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: Bay Terrace Rehab and Healthcare Center **DATE SURVEY COMPLETED:** April 23, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint survey was conducted at this facility from April 20, 2026, through April 23, 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 (seventy) 70. The investigative sample totaled (twenty-three) 23 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement was not met as evidenced by:** Cross Refer to the CMS 2567 – L survey completed April 23, 2026: cross refer F609, F610, F677, F684 and F757.	CROSS REFERENCE E-POC	

Provider's Signature Adam K Martin Title ADMINISTRATOR Date 5/7/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085019	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY TERRACE REHABILITATION AND HEALTH CENTER	889 SOUTH LITTLE CREEK ROAD , DOVER, Delaware, 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		
F0000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility from April 20, 2026, through April 23, 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 seventy (70). The investigative sample totaled twenty-three (23) residents. Abbreviations/definitions used in this report are as follows: ADL's - Activities of Daily Living - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Care Plan - a personalized document that outlines and individuals specific health needs and social needs. DON - Director of Nursing; Gastroesophageal Reflux Disease (GERD)- occurs when stomach acid or, occasionally, stomach content, flows back into your food pipe; LPN - Licensed Practical Nurse; Minimum Data Set (MDS) - standardized assessment forms used in nursing homes; MD - Medical Doctor; NHA - Nursing Home Administrator;	F0000		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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

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F0000	Continued from page 1 PCP - Primary Care Provider - the physician or nurse practitioner that provides the direction of care for a resident; RD - Registered Dietician; RN - Registered Nurse;	F0000		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R83) out of three residents reviewed for abuse the facility failed to ensure immediate reporting of an allegation of abuse. Findings include: The facility policy on abuse last updated January 2026 indicated, "Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g. law enforcement when applicable) within specific time	F0609	A. The facility cannot retroactively correct the deficiency for R83. B. DON/Designee will review investigative file for the last 7 days for allegation of abuse, to ensure that reporting of an allegation of abuse followed timeframe of no later than two hours after the allegation was made. Any issues identified will be addressed with staff involved C. The root cause was determined to be due to staff's misunderstanding of the reporting timeframe when there is for allegation of Abuse. The facility management team, IDT and licensed nurses will be re-educated by the DON/Designee on the reporting timeframe when there is any allegation of abuse. Abuse inquiry form will be utilized and reviewed in AM meeting by NHA/designee for potential allegations of abuse and ensure reporting requirements are met within timeframe. D. Audit by DON/Designee will be conducted to ensure allegations of abuse were reported timely as per reporting timeframe daily x 5 days until 100% compliance is achieved. Following will be a weekly audit x 4 until 100% compliance is sustained, then monthly x 3 months. Audit findings will be reported to QA committee monthly x 3 months.	06/05/2026

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F0609 SS = D	Continued from page 2 frames! a. Immediately but not later than two hours after the allegation is made." 6/12/25 3:31AM - An incident note in R83's clinical record documented that R83 made an allegation of physical staff to resident abuse against E8 (CNA). 6/12/25 11:21 AM - The facility reported an allegation of staff to resident physical abuse involving R83 that allegedly occurred at 2:35 AM to the State Agency; an estimated nine hours after the allegation occurred. 4/23/26 11:06 AM - During an interview with E6 (RN) it was confirmed that R83's allegation of abuse was not immediately reported to the State Agency. E6 stated, "When the [DON] came in, she told me I should have reported it right away and not waited for the day shift." 4/23/26 11:14 AM - During an interview, E2 (DON) confirmed the findings and that the facility verbally educated E6 (RN) on reporting time frames. 4/23/26 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and at the exit conference.	F0609		06/05/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F0610	A. The facility cannot retroactively correct the deficiency for R83, and no other residents were negatively impacted B. DON/Designee will review investigative folder for the last 7 days for any allegation of abuse, to ensure staff was removed from the schedule immediately pending allegation of abuse. C. The root cause was determined to be due to staff misunderstanding the steps to follow when there is an allegation of abuse by removing staff from schedule immediately pending allegation of abuse. The NHA/DON/ADON/Supervisors/Social Services and licensed nurses will be re-educated by the DON/Designee on the steps to follow when there is an allegation of abuse including removing staff from schedule immediately pending allegation of abuse. Abuse inquiry form will be utilized and reviewed in AM meeting by NHA/designee to ensure alleged staff	06/05/2026

