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

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

STATE SURVEY REPORT

NAME OF FACILITY: Encore at West Meadow **DATE SURVEY COMPLETED:** January 12, 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. An unannounced Annual, Complaint and Extended survey was conducted at this facility from January 5, 2026, through January 12, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was (eighty-one) 81. The investigative sample totaled (thirty-seven) 37 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		2/26/2026
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 was not met as evidenced by: Cross Refer to the CMS 2567 – L survey completed January 12, 2026: F553, F557, F561, F627, F641, F656, F657, F684, F689, F695, F730, F745, F791, F812, F837, F838, F843, F844, F881, F909, ~~F941, F944~~, F946, and F949.		

Provider's Signature [signature] Title Exec. Director Date 2/6/26, Rev. 2/10/26

NAME OF FACILITY: Encore at West Meadow **DATE SURVEY COMPLETED:** January 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Abbreviations/definitions in this state report are as follows: DON – Director of Nursing; NHA – Nursing Home Administrator; Pulmonary – related to the lungs; QuantiFeron test – blood test used to detect tuberculosis (TB) infection; TB – tuberculosis/a serious infectious disease that affects the lungs.		
3201.3.0 **3201.3.7** **Title 16 Chapter 11 Subchapter II 1121 Resident Rights**	**Skilled and Intermediate Care Nursing Facilities** **The nursing facility shall comply with 42 CFR 483.10, 483.12, 483.13, 483.15 and/or 483.16 Delaware Code 1121 regarding the rights of residents. Those rights shall be made available in writing to residents, guardians, representatives or next of kin.** **To promote the interests and well-being of the residents in long-term care facilities, all facilities must treat residents in accordance with the following resident's rights: ...** **(8) At the bedside of each resident, the facility shall place and maintain in good order the name, address, and telephone number of the physician responsible for the residents care.** This requirement was not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to have posted the responsible physician's contact information in the resident's rooms as required by State regulation. 7/25/25 – R106 was admitted to the facility room 136a, a semi-private room.	**Corrective Action:** • R106 no longer resides in the facility and there was no opportunity for corrective action. Corrective actions have been ensured by the Director of Nursing for all other residents in the building. Every resident has at their bedside the name, address and telephone number of the physician responsible for their care. The nursing staff were also educated on the need for every resident to have the name, phone number, and the address of the physician responsible for their care while in the facility. **Identification of Other Residents:** • All Residents have the potential to be affected by this deficiency. An audit of 100% of the residents was completed. All residents identified to be affected by this deficiency were supplied with the name, address, and phone number of the physician responsible for their care. **System Changes:** • The Root Cause of the concern was the failure to ensure that the facility placed and maintain in	2/26/2026

Provider's Signature _____ Title Exec Director Date 2/6 & 2/10/26

NAME OF FACILITY: Encore at West Meadow **DATE SURVEY COMPLETED:** January 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	7/26/25 – R106 was moved to a private room 115a. 1/8/26 3:01 PM – An observation of various rooms, specifically rooms 115 and 136, revealed there was no evidence of any sign or notice with the responsible physician's name, address or telephone number. The facility failed to have a notice at each resident's bedside with the responsible physician's name, address and telephone number. 1/8/26 3:05 PM – During the observation of room 136, the current resident [R59] stated, "Oh there is no sign with that information (sic) on in this room or any room that I have been on in the facility. They write down the aide and nurses name on that dry erase board." 1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.	good order, the name, address, and telephone number of the physician responsible for the resident's care at their bedside. This was due to failure of the staff to update the dry erase board every shift. The facility policy for "Resident rights" (rev. 12.2016) was reviewed and found to meet professional standards. The facility system for admitting residents into the facility was reviewed to include having as part of the welcome kits a copy of the attending physician's information placed at their bedside. The Director of Nursing or designee will also provide Resident Rights education to the nursing staff members at our monthly staff meeting going forward. The Executive Director or designee will provide oversight to ensure ongoing compliance. **Success Evaluation:** • An initial 100 % audit have been completed in order to ensure that all of the residents has at their bedside a copy of the physician information that bears the name, address, and the phone number; Audits had a goal of 100% compliance; Then an audit of a random sample of 10% of the residents to include new residents, will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. Results of the audits will be monitored by	

Provider's Signature _____ Title Exec. Director Date 2/6/26, Rev. 2/10/26

NAME OF FACILITY: Encore at West Meadow **DATE SURVEY COMPLETED:** January 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		the Executive Director or Designee. The results of the audits will be reviewed by the Quality Assurance Team.	
3221.6.0 **3221.6.9** **3221.6.9.2.4**	**Services To Residents** **Communicable Diseases** **Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFeron. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category.** This requirement was not met as evidenced by: Based on interview and review of facility documentation, it was determined that for two (E20 and E38) out ten staff sampled for tuberculosis (TB) testing, the facility failed to ensure each staff person met the minimum requirements for pre-employment TB testing. Findings include: 1. Review of E20's (Maintenance Tech) pre-employment documentation revealed: 9/30/25 – Date of E20's first day in the facility.	**Corrective Action:** • Corrective actions have been ensured by the Director of Nursing of Nursing. Corrective action was not possible for E20 as the individual is no longer a staff in the facility. R38 continues to work in the facility, and a chest x-ray was completed that showed no active pulmonary disease to satisfy the pre-employment screening requirement. **Identification of Other Residents:** • All Residents have the potential to be affected. Residents will be protected by ensuring that all newly employed staff members complete the process of TB screening with supporting documentation before they are allowed to work in the facility. A 100% audit of all employees to ensure that the pre-employment TB testing was completed was done. No other staff member was identified from the audit. **System Changes:** • The Root Cause of the concern was the failure to ensure that each staff member met the minimum requirements for pre-employment TB testing. The facility system for TB pre-employment screening was reviewed to include a team that includes the Human	2/26/2026

Provider's Signature [signature] Title Executive Dire. Date 2/6/26, Rev. 2/10/26

NAME OF FACILITY: Encore at West Meadow **DATE SURVEY COMPLETED:** January 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	10/6/25 – Seven days after E20 started working in the facility, E20 had a QuantiFeron test completed. 10/8/25 12:22 PM – E20's QuantiFeron test results stated "... labs were positive. Pt. [Patient] needs chest xr [x-ray] done to rule out active TB." 10/13/25 – E20's chest x-ray results stated, "... No active pulmonary disease." Review of E20's timecards revealed that he worked in the facility from 10/1/25 through 10/4/25 and 10/7/25 through 10/11/25 without having the required pre-employment TB testing. 1/12/26 8:59 AM – During an interview, E1 (Interim NHA) confirmed the finding. 2. Review of E38's (Housekeeping) pre-employment documentation revealed: 3/31/25 – E38 had a QuantiFeron test completed. 4/3/25 – E38's QuantiFeron test results stated, "Positive". 4/15/25 – Date of E38's first day in the facility. 1/12/26 8:59 AM – During an interview, E1 (Interim NHA) confirmed that the facility lacked evidence of a follow-up x-ray. 1/12/26 3:30 PM – Findings were reviewed during the exit conference with E1 and E2 (DON).	Resources Director (HR), Director of Nursing, and the Infection Preventionist to confirm pre-employment screening of newly hired staff members. HR Director will provide this team with advance notice of upcoming orientation. A preemployment screening verification will be conducted by the team to ensure compliance with pre-hire onboarding requirements. The facility policy for "Tuberculosis, Employee screening" (rev. 02.2017) was reviewed and found to meet professional standards. The Director of Nursing or designee will complete education for the Infection preventionist concerning pre-employment TB screening for newly employed staff members. The Executive Director or designee will provide oversight to ensure ongoing compliance. **Success Evaluation:** • An weekly audit of new employees will be completed by the Executive Director or designee to ensure that all employees meet the regulatory requirement for pre-employment TB screening; audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. Results of the audits will be monitored by the Execu-	

Provider's Signature _____ Title Exec. Director Date 2/6/26, Rev. 2/10/26

NAME OF FACILITY: Encore at West Meadow **DATE SURVEY COMPLETED:** January 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
Chapter 11 Long-Term Care Facilities and Services Subchapter IV Criminal Background Checks; Mandatory Drug Screening; Long-Term Care Facilities; Nursing Home Compliance with Title XIX of the Social Security Act	**(b) Definitions. –** **(1) "Applicant" means any of the following:** **a. A person seeking employment in a facility.** **(c) An employer may not employ an applicant for work in a facility before obtaining a criminal history.** **(d) The requirement of subsection (c) of this section may be suspended for 60 days if the employer wishes to employ the applicant on a conditional basis.** **(d)(1) Before an employer may offer conditional employment, the employer must receive verification that the applicant has been fingerprinted by the SBI for purposes of the criminal history.** **(h) An applicant may not be employed in a facility, other than conditionally under subsection (d) of this section, until the applicant's employer has secured the applicant's criminal history.**	tive Director or Designee. The results of the audits will be reviewed by the Quality Assurance Team during the monthly QA meeting.	
§1141 Criminal Background Checks	This requirement was not met as evidenced by: Based on interview and review of facility documentation, it was determined that for one (E37) out of ten staff reviewed for pre-employment background check, the facility failed to have evidence of E37's criminal history background check. Findings include: 1/12/25 8:59 AM – During an interview, surveyor and E1 (Interim NHA) reviewed the pre-employment background check paperwork. The facility only produced a receipt, dated 2/12/25, that E37 was fingerprinted. E1 was unable to produce an eligible letter for employment, where E37's criminal history was reviewed by the BCC (Background Check Center). E1 confirmed the finding.	**Corrective Action:** • Corrective actions have been taken by the Executive Director. E37 was taken off schedule until the background check issue was resolved. E37 had her pre-employment background check completed and has an eligibility letter for employment. **Identification of Other Residents:** • All Residents have the potential to be affected. Residents will be protected by ensuring that all employees meet the regulatory requirement for pre-employment screening and background check. A 100% audit of all employee background check results was	2/26/2026

NAME OF FACILITY: Encore at West Meadow **DATE SURVEY COMPLETED:** January 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	1/12/26 3:30 PM – Finding was reviewed during the exit conference with E1 and E2 (DON).	completed by the Executive Director or designee. No other staff member was identified to have started working in the facility without a background check and an eligibility letter for employment. **System Changes:** • The Root Cause of the concern was a failure by the facility to provide evidence of a criminal history background check for an employee. The facility system for pre-employment screenings and criminal history background checks has been updated to ensure that the Human Resource Director will complete all pre-hire background checks. A list of all employees scheduled for orientation will be provided in advance to Executive Director or Designee who will ensure all prehire screens including background checks have been completed prior to first day of work The facility policy for "Background Screening Investigations" (rev. 3.2019), was reviewed and found to meet professional standards. The Executive Director or Designee will complete education for the Human Resources manager regarding pre-employment screening for new employees before they resume work in the facility. The Executive Director or designee will provide oversight to ensure ongoing compliance. **Success Evaluation:** • An initial 100% audit of all employees was completed with a goal of	

Provider's Signature _____ Title Exec. Director Date 2/6/26, Rev 2/10/26

NAME OF FACILITY: Encore at West Meadow **DATE SURVEY COMPLETED:** January 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		100% compliance; then a 100% Audit of new hires will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. Results of the audits will be monitored by the Executive Director or Designee. The results of the audits will be reviewed by the Quality Assurance Team during the monthly QA meeting.	
1142 Mandatory drug screening.	**(a) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screening.** **(c) The Department shall promulgate regulations, regarding the pre-employment testing of all applicants, for use of all of the following illegal drugs:** **(1) Marijuana/cannabis.** **(2) Cocaine.** **(3) Opiates.** **(4) Phencyclidine ("PCP").** **(5) Amphetamines.** **(6) Any other illegal drug specified by the Department under regulations promulgated under this section.** **(e) The employer must provide confirmation of the drug screen in a manner prescribed by the Department's regulations.** This requirement was not met as evidenced by: Based on interview and review of facility documentation, it was determined that for six (E14, E15, E16, E36, E37 and E38) out of ten	**Corrective Action:** • E14, E15, E16, E36, E37 and E38 are still employed in the facility. Corrective actions are on-going for this deficiency. All employees identified by the deficiency and those identified during the 100% audit of all staff are in the process of getting tested for Marijuana/Cannabis. The Director of Human Resources was educated on the requirement for mandatory drug screening that includes marijuana/Cannabis for new hires. **Identification of Other Residents:** • All Residents have the potential to be affected. No residents were affected by this deficiency. Residents will be protected by ensuring that a pre-employment drug screening is completed for all new hires before they resume work in the facility. **System Changes:**	2/26/2026

Provider's Signature _____ Title Exec. Director Date 2/16/26, Rev. 2/10/26

NAME OF FACILITY: Encore at West Meadow **DATE SURVEY COMPLETED:** January 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	staff sampled for pre-employment drug testing, the facility failed to ensure the mandatory drug screening included marijuana/cannabis testing. Findings include: Review of the following staff member's pre-employment drug screening lacked evidence of marijuana/cannabis testing: -E14 (RN) drug test dated 1/27/25; -E16 (CNA) drug test dated 3/13/25; -E36 (LPN) drug test dated 1/28/25; -E15 (RN) drug test dated 3/28/25; -E37 (Dietary Aide) drug test dated 2/10/25; and -E38 (Housekeeping) drug test dated 3/31/25. 1/12/25 8:59 AM – During an interview, surveyor and E1 (Interim NHA) reviewed the pre-employment drug screening records. E1 confirmed the findings. 1/12/26 3:30 PM – Finding was reviewed during the exit conference with E1 and E2 (DON).	• The Root Cause of the concern was a failure to ensure that the pre-hire drug test panel used for newly hired staff included marijuana/ Cannabis testing. The facility system for mandatory pre-employment drug screening has been reviewed and updated to include testing for Marijuana/ Cannabis before a newly hired staff member start work in the facility. The facility policy for "Credentialing of Nursing Service Personnel" (rev. 5.2019) and "Background Screening Investigation" (rev. 03.2019) were reviewed and found to meet professional standards. The Executive Director or designee will provide oversight to ensure ongoing compliance. **Success Evaluation:** • An initial 100% audit of all employees was completed with a goal of 100% compliance; then an Audit of all new hires will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. Results of the audits will be monitored by the Executive Director or Designee. The results of the audits will be reviewed by the Quality Assurance Team during the monthly QA meeting.	
3221.7.0 **3221.7.1.14.1**	**4202 Control of Communicable and Other Disease Conditions** **Control of Specific Contagious Diseases**	**Corrective Action:** • R92 continues to reside in the facility. Corrective measures were	2/26/2026

