



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: June 12, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced complaint visit was conducted at this facility from June 10, 2025, through June 12, 2025. The deficiencies contained in this report are based on observations, interviews, review of resident clinical records and review of other facility documents, as indicated. The facility census of the first day of the survey was eighty - three (83). The survey sample totaled three (3) residents.</p> <p>Regulations for Skilled and Intermediate Care Nursing Facilities</p> <p>Scope</p> <p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross Refer to the CMS-2567-L completed June 12, 2025: cross refer F609.</p>		

Provider's Signature

[Handwritten Signature]

Title

Administrator

Date

6/25/25

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 06/12/2025
NAME OF PROVIDER OR SUPPLIER SEAFORD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 NORMAN ESKRIDGE HIGHWAY , SEAFORD, Delaware, 19973	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	<p>INITIAL COMMENTS</p> <p>An unannounced complaint visit was conducted at this facility from June 10, 2025 through June 12, 2025. The deficiencies contained in this report are based on observations, interviews, review of resident clinical records and review of other facility documents, as indicated. The facility census of the first day of the survey was eighty - three (83). The survey sample totaled three (3) residents.</p> <p>Abbreviations/definitions used in this report are as follows:</p> <p>BIMS - Basic Inventory of Mental Status, a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cognition deficit, 8-12 reflects moderate cognition deficit and 13-15 score is reflective of normal cognition;</p> <p>DHCQ - Division of healthcare and quality</p> <p>DON - Director of Nursing;</p> <p>MD; Medical doctor;</p> <p>NHA; Nursing home administrator;</p> <p>NP - Nurse Practitioner;</p> <p>RN - Registered Nurse;</p> <p>RP - Responsible person;</p> <p>SW - Social worker;</p>	F0000		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0000	Continued from page 1 UC - Unit Clerk. Do to not having an ePOC user established, the CMS2567report was submitted to the facility on 6/23/2025 as an attachment for submission of their POC.	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(l)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review it was determined that for one (R1) out of three residents reviewed for abuse the facility failed to report an allegation of sexual abuse within the required time constraints. Based on the facility's evidence to correct the noncompliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 6/6/25. Findings include:	F0609	"Past Noncompliance - no plan of correction required"	

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F0609 SS = D	<p>Continued from page 2</p> <p>Review of R1's clinical record revealed:</p> <p>6/27/23 - R1 was admitted to the facility with diagnoses including but not limited to hypertension, low back pain and nervous system disorders.</p> <p>5/27/25 2:38 PM - An incident summary documented "On 5/24/25 [R4 (Spouse)] reported being in the bathroom and R1 and E4 (Activity Aide) were together in the activity room and E4 (Activity Aid) asked R1 to see his private parts R4 also reported R1 was very upset and asked R4 to report this"</p> <p>6/3/25 E1 (NHA) documented "An employee passed me in the hallway and said R4 and R1 wants to see you"</p> <p>6/3/25 - A facility provided statement written by E1 (NHA) documented T.C. (sic) with E5 (Activities Director) I heard on Sunday (5/25/25) from [R5] in the activity room that [R4] told her that E4 (Activity Aide) was trying to look at R1's private parts. I didn't think anything of it because [R1] and [R4] come into activities and talk about their personal business. It's mainly [R4], [R1] just sits there. They do this all the time in there</p> <p>6/3/25 3:30 PM - A facility report was submitted to DHCQ (Division of Healthcare & Quality) for an allegation of abuse.</p> <p>6/11/25 2:57 PM - During an interview E5 confirmed and stated, "I heard on Sunday (5/25/25) from another resident [R5] that [E4] was asking [R1] to see his private parts. [R4] is always in the activities room talking about their business I don't pay her no attention, when it happened, I wasn't there, that's all I know what that resident said to me, and I don't know nothing about it."</p> <p>6/12/25 2:00 PM - An interview with E1 (NHA) confirmed that E6 passed E1 in the hallway and said [R4] and [R1] want to see you [E1] said [E6] did not tell me why they wanted to see me for" E1 also confirmed she was not aware of the alleged abuse until 6/3/25.</p>	F0609		

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F0609 SS = D	Continued from page 3 Based on the review of the facility's thorough investigation, documented response, completion of in-service training, power point presentations and abuse prohibition quizzes (inclusive of resident scenario/situation) audits, staff interviews and further incidents related to abuse it was determined to be past non-compliance. The plan of correction was initiated on 6/3/25 and completed on 6/6/25. 6/12/25 2:10 PM- Findings were reviewed with E1 (NHA), E2 (DON) and E3 (QA, Nurse) at the exit conference.	F0609		