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F0610 SS = D	Continued from page 3 This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R83) out of three residents reviewed for abuse the facility failed to ensure residents were protected from further abuse when the facility failed to remove an employee from resident care immediately after an allegation of abuse. Findings include: The facility policy on abuse last updated January 2026 indicated, "Protection of Resident. Room or staffing changes if necessary to protect residents from the alleged perpetrator." 6/12/25 11:21 AM - The facility reported an allegation of staff to resident physical abuse involving R83 and E8 (CNA). 4/23/26 9:26 AM - Review of E8's (CNA) timesheet revealed that after the allegation of physical abuse involving R83, E8 remained in the facility working with residents until 7:05 AM. 4/23/26 10:56 AM - During an interview, E7 (LPN) the nurse assigned to R83's unit at the time of the incident confirmed that E8 (CNA) remained caring for patients after R83 made an accusation of physical abuse against R83. E7 stated, "She had dementia and a care plan for false accusations what she said didn't make sense, so we stopped him from caring for her room through the rest of the shift. " 4/23/26 11:06 AM - During an interview, E6 (RN) confirmed that E8 (CNA) remained caring for residents after R83 made an allegation of physical abuse. E6 stated, "I told [E8] to care for other patients" E6 then explained that [E2 (DON)] verbally educated her that accused staff must be removed to protect all residents. 4/23/26 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and at the exit conference.	F0610	Continued from page 3 is removed from schedule pending investigation. D. Audit by DON/Designee will be conducted to ensure steps are followed when there is allegations of abuse by immediately removing the staff from schedule pending allegation of abuse daily x 5 days until 100% compliance is achieved. Following will be a weekly audit x 4 until 100% compliance is sustained, then monthly x 3 months. Audit findings will be reported to QA committee monthly x 3 months.	06/05/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and	F0677	A. R10's nails were trimmed and cleaned. B. Dependent residents will be assessed to ensure nails are clean and trimmed.	06/05/2026

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F0677 SS = D	Continued from page 4 personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that for one (R10) out of seven residents reviewed for ADL (Activities of Daily Living), the facility failed to provide ADL care for dependent residents. Findings include: Review of R10's clinical record revealed: 3/26/25 - R10 was admitted to the facility with a diagnosis of terminal prostate cancer and delirium. 1/12/26 - A review of R10's care plan documented that the resident had a self-care deficit for ADLs. 3/24/26 - A quarterly MDS documented that the resident was dependent for personal hygiene. 4/15/26 7:10 AM - A progress note documented that R10 was restless all night and was smearing his feces with his hands. 4/20/26 9:45 AM - An observation of E5 (CNA) providing a bed bath to R10 revealed dark debris beneath three fingernails on the resident's left hand 4/21/26 9:00 AM – An observation of R10's left hand had dark debris beneath three of his fingernails. 4/21/26 10:15 AM - During an interview, E5, CNA stated that during the resident's bed bath, she shaved the resident (R10) and washed his entire body. She confirmed that she did not check or clean the resident's fingernails during the bath and stated she would complete this task immediately. 4/21/26 10:20 AM – E4 (LPN) confirmed that R10's left hand had dark debris beneath three fingernails. E4 stated she has not seen a nail-cleaning device available for use in a long time. 4/21/26 10:20 AM - During an interview, E2 (DON) confirmed that the fingernails for R10 were not cleaned during the bath." 4/23/263:00PM – Findings were reviewed with E1 (NHA), E2 (DON) and at the exit conference.	F0677	Continued from page 4 C. The root cause was determined to be lack of oversight during baths/showers of dependent residents to ensure residents' nails are clean and trimmed. Upon further investigation and review with direct care staff the lack of accessibility to nail cleaning supplies contributed to the issue especially during bed baths/showers. Nursing staff and new hires will be re-educated by DON/Designee to ensure residents' nails are clean and trimmed during baths/showers. Staff will be educated by staff educator/designee on location of nail cleaning supplies and to notify supervisor of any assistance needed. Nursing Supervisor will conduct random audits to ensure nails are clean and trimmed of dependent residents post baths/showers D. Daily audit by ADON/Designee on 10% of the facility census to ensure dependent residents' nails are clean and trimmed post bed baths/showers x 5 days until 100% compliance is achieved. Following will be a weekly audit x 4 until a 100% compliance is sustained, then monthly x 3 months. Audit findings will be reported to QA committee monthly x 3 months	06/05/2026
F0684 SS = D	Quality of Care CFR(s): 483.25	F0684	A. The facility cannot retroactively correct the deficiency for R85. The resident was discharged from the facility.	06/05/2026

