br>10/28 with a SBP of 125.<br><br>November 2025 - R11 was administered metoprolol with below ordered parameters on the following dates:<br><br>11/24 with a HR of 52.<br><br>12/7/25 - An MRR irregularity report documented, "metoprolol is not always held as required by the physician's order. The report lacked evidence of review by R11's attending and was signed by E27 (LPN).<br><br>December 2025 - R11 was administered metoprolol with below ordered parameters on the following dates:<br><br>12/3 with a SBP of 123<br><br>12/10 with a SBP of 126<br><br>12/12 with a HR of 58<br><br>12/16 with a SBP of 113<br><br>12/20 with a SBP of 121<br><br>12/24 with a SBP of 126 and HR of 56<br><br>12/26 with a SBP of 127.<br><br>January 2026 - R11 was administered metoprolol with below ordered parameters on the following dates:<br><br>1/3 with a SBP of 110<br><br>1/4 with a SBP of 114<br><br>1/5 with a SBP of 114<br><br>1/6 with a SBP of 109<br><br>1/10 with a SBP of 126 | F0760 | Continued from page 40<br>A root cause analysis determines there is an opportunity to improve oversight of antihypertensive medications that require administration parameters, such as Metoprolol, to ensure medications are administered in accordance with ordered parameters and appropriate nursing assessment.<br><br>Education began February 27, 2026, when the Staff Developer/designee educated all licensed nurses on regulatory requirements related to medication administration, including verification of ordered parameters prior to medication administration. Education included completion of a nursing assessment when medications are held due to low blood pressure or heart rate, to include obtaining and documenting vital signs, assessing signs and symptoms (e.g. dizziness, weakness, changes in condition). Nurses were also educated to notify the Physician/physician extender as indicated based on assessment findings.<br><br>A standardized process will be implemented requiring the DON/designee to review medication administration records weekly, or as needed, to monitor compliance with medication administration parameters for antihypertensive medications such as Metoprolol. Findings will be reviewed in the High-Risk meeting with the attending physician/physician extender as indicated.<br><br>• The DON/designee will conduct audits of residents prescribed antihypertensive medications with ordered administration parameters (such as Metoprolol) to verify medications are administered within ordered parameters, appropriate nursing assessment is documented, and physician/physician extender notification occurs when parameters are not met.<br><br>4) –Quality Assurance Monitoring / Audit Schedule:<br><br>• Audits three times per week for two weeks of residents receiving antihypertensive medications with administration parameters<br><br>• Weekly audits for four weeks until 100% compliance is achieved.<br><br>• Monthly audits for two months until 100% compliance is achieved.<br><br>Audit findings will be reviewed in the monthly QA&A meeting until 100% compliance is achieved.<br><br>5) Responsible Person: | 04/06/2026 |

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| F0760 SS = D | Continued from page 41<br>1/11 with a SBP of 116<br><br>1/13 with a SBP of 116<br><br>1/17 with a SBP of 117<br><br>1/18 with a SBP of 107 and a HR of 54<br><br>1/19 with a SBP of 103<br><br>1/22 with a SBP of 119<br><br>1/30 with a SBP of 116.<br><br>February 2026 - R11 was administered metoprolol with below ordered parameters on the following dates:<br><br>2/1 with a SBP of 129<br><br>2/2 with a SBP of 125<br><br>2/4 with a SBP of 121 and HR of 59<br><br>2/7/26 - An MRR irregularity report documented "metoprolol not always held consider discontinuing. MRR was signed by E26 (NP) on 2/11/26 who documented that the metoprolol was discontinued.<br><br>2/9/26 - R11's physician's order for metoprolol was discontinued.<br><br>2/13/26 11:08 AM - During an interview E50 (LPN) one nurses who administered R11's metoprolol in February and January confirmed the finding that R11 received their metoprolol when vital signs did not meet ordered parameters. E50 stated, "If the one vital sign is good [within parameters] then I give the medication based on that".<br><br>2/13/26 11:19 AM - During an interview E26 (NP) confirmed that R11's metoprolol was to be held for either parameter and that she was unaware that R11 was administered the metoprolol outside of parameters.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON). | F0760 | Continued from page 41<br>Director of Nursing/Designee. | 04/06/2026 |
| F0790 SS = D | Routine/Emergency Dental Srvcs in SNFs<br><br>CFR(s): 483.55(a)(1)-(5)<br><br>§483.55 Dental services. | F0790 | .<br><br>Tag F790 – Dental Services | 04/06/2026 |