Provider's Signature _____ Title Exec Director Date 2/6/26, Rev. 2/10/26

NAME OF FACILITY: Encore at West Meadow **DATE SURVEY COMPLETED:** January 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Physician and other health care providers who give immunizations shall report information about the immunization and the person to whom it was given for addition to the immunization registry in a manner prescribed by the Division director or designee. This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R92) out of eleven residents reviewed for vaccines, the facility failed to document R92's Prevnar 20 vaccine that was given in the facility in DELVAX, Delaware's online immunization registry. Findings include: Review of R92's clinical record revealed: 10/27/25 – R92 was admitted to the facility. 11/17/25 – R92 was administered the Prevnar 20 vaccine by E10 (Infection Preventionist). 1/8/26 10:35 AM – A review of selected residents' vaccination documentation revealed R92 as vaccinated for pneumococcal infections with the Prevnar 20 vaccine in the Facility EMR. 1/8/25 11:10 AM – A review of DELVAX lacked evidence of documentation of R92's Prevnar vaccine from November 2025. 1/8/26 1:15 PM – During an interview, E10 confirmed that the facility failed to document in DELVAX R92's Prevnar vaccine from November 2025. 1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.	ensured by the Director of Nursing. R92's Prevnar 20 vaccine has been added to the Delaware online immunization registry (DELVAX). The Staff Development Coordinator was educated on the requirement for documenting every immunization completed in the facility in the Delaware online immunization registry. **Identification of Other Residents:** • All Residents have the potential to be affected. A 100% audit of all the residents currently in the facility has been completed by the Director of Nursing to ensure that no other residents in the facility are affected by the deficiency. No other resident was identified in this audit. **System Changes:** • The Root Cause of the concern was a failure to document Prevnar 20 vaccine administered in the facility in DELVAX. The staff development nurse administers all immunizations in the facility and is backed up by a designated Registered Nurse. The facility system for documenting vaccines administered in the facility in DELVAX was reviewed and updated to include an audit of all immunization administered in the facility during the weekly IDT at-risk meeting to ensure that there is no missing documentation in the registry. The Staff Development Coordinator will ensure that all immunization administered in the facility are documented in DELVAX on the day	

Provider's Signature _____ Title Exec. Director Date 2/6/26, Rev. 2/10/26

NAME OF FACILITY: Encore at West Meadow **DATE SURVEY COMPLETED:** January 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		that the vaccines are administered. The facility policies for "Pneumococcal Vaccine" (rev. 10.2019) and "Vaccination of Residents" (rev. 10.2019) were reviewed and found to meet professional standards. The Executive Director or Designee will provide oversight to ensure ongoing compliance. **Success Evaluation:** An initial Audit of all residents that received immunization and currently resides in the facility will be completed by the Director of Nursing or Designee; Audits will be completed immediately; The audit will have a goal of 100% compliance. Then, a 100% audit of all newly vaccinated residents will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. Results of the audits will be monitored by the Executive Director or Designee. The results of the audits will be reviewed by the Quality Assurance Team during the monthly QA meeting.	

Provider's Signature _____ Title Exec Director Date 2/6/26, Rev. 2/10 /a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	**255 POSSUM PARK ROAD , NEWARK, Delaware, 19711**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility from January 5, 2026 through January 12, 2026. The facility census was eighty-one (81) on the first day of the survey. In accordance with 42 CFR 483.73, an emergency preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		01/28/2026
F0000	INITIAL COMMENTS An unannounced Annual, Complaint and Extended survey was conducted at this facility from January 5, 2026 through January 12, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 81. The investigative sample totaled 37 residents. Abbreviations/definitions used in this report are as follows: Acute respiratory failure - Sudden condition that occurs when fluid builds up in air sacs in the lungs resulting in lungs' inability to release oxygen into the blood and organs; AD - Activity Director; ADON - Assistant Director of Nursing; Anticonvulsant - A medication that helps treat and prevent seizures; BIMS (Brief Interview for Mental Status) - A structured assessment tool aimed at evaluating cognition in the elderly. The total possible BIMS score ranges from 0 to 15, with 15 being the best; 13-15: Cognitively intact (decisions consistent and	F0000		01/28/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	**255 POSSUM PARK ROAD , NEWARK, Delaware, 19711**

(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	Continued from page 1 reasonable); 8-12: Moderately impaired (decisions poor; cues/supervision required); 0-7: Severe impairment (never/rarely made decisions); Capacity - an individual's ability to understand and make specific decisions about their healthcare. It is a clinical assessment made by healthcare professionals to determine if a person has the requisite cognitive abilities to make informed decisions and includes four dimensions or criteria: (a) Understanding, (b) Appreciation, (c) Reasoning, and (d) Expression of a Choice. All four must be present for a person to be deemed capable of making healthcare decisions. "Understanding" refers to the ability of the individual to comprehend the information being disclosed in regard to his/her condition as well as the nature and potential risks and benefits of the proposed treatment and alternatives (including no treatment). The "Appreciation" component involves the ability to apply the relevant information to one's self and own situation. The "Reasoning" component refers to evidence that the person's decisions reflect the presence of a reasoning process, e.g., ability to engage in consequential and comparative reasoning and to manipulate information rationally. The fourth component, Expression of a Choice, can itself be deceptively complex. At its most basic level, it simply refers to the ability to communicate a decision; CBC - Complete blood count, lab work; CMP - Complete metabolic panel, lab work; CNA - Certified Nursing Assistant; Delusions - A belief held with strong conviction despite evidence to the contrary; DELVAX - A confidential online computer system used in Delaware by doctors, nurses, schools and practices to keep track of their patients/students immunizations; Dementia - Loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; DON - Director of Nursing; DMOST - Delaware Medical Orders for Scope of Treatment/portable medical orders that respect the patient's goals for care in regard to the use of CPR	F0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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	Continued from page 2 and other medical interventions. The DMOST form is applicable across health-care settings, is reviewable, and is revocable; DNR - Do Not Resuscitate; DPOA - Durable Power of Attorney/special type of POA that allows an individual (principal) to appoint someone else to make healthcare decisions on their behalf when they are unable to do so and continues even after the principal becomes incapacitated; ED - Emergency department; EMR - Electronic medical record; eMAR -Electronic Medication Administration Record; FM - Family Member; HHA - Home health aide; Hydronephrosis - Swelling of a kidney due to a buildup of urine; occurs when urine cannot drain; Hypertension - High blood pressure; leading cause of stroke; hypoxia - A deficiency in the amount of oxygen reaching the tissues; L - Liters; LPN - Licensed Practical Nurse; Medication Administration Record (MAR) - List of daily medications to be administered; MD - Medical Doctor; MDS assessment - Minimum Data Set/a federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; Milliliter - Unit of volume; Neurocognitive disorder - Conditions characterized by a decline in cognitive function due to underlying brain pathology, affecting memory, reasoning, and daily functioning; NHA - Nursing Home Administrator;	F0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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	Continued from page 3 NP - Nurse Practitioner; Ombudsman - A resident representative who investigates reported complaints and helps to achieve an agreement between parties; Orthostatic hypotension - Low blood pressure that occurs when standing after sitting or lying down; Osteoarthritis - A type of joint disease that results from breakdown of joint cartilage and underlying bone; OT - Occupational Therapy; Percutaneous nephrostomy tube - Thin catheter (tube) inserted into the kidney to drain urine directly into a bag, often used when urine flow is obstructed; POA - Power of Attorney/legal authorization that allows someone to make decisions or take actions on behalf of another person (principal) in financial, legal, or medical matters. The POA can be broad or limited, depending on the terms of the POA document; PT - Physical Therapy; PVR - Post-void residual/the amount of urine left in the bladder after urination; Renal - Kidney; RN - Registered Nurse; SS - Social Services; SSD - Social Services Director; Suprapubic catheter - Tube used to drain urine from the bladder; UM - Unit Manager; Ureteral calculous obstruction - When a kidney stone blocks one or both ureters (tubes), preventing urine from draining from the kidneys to the bladder; x - Times.	F0000		
F0553 SS = E	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her	F0553	Corrective Action: •R94 no longer resides in the facility and there was no opportunity for corrective action. R3, R22, R28, continues to reside in the facility. Corrective actions have been ensured by the Director of Social services.	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0553 SS = E	Continued from page 4 person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for four (R3, R22, R28 and R94) out of four residents reviewed for care planning, the facility failed to ensure the care planning process facilitated the inclusion of the resident and/or resident representative in the development and implementation of each residents' person-centered care plan. Findings include: 1. Review of R22's clinical record revealed: 7/10/25 – R22 was admitted to the facility. 7/16/25 – The admission MDS assessment was completed.	F0553	Continued from page 4 The Director of Social services has completed care planning meetings for R3, R22, and R28. R3 care plan meeting was completed on 2/4/2026, R22 was completed on 2/5/2026, and R28 was completed on 2/2/2026. In attendance at the Care plan meetings are the residents, the residents Power of Attorney, the Director of Social Services, the Dietitian, the Director of Activities, the Nurse Unit Manager, and a certified nursing assistant. R3, R22, and R28 have been provided with a copy of the Residents Rights and informed of their right to participate in the development of their care plan. The Director of Social services was also educated on timely scheduling and completion of care planning meetings with residents. Identification of Other Residents: •All Residents have the potential to be affected by this deficiency. An audit of 100% of the residents was completed to identify if there was a failure to have a care plan meeting for any of them. No other resident was noted to have been affected. The Residents right to participate in planning care will continue to be communicated to the Director of Social services and to the residents. System Changes: •The Root Cause of the concern was the failure to ensure that a care plan meeting was held that included the residents and/or their representatives in order to have a person-centered care plan. The facility policy for "Care Plans, Comprehensive Person-Centered" (rev. 12.2016) was reviewed and found to meet professional standards. The facility system for completing care plan meetings by the director of social services has been updated to include a focus on ensuring that residents and their representatives are included in the care planning process. Also included will be a monthly review of compliance with residents and their representatives' participation in care planning at the monthly Quality Assurance and Performance Improvement committee meeting. The Executive Director has completed training for the Director of Social services to ensure timely completion of care plan meetings for residents, and to have the residents and their representatives included/invited to care plan meetings. The Executive Director or designee will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial 100 % audit was completed in February 2026 to ensure that all of the residents/representatives	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0553 SS = E	Continued from page 5 There was no evidence that a care plan conference was held with the resident/resident representative. 10/16/25 – The quarterly MDS assessment was completed. There was no evidence that a care plan conference was held with the resident/resident representative. 2. Review of R94's clinical record revealed: 12/13/25 – R94 was admitted to the facility. 12/19/25 – The admission MDS assessment was completed. R94 was discharged to hospital and returned on 12/24/25. 12/30/25 – The 5-day MDS assessment was completed. There was no evidence that a care plan conference was held with the resident/resident representative. 1/5/26 11:58 AM – During an interview, R94 and R94's family member stated that they don't recall participating in a care plan conference since admission. 1/8/26 3:50 PM – During an interview, E4 (SSD) stated that new admissions have an interdisciplinary meeting within 7 days of admission and short-term rehabilitation residents have care plan meetings based on each resident's progression in therapy. E4 stated that residents in long-term care have a care plan conference every 3 months within the month of the MDS assessment. E4 stated that she either sends an email to the interdisciplinary team members or announces care plan conferences during the morning meeting. E4 stated that she emails an invitation letter to the resident/resident representative. When asked by the surveyor where the care plan conferences are documented to show who participated and the resident's status addressed, E4 stated the care plan information was documented in the electronic health record under progress notes. The surveyor asked E4 to provide copies of the invitation letters to residents/resident representatives and the care plan conference progress notes. 1/9/26 8:55 AM – During a combined interview with E2 (DON), E28 (RN/UM) and E26 (AD), the surveyor was handed a document with handwritten note "No care plan info". Surveyor confirmed that the facility had no evidence of documented care plan conferences and invitations to residents/resident representatives to participate.	F0553	Continued from page 5 were invited to a care plan meetings/conference; that a care plan meeting has been held; Audits had a goal of 100% compliance; Then an audit of a random sample of 10% of the residents will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0553 SS = E	Continued from page 6 2. Review of R3's clinical record revealed: 9/7/23 – R3's initial admission to the facility with diagnoses including anxiety disorder. 2/26/24 – R3 was readmitted to the facility from the hospital with diagnoses including pulmonary embolism (sudden blockage in a lung artery by a blood clot) and multiple sclerosis (nervous system disease that affects the brain and spinal cord). 1/5/26 1:30 PM – In an interview, R3 stated that she cannot recall attending a care plan meeting. 1/9/26 11:00 AM – A review of R3's progress notes lacked evidence of care plan meeting notes for the year 2025. 1/9/26 11:19 AM - In a telephone interview, F3 (Family Member) stated that she was not invited to any care plan meetings in years. 1/9/26 11:35 AM - During an interview, E3 (ADON) stated that she does not take down notes during care plan meetings, but she would check with the Social Worker, (E4 SSD) who was off that day (1/9/25). 1/9/25 2:00 PM – In a follow up interview, E3 confirmed that the facility lacked evidence of R3's care plan conferences. 3. A review of R28's clinical record revealed: 10/21/23 – R28 was admitted to the facility with diagnoses including hypertension and acute respiratory failure. 10/28/25 – R28's annual MDS assessment documented a BIMS score of 13, indicating intact cognition. 12/3/25 – A facility document entitled, "Care Plan Report" stated, "…Last Care Plan Review Completed: 12/03/2025…". 1/5/26 4:08 PM – During an interview, R28 stated, "I don't know about anything regarding my care." The Surveyor asked R28, "Are you informed of when care plan meetings will be held and invited to come?" R28 stated, "No. I haven't been to any care plan meetings." 1/8/26 3:45 PM – During an interview, E2 (DON) stated, "[R28] does not come to care plan meetings and [R28]'s son doesn't return phone calls to come to care plan meetings." The Surveyor asked E2, "Is there any	F0553		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0553 SS = E	Continued from page 7 documentation of when R28 or R28's son was informed of or invited to care plan meetings?" E2 (DON) stated, "[E4, Social Services Director] handles the documentation of care plan meetings." 1/8/26 4:15 PM – The Surveyor submitted a written request to E4 for documentation of R28's care plan meetings, attendees of the meetings and any correspondence to R28 or R28's son informing them of when care plan meetings were scheduled. During an interview E4 stated, "I will look for [R28]'s care plan documents." 1/9/26 10:15 AM – During an interview, E2 stated, "[E4] left a note about [R28]'s care plans. No care plan documentation for [R28] was found." 1/9/26 2:49 PM – Finding was confirmed with E2 and E3 (ADON). 1/12/26 3:30 PM – Findings were reviewed with E1(Interim NHA) and E2 during the Exit Conference.	F0553		
F0557 SS = D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that for one (R92) out of 32 sampled residents, the facility failed to ensure that R92 was treated with dignity and respect. Findings include: Review of R92's clinical record revealed: 10/27/25 – R92 was admitted to the facility. 10/30/23 – R92's admission MDS (Minimum Data Set) revealed that R92's cognition was moderately impaired. 1/7/26 1:50 PM – During an observation, R92, whose bed was near the open door, was seen from the hallway with	F0557	Corrective Action: •R92 continues to reside in the facility. Corrective actions have been ensured by the Director of Nursing. Staff members have been educated on the need to provide R92 with dignity and respect by ensuring that her body is not exposed to others. Staff members are to ensure that the resident wears a pair of pants and have her privacy curtain pulled as needed to ensure that her dignity is maintained. Identification of Other Residents: •All Residents have the potential to be affected. No other residents were affected. The residents' right to respect and dignity will continue to be reviewed with staff members. System Changes: •The Root Cause of the concern was the failure by the facility to ensure that the resident was treated with dignity and respect when her skin and briefs were exposed for others to see. The facility policy "Dignity" (Rev. 2.2021) and "Residents Rights" (revised 12.2016) were reviewed and found to meet professional standards. The Staff Development Coordinator, or designee will complete staff training and in-service for staff members to cover residents' rights and dignity in our monthly staff meetings going forward. The Executive Director and the nursing management team	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0557 SS = D	Continued from page 8 her legs and thighs uncovered, exposing her skin and incontinence pad. R92 had a roommate with a male visitor (unidentified) at that time of observation. 1/7/26 – Subsequent observations from 1:53 PM through 2:01 PM revealed that R92's uncovered legs, thighs and incontinence pads were visible from the hallway. R92's roommate still had the male visitor with her in the same room. 1/7/26 2:05 PM – In an interview, E12 (LPN) confirmed the finding and stated that R2 had the tendency to kick her blanket off her. E12 further stated that she will attend to R92 and will put on her pants. 1/9/26 3:00 PM – Findings were discussed with E2 (DON) and E3 (ADON). 1/12/26 3:30 PM – Findings were reviewed with E1 (Interim NHA) and E2.	F0557	Continued from page 8 will provide oversight to ensure ongoing compliance. Success Evaluation: •A initial 100% audit of all the residents for covering with appropriate clothing, unnecessary exposure, and appropriate use of privacy curtain will be completed to ensure that the residents dignity is respected; Audits will be completed by the Director of Nursing or Designee; Audits will have a goal of 100% compliance; then Audits of a random sample of 10% of residents will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then 10% every other week until 100% compliance is achieved for 3 consecutive evaluations, and then 10% monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and	F0561	Corrective Action: •R22 and R80 continue to reside in this facility. There was no opportunity for corrective action for Resident R106; the Resident no longer resides in the facility. The facility has ensured that R22 and R80's consents were redone by them. The Staff Development coordinator educated all staff members on the right of the residents to self-determination. Identification of Other Residents: •All Residents have the potential to be affected. Residents' consents were audited to determine if their right to self-determination was respected. The Director of Nursing or his designee in to ensure that all resident's identified not to be in compliance have their consents signed by them. Staff members were educated on the need to have the residents sign their consent if their BIMS score is 13 and above. System Changes: •The Root Cause of the concern was a failure to have the residents sign their consents and admission papers by themselves, thereby violating their right to self-determination. The facility policy for "Resident Self Determination and Participation" (rev. 2.2021) was reviewed and found to meet professional standards. Signed consents for new admissions are to be reviewed each morning, Monday to Friday, at the facility	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0561 SS = D	Continued from page 9 community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for three (R22, R80 and R106) out of four residents reviewed for accidents, the facility failed to allow these residents to exercise their right to self-determination by having their family contact representatives sign consents. Findings include: 1. Review of R22's clinical record revealed: 7/7/25 – The facility's Consent for Treatment, as part of the Resident Agreement was electronically signed by R22 that stated, "You authorize Millcroft Living to provide care and treatment consistent with the terms of your Health Center Admission Agreement, dated 7/10/25. You also authorize Millcroft Living to obtain all necessary clinical and/or financial information from the hospital or nursing facility from which you may be transferring... You have the right to request, refuse and/or discontinue treatment. If you are, or become, incapable of making your own medical decisions, we will follow the direction of the Delaware Consent Act. Under the Consent Act, persons shall have legal authority to make medical treatment decisions on your behalf in the following order of priority: -A court appointed guardian, if the health care decision is within the scope of the guardianship; -An attorney-in-fact appointed by you in a Durable Power of Attorney, if the health care decision is within the scope of authority; -A person giving priority by you based on another statutory provision;... This consent for treatment is executed this 7 day of July, 2025." 7/10/25 7:01 PM – An admission note by E15 (RN) documented that R22 was admitted to the facility. The note documented, "... Resident A&O [alert and oriented] x [times] 2-3 and confused... DMOST and all admission paperwork was signed by one of the patients (sic) POA [F5]...". The following consents were signed by F5 (R22's POA) and not R22, the resident: -Consent to scheduling/setting up transportation for appointments and requirement that a family member attend the appointment. F5 signed, dated 7/10/25 and	F0561	Continued from page 9 clinical meeting to identify non-compliance. Review of consents to maintain compliance will be a permanent part of the clinical meetings. The Executive Director or Designee will provide oversight to ensure compliance going forward. Success Evaluation: •An initial 100% audit to ensure compliance with signing of consents will be completed by the Director of Nursing or designee on residents currently in the facility; Audits will have a goal of 100% compliance; Audits will be completed weekly on newly admitted residents until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	**255 POSSUM PARK ROAD , NEWARK, Delaware, 19711**

