DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Seaford Center Nursing Home

DATE SURVEY COMPLETED: September 9, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from September 2, 2025, through September 9, 2025. The deficiencies contained in this report are based on observations, interviews, and review of facility documentation. The facility census was ninety-one (91). The survey sample totaled thirty (30) residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed September 9, 2025: F584, F585, F644, F656, F658, F686, F693, F695, F791, and F880.		

Provider's Signature Heather LNHA Title Administrator Date 9/18/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY , SEAFORD, Delaware, 19973

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E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by the Division of Healthcare Quality, the Office of Long-Term Care Resident's Protection at this facility from September 2,2025 through September 9, 2025. Based on observations, interviews, and document review no Emergency Preparedness deficiencies were identified.	E0000		10/22/2025
F0000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility from September 2, 2025 through September 9, 2025. The deficiencies contained in this report are based on observations, interviews, and review of facility documentation. The facility census was ninety-one (91). The survey sample totaled thirty (30) residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse Assistant; DON - Director of Nursing; IP - Infection Preventionist; LPN - Licensed Practical Nurse; NPE - Nurse Practice Educator; NHA - Nursing Home Administrator; QM - Quality Manager; RN - Registered Nurse; SSD - Social Services Director; UM - Unit Manager; Braden Scale – tool used to determine risk for development of pressure ulcers;	F0000		10/22/2025

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 Care Plan- outlines the plan of action that will be implemented during a patient's medical care; Chronic Obstructive Pulmonary Disease – (COPD) a chronic inflammatory lung disease that causes obstructed airflow from the lungs; Enteral Feeding - Nutrition that is delivered direct to the stomach or the small intestine; Ipratropium-albuterol - A medicine that helps relax the air passages in the lungs; Jevity 1.2 cal - High protein, fiber fortified therapeutic nutrition; MAR - Medication Administration Record; MDS - Minimum Data Set; mg - Milligram; ml - Milliliter; Nebulizer – a drug delivery device used to administer medication in the form of a mist inhaled into the lungs; an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece; Sacral - triangular bone at the base of the spine; Pressure Ulcers (PUs) - TAR - Treatment Administration Record.	F0000		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. 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. The facility must provide- §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.	F0584	Corrective Action of Areas Affected: An inventory sheet was completed for R26 on 09/05/25. The facility purchased and provided new clothing for R50. Other areas affected: An initial audit of current residents in the facility with personal effects was completed by 09/5/25. No current residents were identified as missing clothing. Systemic Changes to Prevent Future Occurrences: A root-cause analysis was completed on 9/5/25 to determine that education on the OPS208: Personal Property: Patients and the Inventory of Personal Effects form was needed for licensed nurses and certified nursing assistants. The Inventory of Personal	10/22/2025

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F0584 SS = D	Continued from page 2 (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. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that for two (R26 and R50) out of three residents reviewed for personal property the facility failed to provide reasonable protection of resident belongings from loss. Findings include: The facility policy on personal property last updated 8/15/23 indicated "Personnel will identify and record the patients/residents' belongings upon admission to the Center. All items bought into the Center will be listed on the Inventory of Personal Effects form and kept in the patient's clinical chart. Any additional items brought into the Center after admission must be added to this list. Any loss will be documented on the property loss form and then referred to the Administrator."	F0584	Continued from page 2 Effects form will be completed upon admission and when new items are obtained. Education given by the Nurse Practice Educator will be completed for licensed nurses and certified nursing assistants by 10/17/25. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment A) to ensure the Inventory of the Personal Effects form is completed for 100% of new admissions and when residents obtain new items. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0584 SS = D	Continued from page 3 1. Review of R26's clinical record revealed: 6/4/25 - A quarterly MDS assessment documented that R26 was mentally intact. 9/2/25 11:10 AM - During an interview, R26 disclosed he had several items of clothing missing. R26 stated, "I have five sweatpants, one hoodie, two sweatshirts, four t-shirt's gone." R26 stated staff said they were "looking into it, the lady across from desk said that but it's been a couple weeks, and I haven't heard anything." 9/3/25 - Review of an undated inventory list for R26 was absent of any record of the residents clothing. All areas for documenting clothing were blank. 9/4/25 12:44 PM - During an interview, E8 (CNA) confirmed that R26 had reported missing clothing, "a few weeks ago" and that a property loss form was not created. E8 stated, "We just check the lost and found." The surveyor then accompanied E8 to the unit's lost and found area and located one pair of sweat paints labeled with R26's name. E8 confirmed them as belonging to R26. 9/4/2025 12:56 PM - During an interview, E9 (RN) unit manager confirmed that R26 "said he had missing clothing" and the staff located "a gray sweater and gray pants." E9 confirmed that staff did not complete a property loss form for R26 and that the inventory belonging list should be completed on admission and updated whenever new items are provided, E9 reported R26 had several belongings including "a cell [phone], clothing, clippers and maybe some sunglasses." R26's inventory list lacked documentation regarding any of those belongings. 2. Review of R50's clinical record revealed: 3/7/19 - R50 was admitted to the facility. 7/24/25 – A quarterly MDS documented a BIMS of 15, and that R50 was cognitively intact 9/2/25 12:22 PM - R50 stated shirt, pants, underwear, and a cowboy jersey are missing,	F0584		