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| F0790 SS = D | Continued from page 42<br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(a) Skilled Nursing Facilities<br><br>A facility-<br><br>§483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(f) of this part, routine and emergency dental services to meet the needs of each resident;<br><br>§483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services;<br><br>§483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility;<br><br>§483.55(a)(4) Must if necessary or if requested, assist the resident;<br><br>(i) In making appointments; and<br><br>(ii) By arranging for transportation to and from the dental services location; and<br><br>§483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview, it was determined that for one (R41) of one resident reviewed for grievance, the facility failed to promptly to initiate the replacement of lost dentures within three days after notification of loss.<br><br>Findings include:<br><br>5/14/25 – A facility-provided grievance form | F0790 | Continued from page 42<br>Corrective Action for Resident Identified:<br><br>Resident R41 is no longer a resident of the facility. The residents' dentures were replaced prior to discharge. The facility was unable to retrospectively correct the issue of May 14, 2025, through January 2026<br><br>2) Identification of other Resident's Potentially Affected:<br><br>The Facility respectfully state that all residents requiring replacement of Dentures have the potential to be affected.<br><br>A facility-wide audit will be conducted to verify that residents who have dentures have them present and available for use and to identify residents who require denture replacement or dental services. Any concerns identified during the audit will be addressed at the time of discovery.<br><br>3 – Systemic Changes / Root Cause Analysis:<br><br>A root cause analysis determined there was an opportunity to strengthen staff knowledge of the facility's dental services process and expectations for timely coordination of dental services to support residents' oral health and ability to eat.<br><br>On February 27, 2026, the Staff Developer/designee-initiated education for the Nursing Home Administrator, Director of Nursing, and Social Services staff regarding the facility's dental services process and expectations for timely coordination of dental services to support residents' oral health and ability to eat. Education included when fee-for-service dental services may be utilized and the expectation that residents requiring dental services are referred to promptly and appointments are scheduled within three days when a dental concern impacts the resident's ability to eat. Additionally, when dental concern impacts a resident's ability to eat, the facility will assess the resident and implement appropriate interventions to support adequate nutrition and hydration. The facility will document all actions taken so the residents can continue to eat and drink adequately while awaiting dental services. The NHA, Nursing, and Social Services will coordinate efforts to timely begin the process to replace lost Dentures of a resident.<br><br>The NHA /designee will audit residents requiring denture replacement to monitor timely identification, | 04/06/2026 |

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| F0790 SS = D | Continued from page 43<br>documented that FM1 reported R41's top dentures were missing. E14 (LPN) completed a room sweep and documented that the 11:00 PM – 7:00 AM shift would complete a second room sweep. The concern was reported to the Director of Nursing. The grievance included a note that a meeting with the Business Office to explore Medicaid eligibility for denture replacement.<br><br>2/18/26 at 1:45 PM – During an interview, E15 stated she was unable to explain the extended timeframe for replacement of the dentures and was unsure why a meeting with the Business Office was required prior to proceeding with replacement. E15 further stated the events that occurred while she was on leave from the facility.<br><br>2/18/26 at 1:53 PM – During a joint interview with E12 (Current Business Office Manager) and E15 (Social Worker), E12 confirmed the facility could have obtained dental services on a fee-for-service basis and was not required to wait for Medicaid eligibility determination prior to replacing the dentures.<br><br>The facility failed to initiate the replacement of the lost dentures within three days of notification and did not document extenuating circumstances that would justify delay.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON). | F0790 | Continued from page 43<br>referral, and coordination of dental services. If a dental referral cannot be scheduled within three days, the facility will document interventions implemented to ensure the resident is able to continue to eat safely and adequately while awaiting dental services.<br><br>Once the C.N.A. reports missing denture to the Nurse Manager, The Nurse Manager will notify the Director of Social Service and the Administrator. The Director of Social Service will initiate communication to the Dentist that a resident needs to be evaluated for Denture replacement.<br><br>4) Quality Assurance/ Monitoring Audits:<br><br>The audit schedule will be:<br><br>Weeks 1–2: Audit 100% of residents requiring denture replacement until 100% compliance is achieved.<br><br>Weeks 3–4: Audit 50% of residents requiring denture replacement until 100% compliance is achieved.<br><br>Months 2–3: Audit 10 residents monthly requiring denture replacement until 100% compliance is achieved.<br><br>Audit findings will be reviewed in the monthly QA&A meeting until 100% compliance is achieved.<br><br>5) Responsible Person:<br><br>NHA/Designee. | 04/06/2026 |
| F0791 SS = D | Routine/Emergency Dental Srvcs in NFs<br><br>CFR(s): 483.55(b)(1)-(5)<br><br>§483.55 Dental Services<br><br>The facility must assist residents in obtaining routine and 24-hour emergency dental care.<br><br>§483.55(b) Nursing Facilities.<br><br>The facility-<br><br>§483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: | F0791 | .<br><br>.<br><br>1)– Immediate Corrective Action for Residents Identified:<br><br>R2 was offered dental services on February 16, 2026, and declined services.<br><br>R56 was offered dental services on March 19, 2026.<br><br>2) – Identification of Other Residents Potentially Affected<br><br>The facility respectfully states that all residents have the potential to be affected. | 04/06/2026 |