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F0684 SS = D	Continued from page 5 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R85) out of three residents reviewed for hospitalization the facility failed to provide appropriate care and monitoring consistent with professional standards of practice. When the facility failed to monitor and restrict fluid intake for R85 admitted with active diagnosis of heart failure. Findings include: Review of R85's clinical record revealed: 4/19/25 through 4/29/25 – R85 was hospitalized for multiple conditions, including heart failure. 4/29/25 - R85 was admitted to the facility with multiple diagnoses including congestive heart failure and kidney disease requiring dialysis. 4/30/25 - An admission assessment completed by E11 (RN) documented that R85 had congestive heart failure. 4/30/25 - R85's baseline care plan revealed that R85's diagnosis of congestive heart failure lacked interventions. 5/1/25 - A nutrition assessment documented that R85 was "receiving therapeutic, regular textured meal plan with 1500 mL fluid restriction... Will continue to monitor oral intake, weight, skin integrity, and labs as available for significant changes and reassess as needed." Review of R85's physicians orders and dietary intake lacked evidence of an order for fluid restriction. 5/1/25 12:05 PM - A progress note in R85's clinical record written by E10 (MD) documented " The patient remains generally weak and clinically deconditioned. The patient has multiple complex co morbidities to include heart failure placing the patient at high risk for re admission [to hospital] without proper care. The patient will require frequent clinical evaluations, neglecting regular monitoring and management may	F0684	Continued from page 5 B. Residents with active diagnosis and treatment for CHF and hemodialysis will be reviewed to ensure fluid restriction monitoring is identified per physician's order C. The root cause was determined to be ineffective transition of care from acute care setting to post-acute with specific directions identified requiring fluid restriction for a resident with CHF and on hemodialysis. Daily in clinical meetings, DON/Designee will review new admissions/readmissions with active diagnosis and treatment for CHF and hemodialysis to ensure fluid restriction is addressed. Provider will be educated by DON/designee to ensure diagnosis specific admission orders is in place as applicable for residents with active diagnosis and treatment for CHF and hemodialysis Dietician will be educated by Regional Dietician/designee to ensure new admissions/readmissions with active diagnosis and treatment for CHF and hemodialysis has fluid restriction monitoring identified as per physician's order. The Licensed nursing staff and new hires will be educated by DON/Designee to review with dietician and provider for new admission/readmission residents when there is an active diagnosis and treatment for CHF and hemodialysis the need for fluid restriction orders. . D. Daily audit by DON/Designee will be conducted to ensure new admissions/readmitted residents with active diagnosis and treatment for CHF and hemodialysis will have fluid monitoring addressed during admission chart check as per physician's order x 5 days until 100% compliance is achieved. Following will be a weekly audit x 4 until 100% compliance is sustained, then monthly x 3 months. Audit findings will be reported to QA committee monthly x 3 months.	06/05/2026