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F0584 SS = D	Continued from page 4 9/2/25 12:25 PM – During an observation, no underwear and no cowboy jersey were located in the resident's room. Observed one shirt, two pairs of pants, and a sweatshirt. 9/4/25 2:30 PM - E4 (Housekeeping director) confirmed that he was going to buy R50 some clothes. 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.	F0584		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice 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. §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. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §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: (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	F0585	Corrective Action of Areas Affected: R50's clothing was replaced by the facility. Re-education to the Housekeeping Director on OPS204: Grievance-Concern policy was completed on 09/09/25. Other areas affected: An initial audit of grievance forms from the last 30 days was conducted to verify completion as per policy on 09/09/25. No deficient practice identified during audit. Systemic Changes to Prevent Future Occurrences: A root-cause analysis was completed on 9/4/25 to determine that education for current staff working in the facility on the policy, OPS204: Grievance-Concerns was needed. An additional focus on the resolution and satisfaction of the resident and/or person(s) filing the grievance form will be reviewed. Education given by the Nurse Practice Educator will be completed for current staff working in the facility by 10/17/25. Monitoring of Corrective Action: The Licensed Nursing Home Administrator and/or designee will conduct audits (attachment B) to ensure 100% of grievance forms are completed with resolution and satisfaction is achieved. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	10/22/2025

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F0585 SS = D	Continued from page 5 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; (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; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (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; (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; (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 (vii) Maintaining evidence demonstrating the result of	F0585		

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F0585 SS = D	Continued from page 6 all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that for one (R50) out of one resident reviewed for grievances, that the facility failed to ensure prompt efforts were made to resolve the resident's concerns. Findings include: Review of R50's clinical record revealed: 3/7/19 - R50 was admitted to the facility. 5/4/24 2:30 PM - A grievance/concern log documented that R50 stated he was unsure where the clothing could have gone, it is possible that the laundry misplaced the clothing. On May 7, 2024, E4 (housekeeping Director) checked the laundry room and did not find any missing clothing. 7/24/25 – A quarterly MDS documented a BIMS of 15, and that R50 was cognitively intact 9/2/25 12:22 PM - During an interview, R50 stated, "my underwear, shirts, pants, and cowboy jersey were missing." 9/4/24 2:30 PM - During an interview with E4 he stated he was going today to buy R50 some clothes. 9/4/24 2:45 PM – An interview with E3 (Quality Manager) confirmed the facility lacked evidence of a prompt response/resolution for R50's missing shirt, pants, underwear, and a cowboy jersey that was reported on 5/4/24. 9/5/25 12:50 PM - E6 (NPE) stated in an interview that if a resident reports a missing item, E6 will complete a grievance log, interview the resident, and obtain written statements from the involved staff. The grievance documentation will then be submitted to the NHA." 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.	F0585		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination.	F0644	Corrective Action of Areas Affected: A Level II PASRR for R4, R74 and R28 was completed and submitted by the Director of Social Services on 09/05/25. Other areas affected: An initial audit of current	10/22/2025