(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
F0561 SS = D	Continued from page 10 wrote "decline". -Authorization to use and/or disclose health information. F5 signed and dated 7/10/25. -Acknowledgement of receipt of resident rights. F5 signed and dated 7/10/25. -Consent to treatment and medication. F5 signed and dated 7/10/25. -Dental care authorization and assignment of benefits. F5 signed, dated 7/10/25 and wrote "decline". -Immunization informed consent for influenza, pneumococcal and Covid-19 vaccinations. F5 signed, dated 7/10/25 and checked "decline" for all three vaccinations. -Pain management consent form. F5 signed, dated 7/10/25 and checked the consent for Tylenol medication. -Foot care authorization and assignment of benefits. F5 signed, dated 7/10/25 and wrote "cut toe nails & [and] fingernails". -Patient portal access consent and authorization form. F5 signed, dated 7/10/25 and checked to voluntarily participate in and obtain access to the Patient Portal. -Bed rails informed consent and release. F5 signed, dated 7/10/25 and checked consent to the use of bed rails as recommended. -Delaware Medical Orders for Scope of Treatment (DMOST) was signed by F5 on 7/10/25 and signed by E11 (contracted NP) on 7/11/25. It should be noted that F5 signed the DMOST document in the signature section above the following statement: "…If [aA]uthorized [rR]epresentative signs, the medical record must document that a physician has determined the patient's incapacity & the [aA]uthorized [rR]epresentative's authority, in accordance with DE [Delaware] law." 7/11/25 – An initial consult note by E11 (contracted NP) documented, "… past medical history of… dementia, major neurocognitive disorder… alert and oriented x 2-3… Discussed with resident [R22] and POA [F5's name] overall goals of care. They wish to be a DNR with treatment of symptoms only. Consent: POA [F5] agreed to discuss advance directives…". This note did not document R22's determination of incapacity. 7/12/25 3:53 PM – The speech therapy evaluation and	F0561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0561 SS = D	Continued from page 11 plan of care documented R22's BIMS as a 13, cognitively intact. 7/13/25 – The social services initial evaluation documented that R22 had a BIMS score of 13, which revealed that R22 was cognitively intact. 1/9/26 8:25 AM – During an interview, E22 (Admissions Coordinator) stated that the facility's practice was that the admitting nurse obtain all of the signed consents and the resident's POA document, if applicable. E22 stated that she completed the resident admission agreement during business hours and that she was not involved with R22's consents or the POA document. The facility failed to promote and facilitate R22's right to self determination with respect to signing his own consents and DMOST. 2. Review of R106's clinical record revealed: 7/25/25 – R106 was admitted to the facility with diagnoses including but not limited to pancreatic cancer. 7/25/25 11:41 AM –R106's [Hospital] Interagency Discharge Orders documented, "… Discharge Diagnoses: Acute hyperactive delirium due to another medical condition… Additional Instructions from the Care Team…You were admitted to the hospital with altered mental status, unable to exactly fond out the cause, but probably medication induced, but now mentation has improved…". 7/25/25 – F7 (R106's wife) signed R106's consents for Acknowledgement of receipt of Resident Rights, Consent to treatment and Medication, Pain Management Consent form and Bed Rails Informed Consent and release form. 7/25/25 8:32 PM – R106's EMR (electronic medical record) Admission Summary documented, "… Patient awake, alert, oriented X3-4… Patient's wife signed all his admission consents and paperwork…". 7/26/25 - F7 declined and signed R106's Dental Care authorization and assignment of benefits. 7/28/25 – E6 (MD) completed R106's DMOST (Delaware Medical Orders for Scope of Treatment) form and had F7 sign it. 7/30/25 – E24 (psych NP) documented in R106's Psychiatric evaluation, "…Mental status Examination:	F0561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0561 SS = D	Continued from page 12 Appearance/Behaviors: calm/cooperative, Sensorium: alert, Orientation: person, place, time, Speech: coherent, Affect: appropriate … Concentrations: fair, insight: poor, Judgment: fair…" 7/31/25 – R106's admission MDS (Minimum Data Set) revealed R106's BIMS (Basic Inventory of Mental Status) as 13, which was reflective of normal cognition. 8/1/25 10:00 AM – F7 signed R106's [facility] Transfer/Discharge Report prior to discharge from the facility to home. 3. Review of R80's clinical record revealed: 8/28/23 – R80 was admitted to the facility. 8/4/25 - R80's quarterly MDS (Minimum Data Set) assessment documented that R80's BIMS (Basic Inventory of Mental Status) as 14, which is reflective of normal mentation. 9/25/25 – R80 was re-admitted to the facility after hospitalization for COVID pneumonia with acute respiratory failure and hypoxia (low oxygen saturation). 9/25/25 11:21 PM – R80's clinical admission nursing progress note documented, "… mental Status: resident is alert & oriented X 3. Oriented to time. Oriented to person, Oriented to place. Level of cognitive impairment: alert. Resident is coherent. Speech is clear. Resident makes self understood (sic). Resident understands others. Mental Status note: alert and oriented X 3." 9/26/25 - E8 (RN/Unit manager) obtained consent via the telephone from F1 (R80's daughter) for the bedrails informed consent and release form. 9/27/25 – E8 obtained consent via the telephone from F1 (R80's daughter) for the appointment scheduling consent, the consent to treatment and medication, the pain management consent form, and the psychopharmacologic medication informed consent forms. The facility failed to allow R80 to exercise his right to self-determination by having his daughter sign consents when R80 was capable of understanding and signing his own consent forms. 10/1/25 – R80's admission MDS assessment documented that R80's BIMS (Basic Inventory of Mental Status) as 13, which is reflective of normal mentation.	F0561		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0561 SS = D	Continued from page 13 10/14/25 – R80 signed his immunization informed consent form. 1/8/26 10:58 AM – During a combined interview, E8 (RN) stated, "[R80} was his own person. He can make his own decisions." E9 (LPN) stated, "Oh, he makes his own decisions. He is able to sign his name. He has MS (multiple sclerosis) so he cannot move his lower extremities but his upper extremities are good." 1/8/26 11AM – During an interview, R80 confirmed that he is able to sign his signature with his right arm. 1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.	F0561		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (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); (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 (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (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. (iii) The facility must also promptly notify the resident and the resident representative, if any, when	F0580	Corrective Action: •The resident R106 no longer resides in this facility. There was no opportunity for corrective action. To prevent future failure to notify a responsible party of changes in a resident, the Director of Nursing or designee have educated all nursing staff regarding the notification requirements for transferred or discharged residents. Identification of Other Residents: •All Residents have the potential to be affected. No other residents were affected. A 100% audit of all discharges and transfers from the facility in the last 30 days was completed to ensure responsible party notifications were ensured where needed. System Changes: •The Root Cause of the concern was the failure to notify family representative of the resident's laboratory results for blood work completed on the day of discharge from the facility. The facility policy "Change in a Resident's Condition or Status" (revised 2.2021) was reviewed and found to meet professional standards. The facility system for daily clinical meetings from Monday to Friday has been updated to include a review of all transfers and discharges to ensure that notification and updates have been provided to responsible parties even when they are no longer in the facility. The Unit Manager will ensure that all the results for previous days' laboratory tests are available for review at the Monday to Friday clinical meetings. The Director of Nursing or Designee will complete education for all nursing staff regarding the requirement to notify transferred or discharged	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0580 SS = D	Continued from page 14 there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) 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 changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R106) out of eighteen residents reviewed for quality of care, the facility failed to notify family representative of the resident's 8/1/25 lab work. Findings include: Facility "Consent for Treatment" form stated, "We will keep you informed about the routine nursing and emergency care we provide to you, and we will answer your questions about the care and service we provide you..." Last reviewed 7/9/2024 7/24/25 – E6 (MD) ordered in R106's EMR, "Labs – CMP (complete metabolic panel), CBC (complete blood count) in one week from date of admission." 7/25/25 – R106 was admitted to the facility with diagnoses including but not limited to pancreatic cancer. 7/31/25 – R106's admission MDS (Minimum Data Set) revealed R106's BIMS (Basic Inventory of Mental Status) as 13, which was reflective of normal cognition. 8/1/25 8:12 AM – R106 had labs (CMP, CBC) drawn at the facility.	F0580	Continued from page 14 residents and their representatives of changes and other information that is relevant to their health outcome. The nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: •A 100% audit of all discharges and transfers in the last 30 days has been completed to ensure responsible party notifications were ensured where needed. Subsequent audits of all transferred or discharged residents will be completed by the Director of Nursing or Designee to ensure that notification has been provided to responsible parties as needed; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0580 SS = D	Continued from page 15 8/1/25 10:00 AM - F7 (R106's wife) signed R106's discharge paperwork and R106 was discharged from the facility. 8/1/25 11:29 AM – R106's lab results were reported to the facility. There were several abnormalities within the lab results, including hyponatremia (low sodium) and anemia (low hemoglobin). 1/7/26 2:42 PM – During a telephone interview, F7 (R106's wife) stated, "They [the facility] never called me with the lab results…Had I known this on Friday, August 1st, I would have taken [R106] to the ED (emergency room) immediately and perhaps we would have had a different outcome…". 1/9/26 10:09 AM – During an interview, E28 (RN/UM) stated, "I remember telling his wife [F7] that he [R106] had labs that morning. I did not call her with the results. We don't have a protocol for that because we rarely get labs on the day of discharge. I guess she got the lab results from the portal." 1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.	F0580		
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §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- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (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; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would	F0627	Corrective Action: •Resident R6 is no longer a resident of the facility. There was no opportunity for corrective action. The Director of Social services has been educated on the discharge procedure for residents being transferred or discharged from the facility to prevent future re-occurrence. Identification of Other Residents: •All Residents have the potential to be affected. No other resident was found to have been affected from the audits completed by the Director of Nursing or his designee. System Changes: •The Root Cause of the concern was the failure to ensure that home health services were arranged for the residents when discharging from the facility prior to his discharge. The facility policy for "Transfer or Discharge, Preparing a Resident for" (revised 12.2016) was reviewed and found to meet professional standards. The system for discharging residents from the facility was reviewed to include ensuring that the social service director will review with the resident and	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0627 SS = D	Continued from page 16 otherwise be endangered; (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 (F)The facility ceases to operate. §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. §483.15(c)(2) Documentation. 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. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (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). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by-	F0627	Continued from page 16 representative at least 24 hours before transfer or discharge, the plan of discharge. The Unit manager will call the resident's family or representative at least 24 hours before discharge to confirm that all needed home medical equipment and services are in place. The Director of Nursing or Designee will complete education for the Director of Social services on the requirements for transferring or discharging a resident from the facility. The Executive Director will provide oversight to ensure ongoing compliance. Success Evaluation: •An audit of all resident discharged from the facility will be completed by the Director of Nursing or Designee to ensure compliance with the facility's policy by making a courtesy phone call to all representatives/POA for residents scheduled to be discharged 24 hours before discharge to confirm that they have all needed home services in place; audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team during the monthly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0627 SS = D	Continued from page 17 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. 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. §483.15(e)(1) Permitting residents to return to facility. 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. (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- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services (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. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is 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.	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	**255 POSSUM PARK ROAD , NEWARK, Delaware, 19711**