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F0684 SS = D	Continued from page 6 result in symptom exacerbation and re-hospitalization. Assessment/Plan strict intake and output's daily weights." 5/5/25 - An admission MDS assessment documented that R85 was cognitively intact, experiencing shortness of breath and had an active diagnosis of heart failure. 5/5/25 - A physician's order was written for R85 be restricted to 1500ml of fluid per day at the request of R85's responsible party. 5/6/25 11:15 AM - A nurses note in R85's clinical record documented that the resident was sent to the hospital from the dialysis center for chest pain and shortness of breath. 4/23/26 1:41 PM - During an interview, E10 (MD) confirmed that R85 should have been placed on fluid restriction on admission. 4/23/26 1:48 PM - During an interview, E11 (RN) confirmed that residents admitted with congestive heart failure and on hemodialysis are usually placed on fluid restrictions. E11 was unable to recall why R85 was not placed on fluid restrictions on admission. 4/23/26 1:54 PM - During an interview, E2 (DON) confirmed that R85 should have been placed on fluid restriction and monitoring prior to 5/5/26. E2 stated "Most residents with congestive heart failure would have had a fluid order but [R85] did not have one." E2 then stated that an order for fluid restriction was written on 5/5/24 because "It was just noticed. The fluid restriction was not in timely." 4/23/26 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and at the exit conference.	F0684		06/05/2026
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F0757	A. R72's medication order was clarified on 3/30/26. B. All residents have the potential to be affected. Pharmacy consultant reports for the last 30 days will be reviewed by DON/Designee to ensure there is no duplication in medication regime identified. C. The root cause was determined to be due to an oversight by the provider when change in order is entered and the licensed nurse did not verify for duplication of orders before inputting the order. Upon further investigation the ordered dosage did not exceed daily recommended dose and	06/05/2026

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F0757 SS = D	Continued from page 7 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R72) out of five residents sampled for medication review, the facility failed to ensure that the residents were free from unnecessary meds when a Protonix order was used in excessive dose. Findings include: Review of R72's clinical record revealed: 1/26/26 - R72 was admitted to the facility. 1/27/26 - A physician's order for Protonix 40 mg give one by mouth two times a day for GERD (gastro-esophageal reflux disease). 2/22/26 - A physician's order for Protonix 40 mg give one tablet by mouth once daily for GERD. 3/30/26 - A Monthly Consultant Pharmacist Report documented "two Protonix orders seen please clarify if both are current orders." Report was signed off and acknowledged by provider. 4/22/26 11:52 AM - During an interview, E10 (MD) confirmed the Consultant Pharmacist Report was reviewed and confirmed that the Protonix order daily was to be discontinued. 4/22/26 11:54 AM - During an interview, E3 (ADON) confirmed that R72 had two active Protonix orders from 2/22/26 to 3/30/26 when the second order was discontinued which totaled 37 additional doses. E3 stated that E2 (DON) or herself were responsible to review the monthly pharmacy reviews and implement any changes that were initiated by E10.	F0757	Continued from page 7 administered on various shifts which caused lack of attention by the nurses administering the medication. Licensed nurses and new hires will be re-educated by DON/Designee to verify during medication order entry that there is no duplicate order prior to entering new medication orders. DON/Designee will re-educate providers on the process to appropriately enter a medication to prevent duplication. Daily, new Medication orders will be reviewed by DON/Designee in clinical AM meetings to ensure there is no duplicate order. DON/Designee will review Monthly pharmacy consultant's report to ensure there is no duplicate therapy. Any issues identified will be addressed. D. Daily audit by DON/Designee will be conducted to ensure new medication orders are reviewed to avoid duplicate orders x 5 days until 100% compliance is achieved. Following will be a weekly audit x 4 until 100% compliance is sustained, then monthly x 3 months. Audit findings will be reported to QA committee monthly x 3 months	06/05/2026

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F0757 SS = D	Continued from page 8 4/22/26 12:11 PM - During an interview, C1 (Pharmacy Technician) confirmed that R2 had two active Protonix orders on the aforementioned dates and that the pharmacy dispensed and delivered those medications to the facility. 4/22/26 12:45 PM - During an interview, E2 (DON) stated that the expectation was that E3 or herself would monitor the monthly pharmacy reviews and address any changes to be implemented. E2 stated that E3 runs a daily report to monitor all new prescription orders and that occasionally nurses on 11:00 PM to 7:00 AM shift will monitor them as well. E2 could not articulate how the how the discrepancy in the medication order was missed. 4/23/26 3:00 PM Findings were reviewed with E1 (NHA), E2 (DON) and at the exit conference.	F0757		06/05/2026