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F0644 SS = D	Continued from page 7 A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for three (R4, R28 and R74) out of three residents reviewed for a level II PASRR, the facility failed to ensure that a referral for a level II PASRR screening was required following a new diagnosis for a mental health disorder. Findings include: 1. Review of R4's clinical record revealed: 5/9/25 - A notice of PASRR level I screening outcome documented the following mental health diagnoses: major depression (recurrent, unspecified), anxiety disorder (suspected), 6/7/25 - R4 was admitted to the facility with diagnoses including but not limited to, bipolar disorder, anxiety disorder and depression. 6/8/25 - A care plan documented that R4 was "at risk for complications related to the use of psychotropic drugs for depression and is at risk for distressed/fluctuating mood symptoms related to depression." 6/9/25 - An initial psychiatric evaluation documented depressed mood and listed the following medications for depression: doxepin 25 mg daily at bedtime, lurasidone 20 mg daily, sertraline 75 mg daily. 6/25/25 - In the electronic chart under active diagnoses, it was documented that R4 had the following diagnoses: bipolar disorder and depression.	F0644	Continued from page 7 residents with newly identified psychiatric diagnosis and psychotropic medications was completed 09/05/25. All Level II PASRR are current. Systemic Changes to Prevent Future Occurrences: A root-cause analysis was completed on 9/3/25 to determine that education for social services, the Licensed Nursing Home Administrator and Director of Nursing was needed on SS105: Pre-admission Screening for Mental Disorder and/or Intellectual Disability Patients policy. Mandatory PASRR training was completed on 09/03/2025 for Social Services, Administrator and Director of Nursing by the National Director of Social Services on the PASRR process. New psychiatric diagnoses will be identified and reported to the Social Service department by the Clinical team after the resident is seen by our psych provider weekly and when a new medication is ordered. Monitoring of Corrective Action: The Licensed Nursing Home Administrator and/or designee will conduct audits (attachment C) to ensure completion of the Level II PASARR as per policy for 100% of new admissions or residents with a new psychiatric diagnosis. Current residents will be identified and reported to the Social Service department by the Clinical team after the resident is seen by our psych provider weekly and when a new medication is ordered. The audit will occur for new admissions until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achleved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0644 SS = D	Continued from page 8 7/26/25 - A re-admission five-day MDS assessment documented that R4 had a diagnoses of bipolar disorder and depression. 9/3/25 1:30 PM - During an interview E3 (Quality Manager), confirmed that R4 required a referral for a Level II PASRR due to a new onset of depression and bipolar disorder in June 2025, and acknowledged that the referral should have been completed but was not. 9/4/25 10:04 AM - During an interview, E7 (Social Worker Director) confirmed that R4 required a referral for a level II PASRR. 2. Review of R74"s clinical record revealed: 1/26/10 - R74 was admitted to the facility with diagnosis including but not limited to, generalized anxiety disorder. 10/9/24 - A PASRR level I screening outcome review documented a mental health diagnosis of anxiety disorder. 5/19/25 - An admission record documented a new onset diagnosis of major depressive disorder. 6/15/25 - A care plan revision documented " resident will demonstrate improved mood state...by the next review." 8/14/25 - A significant change MDS documented, active diagnoses of major depressive disorder and schizophrenia. 9/3/25 - During an interview, E3 (Quality Manager), confirmed that R74 required a referral for a Level II PASRR due to a new onset of major depressive disorder in May and acknowledged that a referral should have been completed but was not. 9/4/25 10:04 AM - During an interview, E7 (Social Worker Director) confirmed that R74 required a referral for a level II PASRR. 3. Review of R28's clinical record revealed: 10/12/19 – R28 was admitted to the facility. 2/15/25 – A facility's electronic charting system documented under "active diagnosis" new diagnosis of depression for R50. 6/9/25 – R28's quarterly MDS documented a new diagnosis	F0644		

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F0644 SS = D	Continued from page 9 of depression. 9/3/25 2:00 PM - An interview was conducted with E6 (SW), who confirmed that she did not have access to the facility's electronic system to place a referral for a PASRR Level II. E6 also confirmed that a PASRR Level II was not completed for the new diagnosis of depression. 9/3/25 2:44 PM - During an interview, E3 (Quality Manager) stated that an internal audit was initiated in August for all residents requiring a referral for a PASRR Level II. E3 confirmed that no PASRR Level II had been completed in response to the new diagnosis of depression. 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.	F0644		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F0656	Corrective Action of Areas Affected: The facility was unable to correct this prior to discharge of R113. R113 was discharged from the facility on 03/31/25. Other areas affected: An initial audit was completed for refusal of care and to ensure care plans were individualized as per the needs of the resident by 09/10/25. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 9/8/25 to determine that education on OPS416: Person-Centered Care Plan policy for licensed nurses was needed. A focus specifically on individualizing refusal care plans with the reason will be reviewed, as indicated by the resident's desire. Education given by the Nurse Practice Educator will be completed for licensed nurses and certified nursing assistants by 10/17/25. Monitoring of Corrective Action:The Director of Nursing and/or designee will conduct audits (attachment D) to ensure accuracy and completion of refusal care plans for 10% of the resident population and charts will be audited for refusal of care as documented in their care plan. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	10/22/2025