(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
F0627 SS = D	Continued from page 18 §483.21(c)(1) Discharge Planning Process 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- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (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. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (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. (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. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (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. (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. (C) If discharge to the community is determined to not be feasible, the facility must document who made the	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0627 SS = D	Continued from page 19 determination and why. (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. (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. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (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. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R6) out of one resident reviewed for discharge, the facility failed to ensure that R6 had home health services arranged per the discharge plan from the facility to home on 12/12/25 (Friday). Findings include: Review of R6's clinical record revealed:	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	**255 POSSUM PARK ROAD , NEWARK, Delaware, 19711**

(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
F0627 SS = D	Continued from page 20 9/26/25 – R6 was care planned for discharge with the goal to be discharged to home. Approaches included: -home health services per physician order; -physician to review discharge and admission orders, care plan and prior level of function; -therapy services per physician order. 12/5/25 – An insurance appeal determination letter documented, "A review of the medical records received shows that the patient [R6] was admitted to a SNF [skilled nursing facility]. Self-care tasks such as bathing, dressing, and toileting require moderate to maximum assistance. Bed mobility tasks require supervision assistance. Transfer tasks require moderate assistance. The patient can walk up to 50 feet with a wheeled walker and moderate assistance. The patient can be transferred to Home with support from Home Health services…". 12/11/25 10:01 AM – A BIMS evaluation by E4 (SSD) revealed that R6 was cognitively intact with a score of 15. 12/11/25 10:03 AM – R6's discharge information was printed and included R6's facesheet, medication review report, 9/29/25 history and physical note by E6 (MD), 12/8/25 acute progress note by E6, 9/26/25 physician's orders to flush nephrostomy (tube) and change dressing, 12/9/25 physical therapy and occupational discharge summaries, and a handwritten prescription for home health care for PT/OT, RN and HHA by E6. (30 pages) 12/11/25 – A discharge progress note by E6 (Medical Doctor) documented, "… Suprapubic catheter and left percutaneous nephrostomy tube were maintained… Ultimately he met his therapy goals. Consequently he was felt stable for discharge to home with close ongoing care as an outpatient... Discharge Instructions: Reviewed with patient and staff Home Health: Per social services Physical and Occupational Therapy Skilled nursing Home health aide… Certification Period: 60 days I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy… Impaired mobility leaving home requires a considerable and taxing effort a normal inability to leave the home Reason for Home Health Services: The patient requires home health services because of the below listed diagnosis… Chronic kidney disease… Hypertension… Hydronephrosis with renal and ureteral calculous	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0627 SS = D	Continued from page 21 obstruction… Bladder outlet obstruction… Physical deconditioning Plan: Patient appears medically stable for discharge to home in the morning with close ongoing care as an outpatient… Social services will arrange for home health care… This was all reviewed at length with the patient and the staff prior to discharge…". 12/12/25 11:00 AM – The Transition of Care and Discharge Summary, started on 12/4/25 at 9:32 PM, documented R6's discharge date of 12/12/25. Under the Social Services section, R6 was being discharged to home/community and had the following services checked that were recommended upon discharge: home health nursing services [B1's company name] and home health therapy services [B1's company name]. Under the nursing section, the summary included that R6 had a suprapubic catheter and a left nephrostomy tube. Under the therapy section, the summary documented that R6 required partial/moderate assistance with bed mobility, dressing, bathroom activity; required substantial/maximal assistance for transfers, bathing and the ability to move from one location to another. 12/12/25 (untimed) – A facility fax cover sheet documented that E4 (SSD) handwrote to B1 (home health company name) "[R6's name] D/C [discharge] 12/12/25 Needs PT, OT, HHA, RN." 12/12/25 1:34 PM – An email transmittal from B1 (home health care company name) confirmed referral information of 31 pages received. 12/12/25 2:06 PM – A discharge summary by E33 (RN) documented, "Resident discharged home alert and in stable condition… Discharged with facility transport with personal belongings, paperwork, remaining medications." 1/5/26 – A typed statement by E4 (SSD) and provided to the surveyor documented, "I have spoken to [R6's name] on several occasions as well as his [R6's family member] on one occasion to discuss the challenges of obtaining home health (PT, OT, HHA and RN) due to his [B8's name] insurance plan. Referrals were sent to [company names of B1, B2, B3, B4, B5, B6 and B7]. [B1]- Could not accept due to no staffing in his area. I also was told that [B1] was having a contracting issue with [B8, name of insurance company] therefore were not taking any of their members. [B2, B3 and B4]- Do not accept his insurance. [B7]- Does not service Newark/Bear area. [B5 and B6]- Had no staff during referral period. When speaking to [R6], I encouraged him that as the new	F0627		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0627 SS = D	Continued from page 22 year approaches, he should consider looking into other insurance options that may have better home health availability for any future needs he may have. This conversation took place via phone on 12/19/25. This was the last time I spoke to [R6]. I also let [R6] know that he should contact his PCP [primary care physician] to get an outpatient PT, OT script for continued therapy." The facility failed to ensure R6 had home health services arranged per the discharge plan. 1/12/26 3:30 PM – Findings were reviewed during the exit conference with E1 (Interim NHA) and E2 (DON).	F0627		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §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. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (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 (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.	F0641	Corrective Action: •R46 continues to reside in this facility. The MDS assessments in question have been completed to reflect the changes stated. The MDS nurses have been educated on the requirements for ensuring assessment accuracy. Identification of Other Residents: •All Residents have the potential to be affected. To identify if other residents were affected, a 100% audit of the most recent MDS assessment for all current residents has been completed by the MDS Coordinators to ensure accuracy. No new concerns regarding MDS assessment accuracy were identified from this audit. System Changes: •The Root Cause of the concern was the failure to accurately complete MDS assessment to reflect changes in behavior and medication status. The facility policy for "Comprehensive Assessments and the Care Delivery Process" (revised 12.2016) was reviewed and found to meet professional standards. The Director of Nursing or Designee will complete education for the MDS nurses on the requirements for assessment and documentation accuracy. The assessment in question was completed by an agency MDS nurse who wasn't aware of the changes in behavior and medication. Going forward MDS assessment for changes in status will be completed by the facility MDS staff. The Executive Director will provide oversight to ensure ongoing compliance. Success Evaluation: •An audit of a random sample of 10% of resident MDS assessments will be completed by the Director of Nursing or Designee to ensure MDS assessment accuracy; audits will have a goal of 100% compliance; Audits will	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0641 SS = D	Continued from page 23 §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R46) out of one resident reviewed for PASARR (Preadmission Screening and Resident Review), the facility failed to complete MDS assessments to accurately reflect changes in R46's behavior and medication status. Findings include: Review of R46's clinical record revealed: 11/15/2024 – R46 was admitted to the facility with diagnoses including hypertension and osteoarthritis. 4/29/2025 – A Behavior Note entered in R46's clinical record documented, "[R46] noted agitated sitting around nurse's station…asking roommate to get off his property…[R46] yelling at everyone to vacate his property…". 5/26/2025 9:30 PM – A Behavior Note entered in R46's clinical record documented, "[R46] continues to yell at the nursing station…". 5/29/25 – A quarterly MDS assessment completed for R46 indicated no behaviors of delusions or yelling at others. 8/22/25 9:04 AM – A Behavior Note entered in R46's clinical record documented, "Staff reported that [R46] was aggressive verbally and physically hitting his CNA in the face…aggression started when [R46] was verbally aggressive to another resident, yelling and cursing at her with family present…". 8/25/25 5:34 PM – An Alert Charting Note entered in R46's clinical record stated, "…[R46] is telling other residents to "shut up" or yells profanity at them. [R46] swatted his hand in front of another resident's face…". 9/2/25- R46's quarterly MDS assessment indicated R46 had not exhibited any behaviors consisting of delusions, hitting, threatening or cursing at others. 8/27/25 7:24 PM – A Behavior Note entered in R46's clinical record documented, "[R46] agitated [sic]…talking about someone stealing his truck, cussing at staff members…". 11/3/25 9:02 PM – A Behavior Note entered in R46's	F0641	Continued from page 23 be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team during the monthly QA meeting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0641 SS = D	Continued from page 24 clinical record documented, "[R46] extremely agitated and hostile. [R46] asked this nurse if she had a gun so he could shoot another resident. [R46] yelled profanity towards other residents…". 11/4/25 4:05 PM – A Behavior Note entered in R46's clinical record documented, "[R46] is agitated at this time and yelling profanity at staff and residents…redirection ineffective…". 11/5/25 5:00 PM - Review of R46's Medication Administration Record documented that Depakote Oral Tablet 125 MG, an anticonvulsant medication, was ordered for R46 to be given three times a day. 11/22/25 – R46's annual MDS assessment indicated R46 had not exhibited any verbal behaviors of threatening, screaming, or cursing at others. The assessment also documented that R46 was not taking an anticonvulsant medication. 1/9/26 2:45 PM – During an interview, E5 (MDS Coordinator) stated, "The MDS assessments should have documented [R46]'s hitting, yelling, and cursing behaviors. The Depakote medication should have been documented as an anticonvulsant on the MDS." 1/9/26 2:49 PM – Finding was confirmed with E2 (DON) and E3 (ADON). 1/12/26 3:30 PM – Findings were reviewed with E1(Interim NHA) and E2 during the Exit Conference.	F0641		
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	F0656	Corrective Action: •R94 is no longer a resident of the facility. There was no opportunity for corrective action. R91 continues to reside in the facility. R91's care plan was reviewed and updated to address the resident's refusal to wear a bra when wearing day clothes. Staff members were educated on the need to update care plan for residents according to their needs and preferences. Identification of Other Residents: •All Residents have the potential to be affected. To prevent other residents from being affected, all nursing staff were educated on the requirements for a comprehensive person-centered care plan, as well as compliance with care plan revisions for all residents as needed. A 100% audit of all residents' care plans has been completed. No other residents were affected. System Changes:	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0656 SS = D	Continued from page 25 (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)- (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 observation, interview and record review, it was determined that for one (R94) out of two residents reviewed for catheters and one (R91) out of three residents reviewed for ADLs (Activities of Daily Living), the facility failed to ensure that a person-centered care plan was developed to address each residents' identified needs. Findings include: 1. Review of R94's clinical record revealed: 12/13/25 – R94 was admitted to the facility with a diagnosis of a stroke. 12/15/25 – A physician's order stated to "bladder scan q6 [every 6 hours]. Straight cath if PVR [post void residual] is greater than 400 ml [milli-liters]. Document output every 6 hours."	F0656	Continued from page 25 •The Root Cause of the concern was a failure to ensure that a person-centered care plan was developed to address the identified needs of the residents. The facility policy for "Care Plans, Comprehensive Person-Centered" (rev. 12.2016) was reviewed and found to meet professional standards. The facility system for the weekly interdepartmental "Residents at Risk" meeting has been updated to include a review of the Comprehensive Care Plan for all residents admitted within the last 7 days, all residents due for a quarterly or significant change MDS assessment, and other residents identified as at risk, to ensure that their Care Plan is up to date and with identified interventions in place. The Director of Nursing or Designee will complete education for all nursing staff regarding the policy for Comprehensive person-centered Care Plans. The Executive Director will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial 100% audit of all resident care plans will be completed to ensure that the Care Plan is up to date for all care items such as resident's activities of daily living functions, diagnosis, behaviors, personal preference, orders, goals, interventions, and has been revised appropriately within the last quarter or since significant change. Subsequent audits of a random sample of a minimum of 10% of residents Care Plans will be completed by the Director of Nursing or Designee to ensure that the Care Plan is up to date and reflects person-centered care interventions; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0656 SS = D	Continued from page 26 Review of the R94's care plan lacked evidence of the development to address R94's urinary retention and the approaches on how the facility would meet R94's needs. 1/9/26 3:08 PM – During a combined interview with E2 (DON) and E3 (ADON), finding was reviewed and confirmed. 2. Review of R91's clinical record revealed: 12/16/25 – R91 was admitted to the facility with diagnoses including severe dementia with agitation. 12/17/25 – R91 had a care plan developed for impaired ability to perform or complete activities of daily living for oneself such as dressing, bathing or toileting. Interventions included to provide assistance as needed. 12/22/25 – R91's admission MDS (Minimum Data Set) revealed that R91's cognition was severely impaired with no mood nor behavioral issues. R91 required substantial to maximal assistance of one staff person for upper body dressing including the ability to dress and undress above the waist using fasteners if applicable. 1/5/26 12:49 PM – In an interview, F2 (Family Member) stated, "Every time I come to visit my mom, she does not have her bra on". They [staff] are not putting my mother's bra on her!" 1/7/26 2:30 PM – An observation of R91 in her room sitting in her wheelchair revealed that R91 did not wear a bra. 1/7/26 2:32 PM - In an interview, E13 (CNA) stated, "I did not put her bra on because she refuses and fights back a lot when you put it on her. [R91] would say 'No, I don't want it'." When asked if she notified the nurse, E13 replied, "No, I did not notify the nurse". 1/7/26 2:45 PM – A further review of R91's record lacked evidence that a person-centered care plan was developed to address R91's refusal to wear a bra when wearing day clothes. 1/9/26 3:00 PM – Findings were discussed with E2 (DON) and E3 (ADON). 1/12/263:30 PM – Findings were reviewed with E1 (Interim NHA) and E2 during the Exit Conference.	F0656		
F0657 SS = D	Care Plan Timing and Revision	F0657	Corrective Action:	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0657 SS = D	Continued from page 27 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R80) out of four residents reviewed for respiratory care, the facility failed to review and revise the resident's care plan. Findings include: 8/28/23 – R80 was admitted to the facility. 9/25/25 – R80 was re-admitted to the facility after hospitalization for COVID pneumonia with acute respiratory failure and hypoxia (low oxygen saturation). 9/25/25- E6 (MD) ordered in R80's EMR, "Change mask/cannula and tubing and clean oxygen concentrator filter every night shift every Thursday."	F0657	Continued from page 27 •R80 continues to reside in the facility. R80's care plan was reviewed and revised to include supplemental oxygen use with stated goal and tasks. All nurses were educated on the requirements for care plan timing and revisions. Identification of Other Residents: •All Residents have the potential to be affected. To ensure that other residents are not affected, all nursing staff members were trained in the requirement for care plan review and revision. A 100% audit of all resident care plans was completed, and no other resident was noted to be affected. System Changes: •The Root Cause of the concern was a failure by oversight to review and revise the residents' care plan after he was admitted into the facility from a hospital stay. The resident was not on oxygen prior to the hospital stay. The facility policy for "Care Plans, Comprehensive Person-Centered" (rev. 12.2016) was reviewed and found to meet professional standards. The facility system for the weekly "Residents at Risk" meeting has been updated to include a review and revision of the Care Plan for all residents due for a quarterly or significant change MDS assessment, new admissions, readmissions and other residents identified as "at risk", to ensure that their Care Plan is up to date. The Director of Nursing or Designee will continue to complete education for all nurses regarding Care Plan review and revisions. The executive Director will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial 100% audit of all resident care plans has been completed to ensure that the Care Plan is up to date for all care items capturing Activities of daily living functions, diagnosis, behaviors, personal preferences, medication orders, goals, interventions and has been revised appropriately within the last quarter or since significant change. Subsequent audits of a random sample of a minimum of 10% of residents Care Plans will be completed by the Director of Nursing or Designee to ensure that the Care Plan is up to date and reflect person-centered care interventions; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	**255 POSSUM PARK ROAD , NEWARK, Delaware, 19711**