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| F0791 SS = D | Continued from page 44<br><br>(i) Routine dental services (to the extent covered under the State plan); and<br><br>(ii) Emergency dental services;<br><br>§483.55(b)(2) Must, if necessary or if requested, assist the resident-<br><br>(i) In making appointments; and<br><br>(ii) By arranging for transportation to and from the dental services locations;<br><br>§483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay;<br><br>§483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and<br><br>§483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation, interview and record review, it was determined that for two (R2 and R56) out of 2 sampled residents for dental services, the facility failed to assist the resident in obtaining routine dental services. Findings include:<br><br>A facility policy and procedure titled, "Dental Services," dated 5/1/25, documented, "It is the policy of the facility to accommodate needed dental services, including routine dental services; to ensure the facility provides the assistance needed or requested to obtain these services... The facility will, if necessary or if requested, assist the resident: a. Making appointments ...".<br><br>1. Review of R2's clinical record revealed: | F0791 | Continued from page 44<br>A facility-wide audit will be conducted of long-term residents identified within the past 3 months through MDS coding for broken teeth by licensed nurses, current oral assessments, or resident interviews as being at risk for cavities or broken teeth. The audit will monitor that routine dental services are offered and referrals are initiated as indicated. Any concerns identified during the audit will be addressed at the time of discovery.<br><br>3)– Systemic Changes / Root Cause Analysis<br><br>A root cause analysis determined there was an opportunity to improve consistency in offering routine dental services for residents who require them.<br><br>On February 27, 2026, the Staff Developer/designee-initiated education for the Nursing Home Administrator, Director of Nursing, and Social Services staff regarding the facility's dental services process and expectations for timely coordination of dental services to support residents' oral health and ability to eat. Education included guidance on the appropriate use of fee-for-service dental services and the expectation that residents requiring dental services are referred promptly, with appointments scheduled within three days when a dental concern impacts the resident's ability to eat. This process and dental policies that align with 483.55 have been incorporated into new hire orientation for the Nursing Home Administrator, Director of Nursing, and Social Services staff.<br><br>A standardized process has been implemented in which the NHA, Nursing, Social Services, and Business Office Manager collaborate during the daily morning meeting to review residents identified through MDS assessments, oral assessments, and resident interviews as needing dental services. This process supports timely identification, coordination, and follow-up for routine dental care and referrals as indicated.<br><br>The Social Worker/designee will review the dental services program with residents and families upon admission and reinforce it during care plan meetings and as needed along with brochures in the front lobby.<br><br>The Social Worker/designee will conduct ongoing audits of long-term residents at the time of annual MDS completion to monitor that routine dental services are offered and referrals are initiated timely. | 04/06/2026 |