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F0656 SS = D	Continued from page 10 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R113) out of thirty residents reviewed in the investigative sample, the facility failed to develop a care plan to address an identified concern. Findings include: Review of R113's clinical record revealed: 10/11/24 – R113 was admitted to the facility. 3/20/25 12:00 AM – A wound note by E12 (Wound NP) documented that R113 was non-compliant with turning and repositioning and tells staff to leave her alone. 3/27/25 3:59 AM – A wound note by E12 (Wound NP) documented that R113 was non-compliant with turning and repositioning and tells staff to leave her alone. 9/4/25 11:08 AM – During an interview, E12 (Wound NP) stated that R113 would refuse to have her wounds touched and resisted care. 9/4/25 12:09 PM – During an interview, E16 (NP) stated that R113 was resistant to care and refused to get out of bed. 9/4/25 11:43 AM – During an interview, E17 (wound nurse) stated that R113 was behavioral, resistant to care and would refuse to allow staff to turn and reposition her. 9/4/25 12:25 PM – A review of R113's care plan lacked	F0656		

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F0656 SS = D	Continued from page 11 evidence for refusals of care that included individualized objectives, goals, and timeframes to meet R113's needs. 9/5/25 10:40 AM – During an interview, E18 (CNA) stated that R113 was very behavioral, would constantly refuse care and refuse to get out of bed. 9/5/25 10:51 AM – During an interview, E6 (RN) stated that R113 refused care and treatments and confirmed that a care plan for refusals should have been completed for her. 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.	F0656		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that for one (R79) out of ninety-one residents screened during the initial pool process the facility failed to ensure that medications were administered in accordance with professional standards. Findings include: The facility policy on medication guidelines last updated January 2025 indicated, "The resident is always observed after administration to ensure that the dose was completed ingested." 9/2/25 9:16 AM - Upon entry into R79's room, the surveyor observed six pills on top of the bedside table. R79 stated "I don't know what these are do you?" The surveyor left the room and immediately returned with E13 (LPN) who confirmed leaving R79's medications without ensuring they were ingested. 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.	F0658	Corrective Action of Areas Affected:The licensed nurse (E13) was re-educated on the PharMerica Medication Administration (Section 7.0) policy on 9/3/25. Additionally, the licensed nurse (E13) completed a medication competency exam on 9/3/25. Other areas affected: Education will be completed with licensed nurses by 10/17/25 to ensure medications for current residents are ingested by residents prior to leaving the room. Systemic Changes to Prevent Future Occurrences:The root cause analysis was conducted on 9/3/25 to determine that education on PharMerica Medication Administration (Section 7.0) policy was needed for licensed nurses. Specifically, a focus on not leaving medication at the bedside when administering medication to residents will be emphasized. Education given by the Nurse Practice Educator will be completed for licensed nurses by 10/17/25. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment E) to ensure 5 licensed nurses are administering medications to residents as per policy. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	10/22/2025
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F0686	Corrective Action of Areas Affected: R12 was repositioned in bed by staff on 09/09/2025.	10/22/2025

