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: Delaware Bay Rehab & Healthcare Center **DATE SURVEY COMPLETED:** July 10, 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 July 6, 2026, through July 10, 2026. The deficiencies contained in this report are based on observation, interview, review of clinical records and other facility documentation, as indicated. The facility census on the first day of the survey was one hundred eleven (111) residents. The survey sample size was forty-four (44) residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**	1. The 5 Day follow up report for R83 is noted as complete in the state reporting system. The 5 Day follow up status was changed from pending to complete for R121's report. 2. All reports submitted to the state reporting system for the last 30 days have been reviewed for completed 5-day follow-up reports. 3. A root cause analysis identified issues with the state reporting system accepting the follow-up reports as well as staff changes at the facility level that resulted in delayed follow-up submissions. A process change was implemented with a shared tracking folder accessible by the NHA, the	August 11, 2026
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 completed on July 10, 2026: Cross refer: F552, F605, F658, F757 and F880.		
3201.9.6 **S/S – D**	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term**		

Provider's Signature Title NHA Date 8/5/2026

NAME OF FACILITY: Delaware Bay Rehab & Healthcare Center DATE SURVEY COMPLETED: July 10, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Care Resident's Protection. The method of reporting shall be directed by the Division. **These requirements were not met as evidenced by:** Based on interview, record review and review of other facility documentation, it was determined for four (R83 & R121) out of twelve residents sampled for reportable incidents, the facility failed to submit the 5 day follow up to the Division within the required timeframe. Findings include: 1. Review of R83's clinical record revealed: 4/15/22 – R83 was admitted to the facility. 1/1/26 7:30 AM – R83 had a witnessed fall during transfer, resulting in R83 being lowered to the floor. 1/9/26 – A facility reported incident for R83 documented that the 5 day follow up was due to the Division. 3/5/26 5:04 PM – The 5 day follow up was submitted to the Division. 7/9/26 11:52 AM – During an interview, E10 (Regional Nurse) stated that the facility was having difficulty entering reports into the system and believes that this report was one that was affected during that timeframe. E10 stated that multiple phone calls and emails were submitted to the Division to get the issue resolved and the report was submitted late during that time. 2. Review of R121's clinical record revealed: 9/24/25 – R121 was admitted to the facility.	DON, the ADON, and the Staff Educator to ensure tracking and timely submissions. 4. The NHA, or designee, will complete an audit of all submissions to the state reportable site for timely 5 day follow up submissions weekly times four or until 100% compliance then monthly times three or until 100% compliance with results submitted to QAPI for review and recommendations. 5. Compliance date: August 11, 2026	

Provider's Signature [signature] Title NHA Date 8/5/2026

NAME OF FACILITY: Delaware Bay Rehab & Healthcare Center **DATE SURVEY COMPLETED:** July 10, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	10/16/25 9:15 AM – A facility reported incident documented R121 experienced a witnessed fall after standing up from the wheelchair, lost balance and fell onto the floor resulting in a scalp laceration to the back of the head and a hematoma. 10/23/25 – A facility five day follow up to the Division documented status for the follow up was, "Pending." 12/18/25 4:14 PM – A Division incident tracking note documented, "As of now the five day follow up has been left "pending" since October despite numerous emails/responses from the facility-they have still not submitted the follow up." 7/9/26 11:52 AM – During an interview, E10 reported the facility was having difficulty entering reports into the reporting system for the five day follow up. In addition, E10 reported "Multiple emails and phone calls to the Division were submitted for resolution and that the five day follow up had been submitted."		
3201.9.8 **3201.9.8.4.2** **S/S – D**	**Reportable incidents are as follows:** **Injury that results in transfer to an acute care facility for treatment or evaluation or which requires neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.** **These requirements were not met as evidenced by:** Based on interview, record review and review of other facility records it was determined for two (R95 and R118) out of five residents inves-	1. The reportable for R95 was submitted at the time of survey. The incident for R118 is a past incident and the resident has since expired so facility is unable to correct the required reporting. 2. All resident injuries in the last 30 days were reviewed for transfer to an acute care facility for treatment or evaluation.	August 11, 2026