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| F0791 SS = D | Continued from page 45<br><br>11/15/24 – R2 was admitted to the facility.<br><br>11/25/24 – A care plan was initiated for R2 with broken/carious teeth, including interventions to coordinate dental care and transportation as needed.<br><br>11/4/25 – The annual MDS assessment documented that R2 was cognitively intact and had obvious or likely cavity or broken natural teeth.<br><br>2/9/26 9:28 AM – During an observation and interview, R2 stated that they have had broken teeth and has told the facility that he wanted them pulled since he was admitted. R2 stated he has not seen a dentist since arriving at the facility. An observation was made of missing teeth, broken teeth on the bottom right, and miscolored teeth and gums.<br><br>2/16/26 9:25 AM – During an interview, E5 (UM) stated that if a resident has a broken tooth, abscess, or dental pain, the Nurse Practitioner would assess them if medication is needed, then let the social worker know to see if they are part of the facility's dental program. If they are not part of the program, then they can schedule the resident to go outside the facility.<br><br>2/16/26 10:08 AM – During an interview, E15 (SW) explained that if a resident is interested in the facility's dental program, they can request information from anyone, specifically mentioning her or the business office. The request is then sent via fax to the dental program. E15 confirmed that R2 was not enrolled in the facility's dental program and had no dentist appointment.<br><br>2/17/26 – An oral cavity assessment for R2 documented that he had some natural teeth lost and has broken, loose, or carious teeth.<br><br>There was a lack of evidence of any routine dental consultation since 11/15/24.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON).<br><br>2. Review of R56's clinical record revealed:<br><br>10/24/23 - R56 was admitted to the facility.<br><br>11/6/23 - A care plan documented that R56 had | F0791 | Continued from page 45<br>4) –Quality Assurance and Monitoring:<br><br>The audit schedule is as follows:<br><br>Month 1 – 100% of quarterly and annual, MDS's until 100% compliance is achieved.<br><br>Month 2 – 75% of quarterly and annual MDS's until 100% compliance is achieved.<br><br>Month 3 – 50% of quarterly and annual MDS's until 100% compliance is achieved.<br><br>Month 4: 25% of quarterly and annual MDS's until 100% compliance is achieved.<br><br>Audit findings will be reviewed in the monthly QA&A meeting until 100% compliance is achieved.<br><br>5) Responsible Person:<br><br>Director of Social Services/Designee. | 04/06/2026 |

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| F0791<br>SS = D | Continued from page 46<br>dental health problems related to poor oral hygiene with broken carious teeth with the following interventions: coordinate arrangements for dental care; diet as ordered; monitor, document, report any oral dental problems needing attention; provide mouth care as per ADL personal hygiene.<br><br>10/9/24 - A progress note documented R56 had a new patient dental exam.<br><br>2/09/2026 11:37 AM - During an interview, R56 stated he had not seen the dentist and was interested in a cleaning.<br><br>2/16/26 2:45 PM - During an interview, E15 (SW) stated when a resident verbalizes they are interested in dental services she will send the documents over to the dental office. E15 stated that caseworkers for insurance provider are responsible to offer services to the residents and she just sends the paperwork over to dental office. E15 provided a list of resident's receiving dental services and confirmed that R56 was not on the list to receive services and did not have an appointment on 10/1/25 or 11/24/25 when the dentist was at the facility.<br><br>2/16/26 3:00 PM - During an interview, E32 (Unit Clerk) stated she was responsible to set up transportation if the resident utilizes an outside dental provider. E32 confirmed that R56 does not have an outside provider for dental.<br><br>The facility failed to assist R56 in obtaining routine dental care since 10/9/24.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0791 | | 04/06/2026 |
| F0812<br>SS = D | Food Procurement,Store/Prepare/Serve-Sanitary<br><br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br><br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local | F0812 | .<br><br>Tag: F812 – Infection Prevention & Control (Outdated Thickened Liquids)<br><br>1) – Immediate Corrective Action<br><br>Upon identification of outdated thickened liquids stored in the refrigerator, the expired products were immediately removed and discarded. | 04/06/2026 |