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F0686 SS = D	Continued from page 12 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that for one (R12) out of two residents reviewed for positioning, the facility failed to turn and reposition the resident and promote the healing of a pressure ulcer in accordance with professional standards of practice to prevent skin breakdown. Findings include: Review of R12's clinical record revealed: 6/20/25 - R12 was admitted to the facility with diagnoses including stroke, dementia, muscle weakness, adult failure to thrive and a stage 3 sacral pressure ulcer. 6/27/25 - An admission MDS documented that R12 was totally dependent for turning and repositioning. R12 had impairments on both sides for the upper and lower extremities. 7/12/25 - A nursing Braden Scale documented R12 with a score of 9.0 (9.0 or below is a very high risk for development of a pressure ulcer). 8/20/25 - A care plan for R12 was documented to include turning and repositioning, as well as performing a skin check every 2 hours. On the following dates and times, R12 was observed lying in bed on his back with the head of the bed upright (approx. 45 - 60 degrees) without any positioning pillows or wedges on 9/2/25: 9:45 AM, 10:50	F0686	Continued from page 12 Other areas affected: Current residents admitted to the facility that have orders for turning and repositioning. Education for licensed nurses and CNA's will be completed by 10/17/25 to ensure adherence to the Care Plan for turning and repositioning. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 9/9/25 to determine that licensed nurses, certified nursing assistants and physical therapy needed education on the Turning and Repositioning Guidelines. Education includes positioning devices appropriate for individual needs of residents and a review of repositioning orders. Education given by the Nurse Practice Educator for licensed nurses, certified nursing assistants and physical therapists will be completed by 10/17/25. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment F) to ensure 10% of current residents are being turned and repositioned as per policy. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0686 SS = D	Continued from page 13 AM, 11:55 AM, and 12:15 PM. 12:50 PM and 2:01 PM. R12 was observed lying in bed on his back for four hours without any turning. 9/4/25 11:08 AM – During an interview, E12 (Wound NP) stated that turning and repositioning is expected every 2 hours even with an air mattress. E12 stated that for R12 the facility has wedges or pillows to reposition him, but he has wiggled to angle himself in bed. 9/9/25 12:20 PM – During an interview, E14 (CNA) stated that for R12, they can use pillows or wedges and that it is not a problem to get him off his back. The facility failed to ensure that R24 was turned and repositioned every two hours. 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.	F0686		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for one (R12) out of one resident reviewed for tube feeding, the facility failed to	F0693	Corrective Action of Areas Affected: R12 tube feed was checked and was labeled correctly on 09/09/25. Other areas affected: Current residents with enteral feeding were checked and labels were in place on 09/09/2025. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 9/9/25 to determine that education on the NSG213: Enteral Management policy was needed for licensed nurses. An emphasis on proper labeling of enteral feeding equipment will be reviewed. Education given by the Nurse Practice Educator with licensed nurses will be completed by 10/17/25. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment G) to validate the enteral feeding policy was followed and equipment was properly labeled for those residents with active enteral feeding orders. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review for recommendations.	10/22/2025

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F0693 SS = D	Continued from page 14 utilize a feeding tube in accordance with current professional standards of practice. Findings include: Review of the facility's policy and procedure titled "Enteral Feeding: Administration by Pump," last revised 2/24/25, documented, "... 15.3.2 Fill in the information on the container's label (patient's name, room number, date, start time, and flow rate) ... 15.3.3 Label the administration set with start date and time ...". Review of R12's clinical record revealed: 6/20/25 - R12 was admitted to the facility with diagnoses including but not limited to stroke, dementia, dysphagia, adult failure to thrive and severe protein-calorie malnutrition. 6/27/25 - An admission MDS documented that R12 was on a mechanically altered diet with a feeding tube. 8/20/25 – A care plan for R12 documented that he has an enteral feeding tube to meet nutritional needs. 9/2/25 10:57 AM – A direct observation revealed that Jevity 1.2 cal (a type of tube feeding) was infusing for R12 using a feeding pump. The Jevity 1.2 cal bottle was not labeled with the date, time or initials of the staff who began the infusion. 9/2/25 12:54 PM – During an interview, E10 (RN) stated that the overnight shift hangs the feeding and they are supposed to date, time and initial it. E10 confirmed that there wasn't a date, time or initials on R12's tube feeding. 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.	F0693		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. 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. This REQUIREMENT is NOT MET as evidenced by:	F0695	Corrective Action of Areas Affected: The nebulizer mask for R13 was placed into a bag provided by the respiratory therapist on 09/09/2025. Other areas affected: An initial audit was completed to ensure that residents with active orders for nebulizer treatments had the nebulizer masks stored appropriately on 09/09/25. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 9/9/25 to determine that education for licensed nurses, certified nursing assistants and respiratory therapy on the Procedure: Nebulizer Small Volume was needed. Education	10/22/2025