(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
F0657 SS = D	Continued from page 28 10/1/25 – R80's admission MDS (Minimum Data Set) assessment documented that R80 was using supplemental oxygen. 1/8/26 12:30 PM – A review of R80's care plan lacked evidence of the addition of R80's supplemental oxygen intervention, goals and tasks. 1/8/26 1:11 PM – During an interview, E7 (RNAC) stated, "I don't see any mention of oxygen therapy in [R80]'s care plan. I will add it." The facility failed to revise R80's care plan to include his supplemental oxygen requirement after the 10/1/25 MDS assessment. 1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.	F0657	Continued from page 28 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate supervision for R22, an independent resident who told multiple staff prior to the incident that he wanted to go home. On 11/10/25, R22 self-ambulated his wheelchair from the healthcare area to the independent living front lobby entrance and exited the building without staff knowledge. R22 continued down a main traffic road where the speed limit was 45 miles per hour for 0.3 of a mile and then called 911 where police officers responded. As a result of the inadequate supervision, R22's elopement from 4:50 AM to 5:21 AM had the potential to have a serious outcome, injury or death. An immediate jeopardy past non-compliance was called on 1/8/26 at 9:57 AM. Based on review and confirmation of the actions taken by the facility in response to this incident and no	F0689	"Past Noncompliance - no plan of correction required"	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0689 SS = SQC-J	Continued from page 29 further elopements had occurred, the facility was back in substantial compliance as of 11/15/25. Findings include: Review of R22's clinical record revealed: 7/10/25 – R22 was admitted to the facility for short term rehab with diagnoses that included, but were not limited to orthostatic hypotension, repeated falls and dementia. 7/10/25 10:03 PM – The elopement evaluation by E23 (LPN) documented that R22 was not at risk for elopement. 7/16/25 – The admission MDS assessment revealed that R22 had a BIMS score of 13, which revealed that R22 was cognitively intact, and had no wandering behaviors. 7/17/25 – A follow-up note by E6 (Medical Doctor) documented that R22 "… carries a history of recurrent falls… [R22] was actually asking when he would be able to be discharged… discussed with staff… Will review disposition with case management social services…". 7/17/25 9:38 PM – The elopement evaluation by E23 (LPN) documented that R22 was not at risk for elopement. 7/31/25 10:56 PM – The elopement evaluation by E23 (LPN) documented that R22 was not at risk for elopement. 8/14/25 – A follow-up progress note by E6 (MD) documented that "… Staff reports ongoing issues with impaired daily care and mobility. There was concern regarding his discharge plan… I was contacted by his primary care physician [D4's name] regarding his plan of care. She had concerns regarding his cognitive decline and his capacity for medical decision making. There were concerns regarding his safety at home and discharge planning issues. The patient denied any issues in this regard. At this time he indicates his goal would be to return home where he lives independently. We did discuss concerns regarding his underlying medical conditions and risks of failure…".	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	**255 POSSUM PARK ROAD , NEWARK, Delaware, 19711**