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| F0812 SS = D | Continued from page 47<br>authorities.<br><br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br><br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br><br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents.<br><br>02/09/2026 9:14 AM Sussex Hall nutrition refrigerator contained three (3) opened cartons of thickened water that were incorrectly dated to reflect the date of disposal as per manufacture recommendations. One container was dated February 3, 2026 and the other two cartons were dated January 31, 2026. The manufacturer's instructions on the cartons state that once opend, any remaining product should be discarded after four (4) days. 02/09/2026 10:08 AM Henelopen Hall Nutrition Refrigerator contained 1 carton of Thickened water that wereincorrectly dated | F0812 | Continued from page 47<br><br>2) – Identification of Other Residents Potentially Affected<br><br>All residents receiving thickened liquids have the potential to be affected.<br><br>A whole-house audit was conducted of all medication room refrigerators, nourishment refrigerators, and any designated storage areas to ensure thickened liquids were within manufacturer expiration dates and properly labeled. Any expired products identified during the audit were immediately discarded at the time of observation.<br><br>3)– Systemic Changes / Root Cause Analysis<br><br>Root cause analysis identified that staff failed to consistently check expiration dates of thickened liquid products when nourishment refrigerators are stocked. It also identified that cartons were not labelled with the dispose date, based on the date the carton was opened.<br><br>On February 27, 2026, the Staff Developer/designee-initiated re-education for all licensed nurses and certified nursing assistants on verifying expiration dates prior to use, ensure proper storage of thickened liquids in accordance with manufacturer guidelines, and adherence to infection prevention standards for food and liquid storage. A standardized process for routinely checking expiration dates was implemented and incorporated into daily practice. Education also addressed that once cartons are opened, it must be labelled with discard date after (4) days. This education has also been incorporated into new hire orientation for all licensed nurses.<br><br>The DON/Infection Preventionist/designee will conduct focused audits on nourishment rooms to monitor expiration dates of thickened water,<br><br>4) – Monitoring / Quality Assurance:<br><br>Week 1: Audit 100% of refrigerators daily until 100% compliance is achieved.<br><br>Week 2: Audit 75% of refrigerators daily until 100% compliance is achieved.<br><br>Week 3: Audit 50% of refrigerators daily until 100% compliance is achieved.<br><br>Audit results will be reviewed through the QAPI | 04/06/2026 |

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| F0812 SS = D | | F0812 | Continued from page 48<br>process. Monitoring will continue until sustained compliance is demonstrated at 100%.<br><br>5) Responsible Person:<br><br>Director of Nursing/Designee | 04/06/2026 |
| F0841 SS = D | Responsibilities of Medical Director<br><br>CFR(s): 483.70(g)(1)(2)<br><br>§483.70(g) Medical director.<br><br>§483.70(g)(1) The facility must designate a physician to serve as medical director.<br><br>§483.70(g)(2) The medical director is responsible for-<br><br>(i) Implementation of resident care policies; and<br><br>(ii) The coordination of medical care in the facility.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview it was determined that the facility failed to the ensure the Medical Director fulfilled his/her responsibility of ensuring implementation of the Drug Regimen Review policy to be consist with current professional standards of care regarding provider documentation in response to identified irregularities. Findings include:<br><br>Cross refer F756<br><br>The facility job description for responsibilities of the medical director indicated, " Provider Supervision and &Consultation: Provide guidance and education to physicians, nurse practitioners, and physician assistants regarding best practices in long-term care. Policy Development & Implementation: Ensure compliance with federal, state, and local healthcare regulations, including CMS and CDC guidelines."<br><br>The facility policy on Drug Regimen Review last updated 5/1/25 indicated, "The attending physician must document in the residents medical record that the identified irregularity has been reviewed and what, if any action has been taken to address it."<br><br>2/18/26 8:52 AM - During an interview E2 (ROD) confirmed that the facility's Medical Director was not ensuring provider compliance with the drug regimen review policy. E2 stated, "Our DON position reviews them and then notifies the provider, but we will be | F0841 | .<br><br>F841 Medical Director<br><br>Plan of Correction<br><br>1) – Corrective Action for Identified Resident:<br><br>The Medical Director was notified of both nursing and physician irregularities identified for Resident R11. Following the review, no new orders or changes to existing orders were indicated at the time.<br><br>2) Identification of Other Residents Potentially Affected<br><br>The Facility respectfully states that all residents have the potential to be affected.<br><br>A facility-wide review will be conducted of the previous and current month Medication Management Review (MMR) summary reports to verify that nursing and physician irregularities are identified, documented, and communicated to the Medical Director or authorized medical provider for review. Any concerns identified during the review will be addressed at the time of discovery.<br><br>3) – Systemic Changes / Root Cause Analysis:<br><br>A root cause analysis determined there was an opportunity to strengthen the process for Medical Director oversight of irregularities identified through the monthly Medication Management Review process.<br><br>The facility will revise and expand its policy to include authorized medical providers in the review and documentation process for irregularities identified during the MMR review. Authorized medical providers include the Medical Director, attending physicians, nurse practitioners, physician assistants.<br><br>A standardized process will be implemented requiring monthly Medical Director review of all MMR summary reports, including nursing and physician irregularities. | 04/06/2026 |