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F0695 SS = D	Continued from page 15 Based on observation, interview, and record review, it was determined that for one (R13) out of one residents reviewed for respiratory care, the facility failed to ensure R13's oxygen mask and nebulizer equipment were stored in a protective plastic bag. Findings include: Review of the facility's policy and procedure titled "Nebulizer: Small Volume," last revised 11/1/23, documented, "... 21.1 Place in treatment bag labeled with patient name and date...". Review of R13's clinical record revealed: 4/10/24 – R13 was admitted to the facility. 4/8/25 – A physician order for R13 documented ipratropium-albuterol solution 0.5 – 2.5 mg/3mL, inhale 3mL orally every 6 hours as needed for shortness of breath or wheezing. 8/20/25 – A care plan documented R13 as receiving respiratory treatments as ordered due to a history of COPD (chronic obstructive pulmonary disease). 8/29/25 – A significant change MDS documented that R13 received respiratory therapy. 9/2/25 10:39 AM – An observation noted R13's oxygen mask with nebulizer unit attached sitting on top of the bedside table. There was no protective bag available for the oxygen mask and nebulizer unit to be placed into. 9/2/25 10:42 AM – During an interview, E10 (RN) confirmed that the oxygen mask with nebulizer unit was sitting on the bedside table and not in a protective bag. E10 stated the respiratory therapist usually puts them in a bag with the resident's name and date on it. 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.	F0695	Continued from page 15 will emphasize on proper storage of the nebulizer mask when the equipment is not in use. Education given by the Nurse Practice Educator to licensed nurses, certified nursing assistants and respiratory therapy will be completed by 10/17/25. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment H) to validate the nebulizer policy was followed for those residents with active nebulizer orders. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities.	F0791	Corrective Action of Areas Affected: R10 was added on the list to be evaluated by the facility's dental provider on 09/25/25. Other areas affected: Current residents needing or wanting dental services will be placed on the list to be seen on the next dental visit scheduled for 10/29/25. Systemic Changes to Prevent Future Occurrences: The	10/22/2025

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F0791 SS = D	Continued from page 16 The facility- §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: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §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; §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 §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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review it was determined that for one (R10) out of two residents reviewed for dental services the facility failed to provide assistance with dental services. Findings include: The facility policy on Dental Services last updated	F0791	Continued from page 16 root cause analysis was conducted on 9/5/25 to determine that education for social services and licensed nurses on OPS160: Dental Services was needed. Education will include offering dental services to residents annually and as needed by social services and/or licensed nurses. Education given by the Nurse Practice Educator for social services and licensed nurses will be completed on 10/17/25. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment I) to validate the dental services policy is followed and newly admitted residents are offered services. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0791 SS = D	Continued from page 17 9/1/22 indicated, "Centers will provide or obtain from an outside resource routine and emergency dental services to meet the needs of each patient." Review of R10's clinical record revealed: 5/8/25 - R10 was admitted to the facility with Medicaid as a source of coverage. 5/15/25 - An admission MDS assessment documented that R10 was cognitively intact and broken natural teeth. 5/31/25 - A care plan was created for R10's dental problems related to broken, loose and carious teeth. Dental referrals as needed was listed as an intervention. 9/2/25 9:30 AM - During an interview, R10 stated, "Supposedly they have a dentist, I talked to the unit manager [E9 (RNUM)] and I haven't heard anything it's been a couple of weeks." 9/4/25 10:12 AM - During an interview, E7 (SSD) reported being unaware of a request for dental services from R10. E7 then provided a list of residents who'd requested to be seen by the facility's contracted dentist at the next scheduled visit. Review of the list dated, 8/25/25 revealed R10 was not scheduled to be seen by the dental provider. 9/4/25 11:45 AM - During an interview, E9 (RNUM) unit manager for R10 confirmed knowledge of R10's need for assistance to see a dentist. E9 stated, "I reached out to [E7 (SSD)] yesterday and asked that [R10] be put on the list. 9/4/25 11:52 AM - During an interview, with both E9 (RNUM) and E7 (SSD) it was confirmed that E7 was not aware of R10's need for assistance with dental services. E7 stated she would email the facilities dental provider that day to attempt to add R10 to the list of residents to be seen. 9/4/25 1:44 PM - E7 (SSD) provided an updated dental provider schedule that documented R10 was now added to	F0791		