(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
F0689 SS = SQC-J	Continued from page 30 8/28/25 – An acute progress note by E6 (MD) documented that "… Staff reports that patient has completed his course of subacute rehabilitation… There was concern regarding his safety and appropriateness for discharge to home to live alone… Patient with desire to return home to live alone. Some concern regarding patient's ability to fully participate in the medical decision-making process as he may be unaware and fully understanding of the risks associated with his underlying medical conditions…". 9/30/25 3:57 PM – A social services note by E4 (SSD) documented "Spoke to resident today about discharging home tomorrow. Resident has been requesting to return home every day and states he is able to make his own decisions…". 10/1/25 8:24 AM – A discharge note by E4 (SSD) documented "Resident is discharging home where he lives alone. Resident has been requesting to return home…". 10/1/25 9:18 AM – A social services note by E4 (SSD) documented "SW [Social Work] had a meeting… Discussed the safety concerns with resident going home alone. Resident is adamant about going home…". It should be noted that R22 was not discharged from the facility on 10/1/25. 10/15/25 – A follow-up psych evaluation by E24 (NP) documented, "…has a past psychiatric history of anxiety, depression, dementia, cognitive deficit… alert and oriented x 3. Patient reports that he wants to go home, reports that he is sad to be (sic) because it is not where he belongs… has some mild forgetfulness due to dementia…". 10/16/25 9:42 PM – The elopement evaluation by E25 (MDS Coordinator) documented that R22 was not at risk for elopement. 10/22/25 3:12 PM – An activity note by E26 (AD) documented that R22 "sits near the lobby or in the hall from time to time… He states his interest is to go home…".	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0689 SS = SQC-J	Continued from page 31 10/23/25 – A progress note by E6 (MD) documented "... It has been 60 days since patient transition into long-term nursing care... He [R22] continues to focus on his discharge to home. We again had a lengthy discussion regarding safety issues in this regard. The patient carries a history of neurocognitive disorder and is unable to provide daily care to himself...". 11/3/25 11:15 AM – A social services note by E4 (SSD) documented that "... Today, resident [R22] asked for his checkbook and told me he would like to hold it in his room...". 11/10/25 5:02 AM – The police report documented "... I was dispatched to 201 Possum Park Road, Newark DE in reference to check on the welfare (sic). Upon arrival, I made contact with [R22] who advised he does not want to be at Millcroft Living anymore and walked out the door. [R22] stated he did not want to go back because he felt trapped. I responded to 255 Possum Park Road (Millcroft Living) and made contact with nurse [E27] who advised he received a phone call from RECOM advising that a patient has left the facility. I advised [E27] that we have [R22] and another Trooper will be transporting him over. [E27] is unsure how he escaped and I advised him that they should be more careful. [R22] refused any medical treatment...". 11/10/25 8:00 AM – A nurse's note by E27 (LPN) documented, "At approximately 0425 [4:25 AM] hours, I entered resident room to check on resident in B bed and observed resident leaving his room toward the area near the nurses station; he typically sits on a sofa near there. By 0500 [5:00 AM] hours, the resident was not in his usual location near the nurses station. I proceeded to search the building and then reported to the night supervisor, who informed me that he had just received a call indicating the resident exited the building and was in someone's custody. I went outside the building with the supervisor to locate the resident. The resident was brought back to the facility by two police officers and handed over after an interview. Resident (sic) when asked where he was going, he stated, 'I was going home in New Castle Delaware (sic) to come get me'...". 11/10/25 9:21 AM – The elopement evaluation by E28 (RN/UM) documented that R22 was at risk for elopement.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0689 SS = SQC-J	Continued from page 32 Following the elopement incident, the facility took the following immediate actions: -11/10/25 – Evening shift and night shift employees were educated on residents remaining within eyesight during shift if not in their rooms. -11/10/25 8:00 AM – Signs were posted to identify risk of elopement. 30-minute checks for 72 hours and check in and out log was created for R22. -11/10/25 9:57 AM - Physician's order obtained for wanderguard bracelet, applied to left ankle and monitored every shift for placement. -11/10/25 10:00 AM – R22 moved to second floor. -11/10/25 all day – Elopement protocol training. -11/13/25 – Elopement drills on evening and night shifts. -11/14/25 – Elopement drill on day shift. -11/14/25 – Elopement protocol training completed. -11/17/25 – Quality assurance meeting held. Reviewed identified time/location of incident; implemented visual site of all resident out of bed between 11 PM – 7 AM outside of 2-hour bed checks; all residents elopement risk have been updated; elopement evaluations to be completed every 4-weeks post admission; communicate any risk; education completed for all staff on risk identification; and elopement drills completed. 1/7/26 at 1:57 PM – During an interview, E29 (Receptionist) stated that the front entrance of independent living has coverage from 8:30 AM to 8:00 PM. E29 stated that the doors are on a timer and lock at 8:00 PM and the main phone transfers to the healthcare nursing station. E29 stated that no doors lock between the healthcare area and the independent living front entrance lobby. 1/7/26 2:05 PM – During an interview, E30 (Maintenance Director) stated that the front entrance door of independent living locks from the outside, not the inside. E30 stated that nobody can get in, but anybody can get out. 1/7/26 2:15 PM – During an interview, E2 (DON)	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0689 SS = SQC-J	Continued from page 33 confirmed that he and E30 watched the facility video of the 11/10/25 elopement and E2 documented the timeline that was provided to the surveyor. The 11/10/25 timeline was: "4:45 AM – [R22] Exited room & [and] goes past the nursing station. 4:48 AM – Goes into IL [independent living] hallway. 4:50 AM – [R22] Left the building. 5:21 AM – Police enter building. 5:28 AM – Nurse met them. 5:42 AM – Escorted [R22] back to his room." 1/7/26 2:55 PM – During a combined interview, E2 and E3 (ADON) confirmed that there have not been any elopements since the 11/10/25 incident involving R22. 1/7/26 2:28 PM – Observation of the front entrance door of independent living revealed that it is a fire exit door and has a sign "in emergency push to open". 1/8/26 9:57 AM – An immediate jeopardy was called in the presence of E1 (Interim NHA), E2 and E3 regarding the 11/10/25 elopement of R22. Based on the immediate actions taken by the facility, no further elopements occurred, and interventions verified by the surveyor onsite during this survey, this incident was past non-compliance. 1/12/25 3:30 PM – Finding was reviewed during the exit conference with E1 and E2.	F0689		
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.	F0695	Corrective Action: •R80 continues to reside in the facility. Corrective actions have been ensured by the Director of Nursing. The supplemental Oxygen tubing was immediately replaced when the surveyors pointed out this deficiency. All nurses were educated on the need to ensure that Oxygen tubing's are changed when due and according to the physician order. Identification of Other Residents: •All Residents on supplemental oxygen have the	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0695 SS = D	Continued from page 34 This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation and interview, it was determined that for one (R80) out of four residents reviewed for respiratory care, the facility failed to provide care consistent with professional standards as the supplemental oxygen tubing was out-of-date. Findings include: 8/28/23 – R80 was admitted to the facility. 9/25/25 – R80 was re-admitted to the facility after hospitalization for COVID pneumonia with acute respiratory failure and hypoxia (low oxygen saturation). 9/25/25- E6 (MD) ordered in R80's EMR, "Change mask/cannula and tubing and clean oxygen concentrator filter every night shift every Thursday." 9/25/25 10:51 PM – R80's alert charting note documented, "Resident arrived at facility via stretcher on oxygen 2L (liters) via nasal cannula…". 1/5/26 (Monday) 2:15 PM – An observation of R80's supplemental oxygen tubing revealed that it was marked as having been changed on 12/26/25 (11 days prior). 1/8/26 (Thursday) 1:11 PM – An observation of R80's supplemental oxygen tubing revealed that it was marked as having been changed on 12/26/25 (14 days prior). 1/9/26 1:37 PM - An observation of R80's supplemental oxygen tubing revealed that it was marked as having been changed on 12/26/25 (15 days prior). The facility failed to provide care consistent with professional standards by failing to replace R80's supplemental oxygen tubing after seven days. 1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.	F0695	Continued from page 34 potential to be affected. A 100% audit of all residents with Oxygen was completed to ensure that all the tubing's were changed when they were due to be changed. No other residents were affected by this deficiency. System Changes: •The Root Cause of the concern was a failure to provide care consistent with professional standards for the supplemental oxygen tubing that was out-of-date. The facility policy for "Departmental (Respiratory Therapy) – Prevention of Infection" (rev.11.2011) was reviewed and found to meet professional standard. The facility system for managing oxygen administration has been updated to include weekly IDT rounds to observe residents with oxygen and ensure that the Oxygen tubing's are changed when due. All supplemental Oxygen tubing's are scheduled to be changed every Thursday on 11-7 shift for uniformity. The Executive Director and the nursing management team will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial 100% audit of all residents with supplemental Oxygen to ensure that Oxygen tubing's are changed when due will be completed; then, an audit of a random sample of 10% of residents with oxygen will be completed by the Director of Nursing or Designee to ensure compliance; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	
F0745 SS = D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is NOT MET as evidenced by:	F0745	Corrective Action: •R22 continues to reside in the facility. Corrective actions have been taken by the Director of Social Services. The resident's nephew who is listed on his Advance Directives as his power of attorney has agreed to be responsible for him and act as his power of attorney going forward. The Director of Social services has been educated on steps to take when there is a change in the power of attorney for residents.	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0745 SS = D	Continued from page 35 Based on record review and interview, it was determined that for one (R22) out of four residents reviewed for accidents, the facility failed to ensure that R22 received medically-related social services, when it was determined that the resident lacked capacity for medical decision making in F6's (MD) progress note dated 11/10/25. Findings include: The facility's job description of Social Worker, updated July 2015, included, but were not limited to the following job duties: -"... 2. Assists with the coordination of Health Center admissions... 9. Maintains regular and on-going relationship with family to discuss needs or concerns, mediates issues that may arise between resident/family/staff...". Cross refer to F553 example #1 and F561 example #1 Review of R22's record revealed: 9/21/25 – A typewritten letter from F5 (R22's POA/friend) to R22 stated, "September 21, 2025... [R22's name] As you have informed me, in a few days you'll be returning to your home. You've asked me for keys and I am enclosing the set you gave me some time ago... I am reminding you I will no longer be available for assistance effective date of this letter. I am officially retiring... I wish you the best in your journey ahead and hope you can find another assistant that gives as much as I have tried to do...". 9/30/25 3:57 PM – A social services note by E4 (SSD) documented, "... Resident states his POA [F5's name] is trying to keep him from returning home and it's his right to return home if he wants. POA [F5] had provided a letter to resident stating that she is handling over his keys to him and does not want to be involved in his care as she is retired... Called and left a message for POA [F5's name] to inform her of the discharge as well. No return phone call." It should be noted that R22 was not discharged from the facility. 10/20/25 – R22's printed facesheet revealed that F5	F0745	Continued from page 35 Identification of Other Residents: •All Residents have the potential to be affected. A 100% audit of all residents was completed, and no other resident was found with this deficiency. System Changes: •The Root Cause of the concern was a failure of the facility to provide medically related social services to the resident. The facility policy for "Advance Directives" (rev.12.2016) and "Resident Representative" (rev. 2.2021) was reviewed and found to meet professional standard. The facility system for reviewing all residents' profiles has been updated to include quarterly review of residents Advance Directives by the Director of Social services or designee in order to monitor changes and the accuracy of the Power of Attorney listed. The Executive Director or designee will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial 100% audit of all residents will be completed for capacity of decision making, identification of decision maker, Copy of Advanced directives on file, and evidence of discharge planning, ; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0745 SS = D	Continued from page 36 continued to be listed as R22's POA despite the 9/21/25 letter that F5 would no longer be available for assistance. There was no evidence of follow-up by social services in response to F5's 9/21/25 letter. 11/10/25 – An acute progress note by E6 (Medical Director) documented, "… He [R22] remains frustrated and angry about being in this facility. We have had multiple discussions in the past regarding his disposition and the discharge planning process. We have discussed multiple times that he is unsafe to live at home alone. Unfortunately, he does not have any options in regards to help at home. He became somewhat agitated during our meeting and refused to answer additional questions regarding his condition… Encounter for assessment of decision-making capacity. Patient does not possess medical capacity to fully partake in medical decision making process. Patient with poor insight and unaware of safety risks. Patient unable to live at home alone without 24-hour supervision. Patient with recent elopement earlier this morning and was found off facility grounds down the street… Patient unable to provide details in regards to this elopement. Social services will continue to work with patient and any family members regarding disposition and ultimate discharge planning process…". The facility lacked evidence of social services follow-up to the 11/10/25 determination of R22's incapacity for medical decision making. 1/5/26 1:07 PM – A copy of R22's current facesheet revealed that F5 continued to be listed as R22's POA-Care despite the 9/21/25 letter provided to R22 and given to the facility stating that she would not be available going forward. The facesheet also listed F8 (R22's family member), but it did not identify F8 as a POA contact. 1/9/25 1:00 PM - During an interview, surveyor asked E2 (DON) for a copy of R22's POA document as it was not in his electronic clinical record. In response, the facility handed the surveyor a copy of an attorney's office cover letter only, dated 8/17/18, that stated the following, "… I am enclosing a copy of a durable power of attorney [DPOA] which give (sic) [F8's first name only, F6's first name only, F5's first name only,	F0745		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0745 SS = D	Continued from page 37 and F9's first name only] the power to act for you, individually or jointly, effective immediately… This document gives [F8's first name, F6's first name, F5's first name, and F9's first name] the power to make health care decisions for you…". It was confirmed that the facility failed to obtain a copy of the actual legal document to confirm the resident's four DPOAs with full names listed, which included F8 (R22's only family member). 1/12/26 3:30 PM – Finding was reviewed during the exit conference with E1 (Interim NHA) and E2.	F0745		
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. 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	F0791	Corrective Action: •R3 continues to reside in the facility. Corrective actions have been ensured by the Director of Nursing. The resident was seen and treated by the facility dental provider on 1/11/2026. The family will notify staff of any outpatient services that they would like the facility to facilitate going forward. Identification of Other Residents: •All Residents have the potential to be affected. A 100% audit of all residents was completed, and no other residents were found to be affected. System Changes: •The Root Cause of the concern was a failure to provide or obtain outside resources for routine dental services for the residents. The facility policy for ""Dental Services" (rev. 12.2016) was reviewed and found to meet professional standards. The facility system for routine/emergency dental services has been updated to include a weekly oral assessment of the residents on their shower days and a monthly review of all residents at the IDT risk meeting of the first Tuesday of every month to identify those in need of dental services. The Director of nursing or designee will assist residents with appointments for dental services. The Executive Director will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial 100% audit of all residents will be completed for dental care needs, consent for dental care and confirmed appointment for dental care; Audits	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	**255 POSSUM PARK ROAD , NEWARK, Delaware, 19711**

(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
F0791 SS = D	Continued from page 38 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 interview and record review, it was determined that for one (R3) out of two residents reviewed for dental services, the facility failed to provide or obtain from an outside resource, R3's routine dental services. Findings include: Cross refer F553 and F656 Review of R3's clinical record revealed: 12/15/25 – R3's quarterly MDS assessment revealed that R3 had a BIMS score of 15 and an intact cognition. 1/5/26 1:35 PM – In an interview, R3 stated that it has been a long time since she was last seen by the dentist. R3 stated, "I did not know that I can be seen by a dentist here in the facility." 1/9/26 11:10 AM – Further review of R3's clinical records lacked evidence of dental consults and appointments for 2025. 1/9/26 11:30 AM - In a telephone interview, F3 (Family Member and POA) stated that she and R3 prefer to set up the appointments and transportation services for R3's outside facility consultations and that included an unsuccessful dental clinic visit. When asked if R3 was seen by the dentist lately, F3 stated that R3 was all set up for the dental visit one time but the dentist (not identified) did not see R3. F3 stated, "The dental clinic was very tight, the place for her to sit could not accommodate [R3's] motorized chair. [R3] was not seen at all. I am wondering if the facility has a dentist that visits the place so [R3] will not have the same accommodation issue again."	F0791	Continued from page 38 will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0791 SS = D	Continued from page 39 1/9/26 11:50 AM - During an interview, E3 (ADON) stated she was aware that R3 canceled her dental appointment in the past. E3 also stated that she was aware of the accessibility issue of R3's motorized chair when R3 went out to the dental clinic. E3 stated, "I was just talking to [F3] on the phone now, and I told her we have a dentist [D3] who comes to the facility and he can see [R3]." 1/9/25 2:30 PM – In a follow up interview, E3 reported to the surveyor that D3 will see R3 for dental consultation on Sunday, 1/17/26. 1/12/26 3:30 PM – Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.	F0791		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (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. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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 foodborne illness to the residents, in reference to the FDA Food Code. Findings include:	F0812	Corrective Action: •Corrective actions have been taken by the Food and Beverage Director. All undated food items and moldy food were removed from the walk-in freezer and thrown away. The Food and Beverage Director or designee will check the freezer daily for undated and moldy food items. All kitchen staff have been educated on making sure that all open food items in the walk-in freezer are dated and free of mold. Identification of Other Residents: •All Residents have the potential to be affected. To prevent other residents from being affected, the food and beverage director or designee will ensure that a daily check of the freezer and other food storage area is completed, and all undated and moldy food items are removed. System Changes: •The Root Cause of the concern was a failure to ensure that the food items in the walk-in freezer were dated and without mold. The facility system for food storage in the kitchen has been updated to include daily documented rounds and audits by the Food and Beverage Director or designee to ensure that there are no undated or moldy food items in the walk-in freezer or any other storage in the kitchen. A copy of the documented audit will be provided to the Executive Director daily. The facility policy for "Preventing Foodborne Illness – Employee Hygiene and Sanitary Practices" (rev. 10.2017) was reviewed and found to meet professional standards. The Food and Beverage Director or Designee will complete education for all	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0812 SS = E	Continued from page 40 1/7/26 9:40 AM – During a kitchen tour with E31 (Director of Food and Beverages), the surveyor observed multiple open food items in the walk in freezer that were not dated. The undated items included one bag of potato French fries, one bag of uncooked sweet potato fries, three bags of dinner rolls, three bags of bagels (one of which contained a moldy bagel), three bags of English muffins, and seven bags of sliced wheat bread. 1/7/26 4:15 PM – The findings were reviewed with E1 (Interim NHA).	F0812	Continued from page 40 dietary staff regarding appropriate standards for kitchen food storage. The Executive Director will provide oversight to ensure compliance going forward. Success Evaluation: •A food service sanitation audit to ensure compliance regarding kitchen storage standards, which include ensuring that all open food items are dated and not moldy will be completed by the Food and Beverage Director or designee; Audits will have a goal of 100% compliance; Audits will be completed daily until 100% compliance is achieved for 3 consecutive evaluations, then 3 times a week until 100% compliance is achieved for 3 consecutive evaluations, then weekly until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team at the monthly Quality Assurance meeting.	
F0837 SS = C	Governing Body CFR(s): 483.70(d)(1)-(3) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. §483.70(d)(3) The governing body is responsible and accountable for the QAPI program, in accordance with §483.75(f). This REQUIREMENT is NOT MET as evidenced by: Based on interview and facility record review, it was	F0837	Corrective Action: •The facility has taken immediate steps to ensure the governing body is established, documented, and actively responsible for the management and oversight of the facility. On 1/15/26, the facility obtained and compiled the official list of governing body members, including names, titles, and contact information. Documentation verifying the governing body structure and oversight responsibilities has been created and implemented. The governing body has formally appointed the Administrator as responsible for the day-to-day management of the facility and confirmed accountability and reporting structure. Identification of Other Residents: •All residents have the potential to be affected by this deficient practice; however, no residents experienced negative outcomes related to this finding. System Changes: The root cause of concern was failure to provide evidence that the facility has an active governing body that is responsible for establishing and implementing policies regarding the management of the facility. To ensure ongoing compliance with §483.70(d): •A Governing Body Roster and Contact List has been created and placed in the Administrator office and	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0837 SS = C	Continued from page 41 determined that the facility failed to ensure that it has an active governing body that is responsible for establishing and implementing policies regarding the management of the facility. Findings include: Review of facility documents revealed: 12/15/25 – A Bill of Sale between O1(former facility owner) and O2 (new facility owner) was made and entered into. 1/12/26 9:00 AM – A request for the names and contact information of the members of the governing body was made to E1 (Interim NHA). 1/12/26 2:46 PM – E1 confirmed that the facility did not have the names and contact information of the members of the governing body. 1/12/26 3:30 PM – Findings were reviewed with E1 and E2 (DON) during the Exit Conference.	F0837	Continued from page 41 Survey Readiness Binder. A Governing Body Policy was developed and implemented outlining: •Roles and responsibilities of the governing body •Executive Director appointment and accountability structure •Oversight of policies and facility operations •Oversight and accountability of the QAPI program The governing body will meet at least quarterly to review: •Facility operations •QAPI reports and performance improvement activities •Regulatory compliance and policy implementation Meeting minutes will be documented and maintained. •The Executive Director and Director of Nursing were educated on governing body documentation and regulatory requirements on 1/15/26. The Executive Director or designee will provide oversight to ensure ongoing compliance. Success Evaluation: The Executive Director/Administrator will audit compliance monthly until 100% compliance is achieved for 3 consecutive months: •Governing body roster remains current •Quarterly meeting schedule is maintained •Meeting minutes are completed and retained Additional audits will be completed as needed based upon level of compliance. Audits will be reviewed at the Quarterly QAPI meeting.	
F0838 SS = F	Facility Assessment CFR(s): 483.71(a)(1)(3)(b)(1)(c)(1)-(5) §483.71 Facility assessment.	F0838	Corrective Action: The facility completed a full review and update of the Facility Assessment. All required addendums and supporting documentation were developed and attached, including the PBJ report, staff certification	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	**255 POSSUM PARK ROAD , NEWARK, Delaware, 19711**