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| F0841 SS = D | Continued from page 49<br>changing that."<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON). | F0841 | Continued from page 49<br><br>Nursing irregularities refer to issues with medication administration or documentation, while the Physician irregularities refer to concerns related to the prescribing or clarity of medication orders. The Medical Director was notified of both nursing and physician irregularities of Resident R11 and following review, no new orders or changes to the existing orders were indicated at that time. A standardized process has been implemented requiring that summary reports are reviewed in the weekly High-Risk Meeting with the Medical Director for ongoing oversight.<br><br>The Staff Developer/designee will educate the Medical Director and licensed nursing staff on the revised process and oversight expectations.<br><br>The NHA /designee will audit MMR summary reports to verify Medical Director review and documentation of both nursing and physician irregularities.<br><br>4) – Quality Assurance Plan/Monitoring:<br><br>Audit Schedule (Weaning Process)<br><br>Month 1: Audit 100% of MMR summary reports until 100% compliance is achieved.<br><br>Month 2: Audit 75% of MMR summary reports until 100% compliance is achieved.<br><br>Month 3: Audit 50% of MMR summary reports until 100% compliance is achieved.<br><br>Month 4: Audit 25% of MMR summary reports until 100% compliance is achieved.<br><br>Audit findings will be reviewed in the monthly QA&A meeting until 100% compliance is achieved.<br><br>5) Responsible Person:<br><br>NHA/Designee | 04/06/2026 |
| F0842 SS = D | Resident Records - Identifiable Information<br><br>CFR(s): 483.20(f)(5),483.70(h)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br><br>(i) A facility may not release information that is resident-identifiable to the public.<br><br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance | F0842 | .<br><br>Tag: F0842 – Incident Report Accuracy/Consistency<br><br>Tag: – Incident Report Accuracy/Consistency<br><br>1) –Immediate Corrective Action for Resident: | 04/06/2026 |

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| F0842 SS = D | Continued from page 50<br>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.<br><br>§483.70(h) Medical records.<br><br>§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br><br>(i) Complete;<br><br>(ii) Accurately documented;<br><br>(iii) Readily accessible; and<br><br>(iv) Systematically organized<br><br>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records,<br><br>regardless of the form or storage method of the records, except when release is-<br><br>(i) To the individual, or their resident representative where permitted by applicable law;<br><br>(ii) Required by Law;<br><br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br><br>(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.<br><br>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(h)(4) Medical records must be retained for-<br><br>(i) The period of time required by State law; or<br><br>(ii) Five years from the date of discharge when there | F0842 | Continued from page 50<br>Resident R41 is no longer a resident of the facility. The facility was unable to correct R41's incident report of 12/15/25 retrospectively.<br><br>The Licensed Practical Nurse (LPN) responsible for completing the incident report was educated on documentation accuracy, consistency, and the requirement to ensure alignment between the incident report and supporting clinical documentation.<br><br>2) – Identification of Other Residents Potentially Affected:<br><br>Any resident experiencing a fall with injury has the potential to be affected.<br><br>A facility-wide review will be conducted of all fall incident reports from the past two weeks to verify accuracy, completeness, and consistency with supporting clinical documentation, including nursing progress notes, injury documentation, physician and responsible party notification, and care plan updates. Any concerns identified during the review will be addressed at the time of discovery.<br><br>3) – Systemic Changes / Root Cause Analysis:<br><br>A root cause analysis determined the facility did not have a standardized process for reviewing fall incident reports.<br><br>The Staff Developer/designee-initiated education on February 27, 2026, for licensed nurses regarding a standardized review process requiring the Unit Manager/designee or licensed nurse to review all fall incident reports prior to the morning clinical meeting for accuracy, completeness, and consistency with nursing progress notes, injury documentation, physician and responsible party notification, and care plan updates. The education included detailed review of each section of the fall incident report to monitor accurate and complete documentation and this process has been incorporated into new hire orientation for all licensed nurses.<br><br>The DON/designee will conduct ongoing audits of fall incident reports to monitor compliance and ensure sustained accuracy.<br><br>4) – Quality Assurance /Monitoring:<br><br>Audit Schedule<br><br>100% of fall incident reports per week for four weeks until 100% compliance is achieved. | 04/06/2026 |