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F0791 SS = D	Continued from page 18 the list of residents to be seen by the dentist next visit. 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.	F0791		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880	Corrective Action of Areas Affected: On 09/09/25, the Infection Preventionist (E17) and Nurse Practice Educator (E6) were re-educated on IC308: Enhanced Barrier Precautions. Recommendations from Centers for Disease Control and Prevention (CDC) were reviewed with E17 and E6 to utilize appropriate PPE (face mask and shield) for procedures with a potential risk for splash or spray was needed. Additionally, the IC201: Cleaning and Disinfecting process was reviewed with E17 and E6 for the facility's cell phone used to document wound pictures. Other areas affected: Education was completed on 09/09/2025 to ensure proper cleaning and appropriate PPE. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 9/8/25 to determine that education licensed nurses on the policy IC308: Enhanced Barrier Precautions and PPE recommendations from the CDC for procedures with the potential risk for splash and spray. Also, education will include the review of the sanitation process for cleaning devices per policy. Education given by the Nurse Practice Educator for licensed nurses will be completed on 10/17/25. D. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment J) to validate that infection control practices for 10% of residents with precautions and the sanitation process for devices is followed as per policy. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	10/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD CENTER	1100 NORMAN ESKRIDGE HIGHWAY , SEAFORD, Delaware, 19973

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F0880 SS = D	Continued from page 19 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that for one (R47) out of three residents reviewed for wound care the facility failed to ensure adherence to practices that prevent the spread infection. Findings include: The CDC's webpage entitled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to prevent the spread of Multidrug-resistant Organisms (MDRO's) indicated "Enhanced Barrier Precautions: Examples of high-contact resident care activities requiring gown and glove use for EBP include wound care: any skin opening requiring a dressing. (Face protection may also be needed if performing activity with risk of splash or spray). https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.html	F0880		

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F0880 SS = D	Continued from page 20 Review of R47's clinical record revealed: 8/21/25 - R47 was admitted to the facility with multiple conditions including Hidradenitis Suppruativa (HS - a chronic inflammatory skin condition characterized by painful lumps, abscesses [pus filled areas] and scarring) and was being treated for wound infections related to the diagnosis. 8/22/25 - A physician's order was written for R47 to be placed on Enhanced Barrier Precautions. 8/22/25 - A physician's order was written for R47 to receive Clindamycin gel, an antibiotic for three months, apply to groin topically twice a day to the infected wounds. 9/2/25 10:03 AM - During initial pool screening, R47's sheets were observed with moderately sized circular pale pink stains. R47 explained having open wounds that sometimes drained. 9/4/25 - 10:26 AM - E17 (IP) was made aware that a dressing change observation would occur. 9/4/25 10:39 AM - During a dressing change observation, E17 (IP) and E6 (NPE) entered R47's room to complete a dressing change. E17 was observed without a face covering. E17 placed a clean drape on R47's bedside table and placed the dressing change supplies, a medicine cup of the wound cleaning agent ordered, a tube of the antibiotic ointment, several packs of gauze and a cell phone. The cell phone glass was in a case, the face of the cell phone had an opaque, appearance, with fingerprints and smears visible on its face. 9/4/25 10:49 AM - During the same dressing change E6 (NPE) removed R47's soiled dressings, E17 (IP) then poured the cleaning agent from a medicine cup onto gauze held by E6. The open mouth of the cup created a potential for splashing. E6 cleaned R47's wounds removed her gloves and changed to another pair of gloves. E17 then opened a pack of gauze, pulled the gauze from the pack touching it directly with her gloved hand and handed it to E6 to pat R47's wounds dry. E17 then grabbed the cell phone and took pictures of the wounds, leaning in very closely to R47's wounds	F0880		

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F0880 SS = D	Continued from page 21 that were prone to drainage and abscess. E17 again opened a pack of gauze, pulled the gauze from the pack touching it directly with her gloved hand squeezed antibiotic ointment on the gauze and applied it to R47's wounds. E17 then covered R47's wound. 9/4/25 11:10 AM - During an interview, E17 (IP) confirmed that she did not wear a face covering and touched a cell phone during the dressing change. E17 disputed the use of a face covering because "[R47's] wound was not being irrigated, and the phone was cleaned before." At no point prior to the dressing change did the surveyor observe the phone being cleaned. When the surveyor attempted to indicate the smears on the phone E17 began cleaning and wiping the phone. 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.	F0880		