(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
F0838 SS = F	Continued from page 42 The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. §483.71(a) The facility assessment must address or include the following: §483.71(a)(1) The facility's resident population, including, but not limited to: (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population, using evidence-based, data-driven "methods" that considering the types of diseases, conditions, physical and behavioral health needs, cognitive disabilities, overall acuity, and other pertinent facts that are present within that population, consistent with and informed by individual resident assessments as required under § 483.20; (iii) The staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population; (iv)The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.71(a)(2) The facility's resources, including but not limited to the following: (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, behavioral health, and specific	F0838	Continued from page 42 requirements, education schedule summary, infection control risk assessment, inventory listing, emergency preparedness/all hazards risk assessment, HIPAA security compliance information, authorization for disclosure policy, and updated facility profile. The revised assessment was reviewed and approved by the Administrator, Director of Nursing, and Governing Body. Identification of Other Residents: Because the Facility Assessment applies to the entire resident population, all residents had the potential to be affected. A facility-wide review of resources, staffing, competencies, emergency preparedness, and infection control processes was conducted to ensure the assessment accurately reflects the current resident population and services provided. System Changes: The root cause of concern was failure to provide evidence that the facility assessment had all documentation and was updated. The facility implemented a Facility Assessment policy requiring the assessment to be reviewed and updated at least annually and whenever there is a significant organizational or operational change. A standardized Facility Assessment binder and attachment checklist were implemented to ensure all required supporting documents are maintained. The Facility Assessment will be reviewed quarterly in QAPI and PBJ staffing data will be incorporated into staffing and competency planning. The executive Director or designee will provide oversight to ensure ongoing compliance. Success Evaluation: The facility assessment tool will be reviewed by Executive Director/Designee monthly until 100% compliance is achieved for 3 consecutive months, then quarterly to ensure completeness and accuracy to ensure 100% compliance is achieved Additional audits will be completed as needed based upon level of compliance. Audits will be reviewed at the Quarterly QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0838 SS = F	Continued from page 43 rehabilitation therapies; (iv) All personnel, including managers, nursing and other direct care staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.71(a)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach as required in §483.73(a)(1). § 483.71(b) In conducting the facility assessment, the facility must ensure: § 483.71(b)(1) Active involvement of the following participants in the process: (i) Nursing home leadership and management, including but not limited to, a member of the governing body, the medical director, an administrator, and the director of nursing; and (ii) Direct care staff, including but not limited to, RNs, LPNs/LVNs, NAs, and representatives of the direct care staff, if applicable. (iii) The facility must also solicit and consider input received from residents, resident representatives, and family members. §483.71(c) The facility must use this facility assessment to: §483.71(c)(1) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care as required in § 483.35(a)(3).	F0838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0838 SS = F	Continued from page 44 §483.71(c)(2) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. §483.71(c)(3) Consider specific staffing needs for each shift, such as day, evening, night, and adjust as necessary based on any changes to its resident population. §483.71(c)(4) Develop and maintain a plan to maximize recruitment and retention of direct care staff. §483.71(c)(5) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and facility record review, it was determined that the facility failed to ensure that it had a documented and updated facility assessment that included the conditions in the addendum. Findings include: Review of facility documents revealed: 1/5/26 – A Significant Organizational Change facility assessment tool was completed by E1 (Interim NHA). 1/9/26 3:00 PM – A review of the facility assessment tool lacked evidence that the following addendums were included and attached in the assessment: - Facility - Payroll Based Journal Report - Staff Certification Requirements - Education Schedule Summary - Infection Control Risk Assessment - Inventory Listing - All Hazards Risk Assessment/Emergency Preparedness Plan	F0838		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0838 SS = F	Continued from page 45 - HIPAA Security Compliance Information - Authorization for Disclosure Policy & Procedure 1/12/26 9:00 AM – A request for the attachments to the addendum was made to E1 (Interim NHA). 1/12/26 2:46 PM – E1 confirmed that the facility did not have the attachments to the facility assessment addendum. 1/12/26 3:30 PM – Findings were reviewed with E1 and E2 (DON) during the Exit Conference.	F0838		
F0843 SS = D	Transfer Agreement CFR(s): 483.70(i)(1)(2) §483.70(i) Transfer agreement. §483.70(i)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(i)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.	F0843	Corrective Action: Corrective action was ensured by the Executive Director. A transfer agreement was prepared and sent to all the facilities approved for participation under the Medicare and Medicaid programs where this facility transfers residents for medical care to ensure timely admission when transfer is medically necessary. Identification of Other Residents: All residents have the potential to be affected, but none was affected by this deficiency. System Changes: The Root Cause of this concern was a failure to that the facility had a written transfer agreement in effect with one or more hospitals approved for participation in Medicare/Medicaid programs. The facility system for annual renewal of contracts and agreements with stakeholders was reviewed and updated to include a written transfer agreement between this facility and other facilities where we send our residents for medical care. The facility policy for "Facility Transfer Agreement" (rev.2.2026) was reviewed and found to meet professional standards. The Executive Director or Designee will provide oversight to ensure ongoing compliance. Success Evaluation: Since renewal of the agreement is on a yearly basis, a yearly audit of the facility Transfer Agreement will be completed by the Executive Director or Designee every	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0843 SS = D	Continued from page 46 This REQUIREMENT is NOT MET as evidenced by: Based on interview and facility record review, it was determined that the facility failed to ensure that it had a written transfer agreement in effect with one or more hospitals approved for participation in Medicare/Medicaid programs. Findings include: Review of facility documents revealed: 12/15/25 – A Bill of Sale between O1(former facility owner) and O2 (new facility owner) was made and entered into. 1/12/26 9:00 AM – A request for the facility's written transfer agreement was made to E1 (Interim NHA). 1/12/26 2:46 PM – E1 confirmed that the facility did not have a written transfer agreement. 1/12/26 3:30 PM – Findings were reviewed with E1 and E2 (DON) during the Exit Conference.	F0843	Continued from page 46 January to ensure compliance. The result of the audit will be reviewed by the Quality Assurance Team at the first Quality Assurance meeting of every year.	
F0844 SS = D	Disclosure of Ownership Requirements CFR(s): 483.70(j)(1)-(3) §483.70(j) Disclosure of ownership. §483.70(j)(1) The facility must comply with the disclosure requirements of §420.206 and 455.104 of this chapter. §483.70(j)(2) The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in- (i) Persons with an ownership or control interest, as defined in §§420.201 and 455.101 of this chapter; (ii) The officers, directors, agents, or managing employees; (iii) The corporation, association, or other company responsible for the management of the facility; or (iv) The facility's administrator or director of nursing. §483.70(j)(3) The notice specified in paragraph (k)(2) of this section must include the identity of each new	F0844	Corrective Action: Corrective action was ensured by the Executive Director. A copy of the disclosure of ownership is presently on file in the facility. A written notice was sent to the state agency responsible for licensing in the state of Delaware that identifies the new owner of the facility on 1/13/2026. Identification of other Residents: All residents have the potential to be affected. No residents were affected by the deficiency. System Changes: The Root Cause of this concern was a failure to ensure that the facility was in compliance with the disclosure of ownership requirements. The facility will make sure that in the future a timely written notice is forwarded to the state's licensing agency whenever there is a change in any principal officer, controlling interest, or ownership of the facility. All Changes in principal officers, controlling interests or ownership will be discussed at the facility monthly QAPI meeting to identify non-compliance, and the Executive Director or designee will provide oversight to ensure ongoing compliance. Success Evaluation:	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0844 SS = D	Continued from page 47 individual or company. This REQUIREMENT is NOT MET as evidenced by: Based on interview and facility record review, it was determined that the facility failed to ensure that it has complied with the disclosure of ownership requirements. Findings include: Review of facility documents revealed: 12/15/25 – A Bill of Sale between O1(former facility owner) and O2 (new facility owner) was made and entered into. 1/12/26 9:00 AM – A request for the facility's written notice to the State Agency responsible for licensing with disclosure requirements at the time of change was made to E1 (Interim NHA). 1/12/26 2:46 PM – E1 confirmed that the facility did not have the document with the facility disclosure of ownership requirements. 1/12/26 3:30 PM – Findings were reviewed with E1 and E2 (DON) during the Exit Conference.	F0844	Continued from page 47 Since the Disclosure of ownership is only required when there is a change in principal officers, controlling interest, or ownership of the facility, an audit will be completed monthly at the facility by the Executive Director or designee to identify changes in principal officers, controlling interest, and ownership and the notification of all the necessary bodies of such changes. Audit goal will be 100% compliance. The result of the audit will be reviewed by the quality Assurance Team at the monthly Quality Assurance meetings.	
F0880 SS = F	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;	F0880	Corrective Action: •Corrective actions have been completed by the Executive Director for this deficiency. The smaller auxiliary room in the laundry area will henceforth be used as a hold area for dirty linen and clothes. All washing would be done in the main washing room. Drying, folding and storage will take place in the room that has the dryers from where clean linens and resident's personal clothes will be returned to the floors. The laundry aides were educated on the new pattern of workflow to prevent cross contamination of laundry. Identification of Other Residents: •All Residents have the potential to be affected. No resident was identified as having become infected from cross contamination of laundry items. System Changes: •The Root Cause of the concern was the failure to handle, store, process, and transport linens in the laundry room to prevent the spread of infection. The facility system for handling laundry from holding dirty laundry to processing, storage and transport has been reviewed to include not using the small auxiliary room	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0880 SS = F	Continued from page 48 §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: (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.	F0880	Continued from page 48 in the laundry area for clean laundry going forward and using the designated clean laundry room for all storage and transporting of clean items to the floor. The facility policy "Departmental (Environmental Services) – Laundry and Linen" (rev. 1.2014) was reviewed and found to meet professional standards. The Director of Housekeeping or Designee will complete education for all laundry staff regarding the requirements for keeping dirty laundry separate from clean laundry in other to prevent infection. The Executive Director will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial audit of the laundry area will be completed by the Director of Housekeeping or Designee; Audits will have a goal of 100% compliance; Audits will then be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team during the monthly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0880 SS = F	Continued from page 49 This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to handle, store, process, and transport laundry in a manner that prevents cross contamination. Findings include: 1/7/26, 10:30 AM – During a laundry tour with E32 (Housekeeping Staff), the surveyor observed that a smaller auxiliary laundry room was located adjacent to the main washer/dirty room, with its only entrance/exit door opening directly into the dirty laundry area. The smaller room contained a household type washers and dryers. The door to this room was open at the time of the observation. E32 stated that personal clothing for residents is washed and dried in this smaller room, and that clean laundry is then transported out through the main washer/dirty room. E32 reported that this practice has been in place for years. A designated clean laundry room exists on the opposite side of the main washer room; however, it was not being used for the processing or transport of these personal clothing items. 1/7/26 4:15 PM – The findings were reviewed with E1 (Interim NHA).	F0880		
F0881 SS = E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for four (R3, R4, R39, R87) out of six reviewed for infection control, the facility failed to maintain an infection control program that obtained and documented on the monthly line listing the organism being treated by antibiotics. Findings include:	F0881	Corrective Action: •R3 and R39 continue to reside in the facility. R4 and R87 are no longer residents of the facility and there was no opportunity for corrective measures for them. Corrective actions have been ensured by the Director of Nursing for R3 and R39. An updated line list was completed that included the type of organisms that was treated with anti-biotics. The Staff Development coordinator, who is also the Infection preventionist, was educated on the proper completion of the monthly line list for infections. Identification of Other Residents: •All Residents have the potential to be affected. An initial 100% audit of all monthly line list for the last 6 months was completed and updated to include organisms being treated by Antibiotics. Going forward all monthly line list will include organisms being treated with antibiotics. System Changes:	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0881 SS = E	Continued from page 50 1. Review of R3's clinical record revealed: 9/7/23 – R3 was admitted to the facility with diagnoses including but not limited to multiple sclerosis and neurogenic bladder with an indwelling suprapubic catheter. 12/31/25- R3's EMR Follow Up note documented, "…Patient seen for follow-up status post recent emergency room visit…She [R3] was recently seen in the emergency room for UTI (urinary tract infection) and continues on antibiotics at this time." 1/8/26 11:41 AM – A review of the December 2025 infection control line listing revealed documentation of R3 receiving Cefpodoxime (an antibiotic) from 12/30/25 to 1/4/26. There was no documentation of the organism being treated on the line listing. 1/8/26 1:15 PM – During an interview, E10 (Infection Preventionist) confirmed that the facility had not followed up with the emergency room to ascertain the urinary tract organism that R3 was being treated for. The facility failed to obtain and document the organism being treated with antibiotics as required for their infection surveillance program. 2. Review of R4's clinical record revealed: 9/25/25 – R4 was admitted to the facility with diagnoses including but not limited to dementia. 1/8/26 11:45 AM – A review of the October 2025 infection control line listing revealed documentation of R4 receiving ciprofloxacin (an antibiotic) from 10/6/25 to 10/13/25. There was no documentation of the organism being treated in the line listing. The facility failed to obtain and document the organism being treated with antibiotics as required for their infection surveillance program. 3. Review of R39's clinical record revealed: 11/10/22 - R39 was admitted to the facility with diagnoses including, but not limited to, non-Hodgkin lymphoma. 11/27/25 – E11 (NP) documented in R39's EMR progress notes, "…He [R39] follows with Urology and had a urinalysis done and positive for UTI with recommendations for amoxicillin x 7 days."	F0881	Continued from page 50 •The Root Cause of the concern was a failure to maintain an infection control program that documented on the monthly line listing the organism being treated with antibiotics. The facility policy for "Antibiotic Stewardship – Review and Surveillance of Antibiotic Use and Outcomes" (rev. 12.2016) was reviewed and found to meet professional standards. The Infection Preventionist will ensure that the line list includes organisms identified as causing an infection going forward. The line list format was updated to include column to document causative agents of any infection in the facility. The facility system for completing the monthly line listing will include a weekly review of the list by the Director of Nursing or designee to ensure documentation of organisms being treated on the line list going forward. The Infection preventionist will submit a copy of the line list as part of her weekly report to the director of nursing every Friday for review. The Executive Director or designee will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial 100% audit of line list in the last 6 months will be completed. Any new concerns identified by this audit will be corrected upon discovery; Audits will have a goal of 100% compliance; Subsequent Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0881 SS = E	Continued from page 51 1/8/26 11:48 AM – A review of the November 2025 infection control line listing revealed documentation of R39 receiving amoxicillin from 11/25/25 to 12/2/25. There was no documentation of the organism being treated on the line listing. 1/8/26 1:15 PM – During an interview, E10 (Infection Preventionist) stated that the facility uses McGeer's criteria for antibiotic stewardship. 1/8/25 2:10 PM – A review of R39's EMR lacked documentation of symptoms that support prescribing an antibiotic according to the McGeer Criteria for Infection Surveillance. R39's documented vital signs showed no evidence of a fever at any time during the month of November 2025. R39 had not documented lab work since August 2025, so there were no documented leukocytosis or microbiologic urine specimen results. 1/8/26 1:15 PM – During an interview, E10 confirmed that the facility had not followed up with the urology practice to ascertain the urinary tract organism that R39 was being treated for. The facility failed to obtain and document the organism being treated with antibiotics as required for their infection surveillance program. 4. A review of R87's clinical record revealed: 6/2/24 – R87 was admitted to the facility with diagnoses including, but not limited to, pancreatic cancer. 1/8/26/12:01 PM - A review of the November 2025 infection control line listing revealed documentation of R87 receiving doxycycline from 11/25/25 to 11/29/25. There was no documentation of the organism being treated on the line listing. The facility failed to obtain and document the organism being treated with antibiotics as required for their infection surveillance program. 1/8/26 11:30 AM – A review of the October, November, and December 2025 infection control line listing revealed multiple urinary tract infections documented as being treated with antibiotics without documentation of the pathogen/organism. -October 2025 Infection control line listing had four UTIs that were treated with antibiotics; only one listing named the organism.	F0881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0881 SS = E	Continued from page 52 -November 2025 infection control line listing documented seven UTIs that were treated with antibiotics; only two listings named the pathogen. -December 2025 infection control line listing documented three UTIs treated with antibiotics; only one of the listings named the organism. 1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.	F0881		
F0909 SS = D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, it was determined that for one (R94) out of four residents reviewed for accidents, the facility failed to ensure R94's bilateral bed rails were being included in a routine maintenance safety check. Findings include: Review 94's clinical record revealed: 1/5/26 2:11 PM - Observation of bilateral bed rails positioned up on R94's bed. 1/9/26 9:49 AM - Observation of R94 in bed revealed bilateral bed rails positioned up and no gap. R94 confirmed that he used them during therapy sessions. 1/9/26 10:13 AM - During an interview, E30 (Maintenance Director) was asked if there are routine maintenance/safety inspections of bed rails being performed in the facility. He stated no, but he would start doing this. E30 stated that maintenance staff would apply resident bed rails when the request was submitted through the maintenance work order system. He also stated that therapy would remove bed rails if they were no longer necessary.	F0909	Corrective Action: •R94 continues to reside in the facility. Corrective actions have been ensured by the Executive Director. R94's bed frame, mattress and bed frame were inspected for compatibility and were found to be compatible. The Director of Environmental services and his staff members were educated on periodic inspection of all beds, mattresses and bed rails and any defect to be reported to the Executive Director. Identification of Other Residents: •All Residents have the potential to be affected. The Director of Environmental Services, or designee will ensure that all the beds in the facility were checked for compatibility with the mattresses, and the side rails. All were found to be compatible. System Changes: •The Root Cause of the concern was a failure to ensure that bilateral rails were included in routine maintenance safety checks. The facility system for routine maintenance safety checks for beds has been updated to include a quarterly check of all beds by the Director of Environmental Services or designee. The checks will focus on safety and compatibility of the beds with the mattresses and side rails. The facility policy for "Bed Safety" (rev. 12.2007) was reviewed and found to meet professional standards. The Executive Director or the Staff Development Coordinator will complete education for the Director of Environmental Services and all maintenance staff regarding routine maintenance safety checks for all beds with bed rails using the FDA's "A Guide to Bed Safety, Bed rails in Hospitals, Nursing Homes and Home Health care: The Facts" from fda.gov. The Executive	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0909 SS = D	Continued from page 53 1/12/26 3:30 PM - Finding was reviewed during the exit conference with E1 (Interim NHA) and E2 (DON).	F0909	Continued from page 53 Director or Designee will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial audit of 100% of the beds in the facility was completed to ensure that the bed, mattress and bed rail are compatible and safe ; Audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team at the monthly Quality Assurance meeting.	
F0941 SS = D	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documentation, it was determined that for seven (E14, E15, E16, E17, E18, E19, and E21) out of seven facility staff reviewed, the facility failed to ensure that the required Communications training was completed. Findings include: 1/12/26 1:30 PM – Review of the facility training records revealed a lack of evidence of Communications training for the following facility staff: 2/4/25 - E14's first day in the facility as RN (Registered Nurse). 4/1/25 – E15's first day in the facility as RN. 3/18/25 – E16's first day in the facility as CNA (Certified Nurse Aide). 9/16/25 – E17's first day in the facility as CNA. 6/10/25 – E18's first day in the facility as CNA.	F0941	Corrective Action: •Corrective measures have been ensured by the Director of Nursing for this deficiency. Staff communication training was completed for all staff members. The Staff Development coordinator was educated on the need to complete all state-required training and education for all employees in the facility. Identification of Other Residents: •All Residents have the potential to be affected. No residents were affected by this deficiency. A 100% audit of all staff members was completed, and the required communication training was completed for all staff. System Changes: •The Root Cause of the concern was the failure of the facility to ensure that the required communication training was completed for staff members. The facility policy for "Staff Development Program" (rev. 5.2019) were reviewed and found to meet professional standards. The system for onboarding new staff members was reviewed to include adding the required communication training and education to be part of what is completed during the 3-day orientation period. The staff development coordinator will complete this training and education. The Executive Director or designee will provide oversight to ensure ongoing compliance. Success Evaluation:	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0941 SS = D	Continued from page 54 10/8/24 – E19's first day in the facility as LPN (Licensed Practical Nurse). 11/18/25 – E21's first day in the facility as Restorative Aide/CNA. 1/12/26 2:00 PM – Findings were discussed with E1 (Interim NHA). 1/12/26 3:30 PM – Findings were reviewed with E1 and E2 (DON) during the Exit Conference.	F0941	Continued from page 54 •An initial audit of 100% of staff members will be completed by the Director of Nursing or Designee to ensure that communication training was completed; audits will have a goal of 100% compliance; Audits will be completed weekly until 100% compliance is achieved for 3 consecutive evaluations, then every other week until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team during the monthly QA meeting.	
F0944 SS = E	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documentation, it was determined that for seven (E14, E15, E16, E17, E18, E20 and E21) out of seven facility staff reviewed, the facility failed to ensure that the required QAPI (Quality Assurance and Performance Improvement) training was completed. Findings include: 1/12/26 1:30 PM – Review of the facility training records revealed a lack of evidence of QAPI training for the following facility staff: 2/4/25 - E14's first day in the facility as RN (Registered Nurse). 4/1/25 – E15's first day in the facility as RN. 3/18/25 – E16's first day in the facility as CNA (Certified Nurse Aide). 9/16/25 – E17's first day in the facility as CNA. 6/10/25 – E18's first day in the facility as CNA. 9/30/25 – E20's first day in the facility as Maintenance Tech.	F0944	Corrective Action: •Corrective action was ensured by the Director of Nursing. The (Quality Assurance and Performance Improvement) QAPI program training was completed for all staff members. The Staff Development coordinator was educated on the need for the inclusion of mandatory training that outlines and informs staff of the elements and goals of the facility's Quality Assurance and Performance Improvement program. Identification of Other Residents: •All Residents have the potential to be affected. No residents were affected by this deficiency. A 100% audit of all staff members was completed and the mandatory QAPI training was completed for all. System Changes: •The Root Cause of the concern was a failure to ensure that the required QAPI training was completed. The facility system for onboarding new staff members was reviewed to include adding all required training and education, especially the QAPI training, to be part of what is completed during the 3-day orientation period. The facility policy for "Staff Development Program" (rev. 5.2019), was reviewed and found to meet professional standards. The Staff Development Coordinator will complete all QAPI training for all staff members. The Executive Director or designee will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial audit of 100% of staff members including newly hired staff will be completed by the Director of	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0944 SS = E	Continued from page 55 11/18/25 – E21's first day in the facility as Restorative Aide/CNA. 1/12/26 2:00 PM – Findings were discussed with E1 (Interim NHA). 1/12/26 3:30 PM – Findings were reviewed with E1 and E2 (DON) during the Exit Conference.	F0944	Continued from page 55 Nursing or designee; Audits will be completed until 100% compliance is achieved for 3 consecutive evaluations, then an audit of a random sample of 10% of staff members will be completed every two weeks until 100% compliance is achieved for 3 consecutive evaluations, and then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team during the monthly QA meeting	
F0946 SS = E	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics. The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documentation, it was determined that for four (E16, E18, E20, and E21) out of four facility staff reviewed, the facility failed to ensure that the required Corporate Compliance and Ethics training was completed. Findings include: 1/12/26 1:30 PM – Review of the facility training records revealed a lack of evidence of Corporate Compliance and Ethics training for the following facility staff: 3/18/25 – E16's first day in the facility as CNA (Certified Nurse Aide). 6/10/25 – E18's first day in the facility as CNA. 9/30/25 – E20's first day in the facility as Maintenance Tech.	F0946	Corrective Action: •Corrective action was ensured by the Director of Nursing. The Compliance and Ethics Training was completed for all staff members on 2/4/2026. The Staff Development Coordinator was educated on the need to include Compliance and Ethics Training in the staff's annual and onboarding training programs. Identification of Other Residents: •All Residents have the potential to be affected. No residents were affected by this deficiency. A 100% audit of all staff members has been completed by the Staff Development Coordinator, and the compliance and Ethics training was completed for all. System Changes: •The Root Cause of the concern was a failure to ensure that the required corporate compliance and ethics training was completed for staff members. The facility system for completing annual training for staff members and onboarding for new staff was reviewed to include Compliance and Ethics training. The facility policy for "Staff Development program" (rev.5.2019) was reviewed and found to meet professional standards. The Staff Development Coordinator will complete Compliance and Ethics training for all staff. The Executive Director or designee will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial audit of 100% of staff members for compliance on receiving education on Compliance and Ethics will be completed by the Director of Nursing or designee; Audits will be completed until 100% compliance is achieved for 3 consecutive evaluations,	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	**255 POSSUM PARK ROAD , NEWARK, Delaware, 19711**