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| F0842 SS = D | Continued from page 51<br>is no requirement in State law; or<br><br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(h)(5) The medical record must contain-<br><br>(i) Sufficient information to identify the resident;<br><br>(ii) A record of the resident's assessments;<br><br>(iii) The comprehensive plan of care and services provided;<br><br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br><br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br><br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on record review and interview it was determined that the facility failed to ensure accuracy of resident records for one (R41) out of six residents reviewed for falls when R41's fall incident report contained inaccurate information regarding an injury. Findings include:<br><br>Review of R41's clinical record revealed; 12/15/25 1:09 PM - A progress note in R41's clinical record documented, "At 1235, while this writer was at the meds cart giving out afternoon med, heard a bomb sound behind in the dining area, immediately turned and saw patient lying face down on the floor. Immediately assessed patient and a hematoma noted on patient forehead...". 12/15/25 - The incident report for R41's fall documented, "No injuries observed at time of incident" in the injuries observed at time of incident section. 2/18/26 12:03 PM - During an interview E40 (R--) confirmed the finding and stated, "they did write it in the other section". 2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON). | F0842 | Continued from page 51<br><br>50% of fall incident reports per week for four weeks until 100% compliance is achieved.<br><br>25% of fall incident reports per week for four weeks until 100% compliance is achieved.<br><br>Audit findings will be reviewed in the monthly QA&A meeting until 100% compliance is achieved.<br><br>5) Responsible Person:<br><br>Director of Nursing/Designee | 04/06/2026 |
| F0584 SS = C | Safe/Clean/Comfortable/Homelike Environment<br><br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment. | F0584 | 1) IMMEDIATE CORRECTIVE ACTION:<br><br>Upon notification of the concern, the Facility immediately ceased all non-emergent overhead paging. | 04/06/2026 |

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| F0584 SS = C | Continued from page 52<br><br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br><br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.<br><br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br><br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on observation and interview it was determined that the facility failed to ensure a homelike environment when the facility repeatedly utilized an overhead paging system to communicate with other staff. Findings include: | F0584 | Continued from page 52<br><br>2) IDENTIFICATION OF OTHER RESIDENTS:<br><br>The Facility respectfully states that all residents had the potential to be affected by overhead paging.<br><br>3) SYSTEMIC CHANGES/ROOT CAUSE ANALYSIS:<br><br>A root cause analysis determined the Facility did not have a system in place such as two-way radios, to reduce non-emergent overhead paging.<br><br>Beginning, February 27, 2026, the Staff Developer/designee-initiated education for staff across all Departments regarding the prohibition of non-emergent overhead paging and reinforcement of resident's rights related to maintaining a respectful and quiet environment. The use of walkie talkie will be implemented as a substitute to overhead paging as well as the use of group WhatsApp text and Text em all.<br><br>4) QUALITY ASSURANCE:<br><br>The NHA/designee will conduct observational audits on various shifts and days to monitor compliance with the overhead paging.<br><br>NHA/designee will conduct audits as follows:<br><br>Week 1: 5 audits per week (including 1 weekend audit and covering all three shifts.) until 100% compliance is achieved.<br><br>Week 2: 4 audits per week (varied shifts/days) until 100% compliance is achieved<br><br>Week 3: 3 audits per week (varied shifts/days) until 100% compliance is achieved.<br><br>Week 4: 2 audits per week (varied shifts/days) until 100% compliance is achieved.<br><br>Audits result will be reviewed in the monthly QA&A meeting until 100% compliance is achieved.<br><br>5) RESPONSIBLE PERSON:<br><br>NHA/Designee. | 04/06/2026 |

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| F0584 SS = C | Continued from page 53<br>During random observations overhead paging for non-emergent communication was heard the following times: 2/12/26 10:45 AM.<br><br>2/12/26 10:47 AM.<br><br>2/12/26 11:01 AM.<br><br>2/13/26 11:58 AM.<br><br>2/13/26 1:12 PM.<br><br>2/16/26 1:24 PM.<br><br>2/16/26 1:59 PM.2/16/26 2:59 PM.<br><br>2/13/26 9:58 AM - During the facility resident council meeting an anonymous resident confirmed the overhead paging by facility staff was unpleasant.<br><br>2/17/26 3:21 PM - During an interview E1 (NHA) confirmed the facility utilized overhead paging to communicate with other staff members. E1 stated "We use it during the day, but we stop at 7:00 PM."<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON). | F0584 | | 04/06/2026 |
| F0568 SS = A | Accounting and Records of Personal Funds<br><br>CFR(s): 483.10(f)(10)(iii)<br><br>§483.10(f)(10)(iii) Accounting and Records.<br><br>(A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.<br><br>(B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.<br><br>(C)The individual financial record must be available to the resident through quarterly statements and upon request.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, it was determined that for one (R2) out of two residents reviewed for personal funds, the facility failed to ensure that the resident received their quarterly | F0568 | | 04/06/2026 |

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| F0568 SS = A | Continued from page 54<br>personal funds statement. Findings include:<br><br>A facility policy titled, "Quarterly Accounting of Resident Funds," with the last revision of 1/2026, documented, "... 1. An individual quarterly accounting of funds managed by the facility will be provided to each resident with personal funds entrusted to the facility ...".<br><br>Review of R2's clinical record revealed:<br><br>11/15/24 – R2 was admitted to the facility.<br><br>11/4/25 – A Brief Interview for Mental Status (BIMS) evaluation documented R2 with a score of 15 out of 15, showing an intact cognitive status.<br><br>2/16/26 9:50 AM – During an interview, R2 stated that he had not received a statement in over 6 months.<br><br>2/17/26 10:20 AM – During an interview, E12 (BOM) stated that she just began work at the facility last week. E12 stated that if the resident is of sound mind, she provides them with a quarterly statement. E12 stated that she doesn't have a way to confirm that a resident or representative receives their statements.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0568 | | 04/06/2026 |
| F0569 SS = A | Notice and Conveyance of Personal Funds<br><br>CFR(s): 483.10(f)(10)(iv)(v)<br><br>§483.10(f)(10)(iv) Notice of certain balances.<br><br>The facility must notify each resident that receives Medicaid benefits-<br><br>(A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and<br><br>(B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.<br><br>§483.10(f)(10)(v) Conveyance upon discharge, eviction, or death. | F0569 | | 04/06/2026 |

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| F0569 SS = A | Continued from page 55<br><br>Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with State law.<br><br>This REQUIREMENT is NOT MET as evidenced by:<br><br>Based on interview and record review, it was determined that for one (R2) out of two residents reviewed for personal funds, the facility failed to ensure that a Medicaid recipient resident was notified when their account balance was $200 below the Supplemental Security Income (SSI) resource limit. Findings include:<br><br>A facility policy titled, "Resident Personal Funds," with the last revision of 1/2026, documented, "... 1. The company must notify each resident that receives Medicaid benefits: a. When the amount in the resident's account reaches $200 less than the SSI resource limit for one person ...".<br><br>Review of R2's clinical record revealed:<br><br>11/15/24 – R2 was admitted to the facility.<br><br>11/4/25 – A Brief Interview for Mental Status (BIMS) evaluation documented R2 with a score of 15 out of 15, showing an intact cognitive status.<br><br>2/12/26 – A review of R2's account summary documented the following balances:<br><br>4/3/25: $2,024.18<br><br>5/2/25: $2,003.29<br><br>6/3/25: $1,985.77<br><br>7/3/25: $2,015.88<br><br>8/1/25: $2,010.88<br><br>9/3/25: $2,060.09<br><br>10/3/25: $2,105.23<br><br>11/3/25: $2,170.23<br><br>12/3/25: $2,195.49<br><br>1/2/26: $2,248.49 | F0569 | | 04/06/2026 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 02/18/2026 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **EXCELCARE AT LEWES LLC** | **301 OCEAN VIEW BLVD , LEWES, Delaware, 19958** |

| (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 |
|---|---|---|---|---|
| F0569 SS = A | Continued from page 56<br><br>2/3/26: $2,293.68<br><br>2/16/26 9:50 AM – During an interview, R2 stated that he did not know there was a maximum limit for his account and that the facility had not told him that he was close to his maximum limit since his admission.<br><br>2/17/26 10:20 AM – During an interview, E12 (BOM) stated that she just began work at the facility last week. E12 stated that if the resident is their own decision-maker, she would speak with the resident when the account balance is between $1,700 and $1,800 to determine whether the resident has any personal needs they can spend their money on. Then she documents this in a general note in the chart. After reviewing the amounts in R2's account, E12 stated she would have notified him about the amount.<br><br>2/17/26 10:25 AM – During an interview and review of all general notes for R2, there was no note indicating notification of reaching the SSI limit from 11/20/24 to the current date. E12 pulled up the general notes in R2's chart and confirmed there were no notes.<br><br>2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON). | F0569 | | 04/06/2026 |