(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
F0946 SS = E	Continued from page 56 11/18/25 – E21's first day in the facility as Restorative Aide/CNA. 1/12/26 2:00 PM – Findings were discussed with E1 (Interim NHA). 1/12/26 3:30 PM – Findings were reviewed with E1 and E2 (DON) during the Exit Conference.	F0946	Continued from page 56 then an audit of a random sample of 10% of staff members will be completed every 2 weeks until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team in the monthly QA meeting.	
F0949 SS = E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documentation, it was determined that for seven (E14, E15, E16, E17, E18, E20 and E21) out of seven facility staff reviewed, the facility failed to ensure that the required Behavioral Health Care Needs training was completed. Findings include: 1/12/26 1:30 PM – Review of the facility training records revealed a lack of evidence of Behavioral Health Care Needs training for the following facility staff: 2/4/25 - E14's first day in the facility as RN (Registered Nurse). 4/1/25 – E15's first day in the facility as RN. 3/18/25 – E16's first day in the facility as CNA (Certified Nurse Aide). 9/16/25 – E17's first day in the facility as CNA. 6/10/25 – E18's first day in the facility as CNA. 9/30/25 – E20's first day in the facility as Maintenance Tech. 11/18/25 – E21's first day in the facility as Restorative Aide/CNA. 1/12/26 2:00 PM – Findings were discussed with E1 (Interim NHA).	F0949	Corrective Action: •Corrective action was ensured by the Director of Nursing. The Behavioral Health Training was completed for all staff members on 2/4/2026. The Staff Development Coordinator was educated on the need to include Behavioral Health Training in the staff's annual and onboarding training programs. Identification of Other Residents: •All Residents have the potential to be affected. No residents were affected by this deficiency. A 100% audit of all staff members has been completed by the Staff Development Coordinator, and the Behavioral Health training was completed for all. System Changes: •The Root Cause of the concern was a failure to ensure that the required Behavioral Health Care Needs training was completed for staff members. The facility system for completing annual training for staff members and onboarding for new staff was reviewed to include Behavioral Health Care training. The facility policy for "Behavioral Health" (rev.5.2019) was reviewed and found to meet professional standards. The Staff Development Coordinator will complete Behavioral Health Training for all staff. The Executive Director or designee will provide oversight to ensure ongoing compliance. Success Evaluation: •An initial audit of 100% of all staff members including newly hired employees will be completed for Behavioral Health Training by the Director of Nursing or designee; Audits will be completed until 100% compliance is achieved for 3 consecutive evaluations, then an audit of a random sample of 10% of staff members will be completed every 2 weeks until 100% compliance is achieved for 3 consecutive evaluations, then monthly until 100% compliance is achieved for 3 consecutive evaluations. Additional audits will be completed as needed based upon the level of compliance.	02/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0949 SS = E	Continued from page 57 1/12/26 3:30 PM – Findings were reviewed with E1 and E2 (DON) during the Exit Conference.	F0949	Continued from page 57 The results of the audits will be reviewed by the Quality Assurance Team in the monthly QA meeting.	