Provider's Signature Callie Kline Title NHA Date 8/5/26

NAME OF FACILITY: Delaware Bay Rehab & Healthcare Center **DATE SURVEY COMPLETED:** July 10, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	tigated for accidents the facility failed to report to R95's unwitnessed fall that resulted in a laceration to the head and transfer to the hospital for evaluation and treatment. Findings include: 1. Review of R95's clinical record revealed: 5/18/26 – R95 was admitted to the facility. 6/27/26 2:45 PM – A review of a facility form titled "Incident Statement" documented "Unwitnessed fall [R95] was found on the floor prone position in hallway near nursing station. [R95] had a laceration in the middle of the forehead with moderate bleeding. R95 complained of right knee pain. [R95] was sent to the hospital by ambulance." 6/27/26 8:48 PM – A review of a progress note documented, [R95] returned from the hospital status post fall. 6/28/26 2:26 AM – A review of a progress notes documented, "[R95] returned from the hospital. Forehead with vertical linear laceration approximate 3 cm (centimeters) with five sutures. R95 awake alert to self. Continue status post fall monitoring. No bleeding noted." 7/1/26 1:08 PM – A review of a complaint reported and submitted to the Division documented R95 stood up and fell from the wheelchair. Further review of the complaint documented R95 fell on 6/27/26 2:45 PM. 7/10/26 10:02 AM – During an interview, E2 (DON) reported and confirmed "The facility did not report R95's fall to the Division." 2. R118's clinical record revealed:	None were found that required reporting per the reportable incidents' regulation. 3. A root cause analysis identified a gap in understanding the specific regulation regarding transfers to an acute care facility. The NHA and DON were educated by the Regional Vice President of Operations on reportable incidents. A spreadsheet was created to track all falls, identify whether any falls resulted in evaluation at an acute care facility and if so, was it reported to the state. This process change will be a live document available to the NHA, DON, ADON, and Staff Educator and will provide review and accountability through multiple staff monitoring information and follow up. 4. The NHA, or designee, will complete an audit of all resident injuries for transfer to an acute care facility for treatment or evaluation and to ensure timely reporting to the state reporting site	

Provider's Signature [signature] Title NHA Date 8/5/2026

NAME OF FACILITY: Delaware Bay Rehab & Healthcare Center **DATE SURVEY COMPLETED:** July 10, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	10/1/25 – R118 was admitted to the facility with diagnoses including by not limited to Alzheimer's Disease, Down Syndrome, and muscle weakness. 10/5/25 – R118's fall care plan included, "... Has the potential for falls related to impaired mobility and balance, assistance needed with toileting and activities of daily living..." 1/9/26 – R118's significant change MDS documented a BIMS score of 99, indicating an inability to participate in a cognitive assessment. The MDS also documented that R118 was dependent on the staff for all activities of daily living. 3/23/26 10: 59 AM – R118's clinical record included, "Staff notified this nurse that resident [R118] had fallen in satellite common area. Resident lying face down in prone position with blood noted to facial area... Resident noted to have a laceration to right side of forehead. Pressure dressing applied. Unresponsive to tactile or verbal stimuli... Resident to be sent out 911 at this time. 911 notified. Resident left facility via stretcher with EMS with neck collar placed and pressure dressing intact... " 3/23/26 8:30 PM – R118's clinical record included, "Resident [R118] back from the hospital at 8:30 pm with stitches placed on his forehead... " 7/9/26 10:00 AM – A review of the facility's investigative documentation lacked evidence of notification to the Division per reporting guidelines that the R118 was sent to hospital for evaluation after the fall.". During an interview, E2 (DON) stated, "The incident was not reported because it was not considered a serious injury."	weekly times four weeks or until 100% compliance then monthly times three or until 100% compliance achieved with results reported to QAPI for review and recommendations. 5. Compliance date: August 11, 2026	

Provider's Signature Callie Hare Title NHA Date 8/5/2026

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: Delaware Bay Rehab & Healthcare Center **DATE SURVEY COMPLETED:** July 10, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	7/10/26 2:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.		

Provider's Signature Allie Kline Title NHA Date 8/5/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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 conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from July 6, 2026 through July 10, 2026. 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 July 6, 2026 through July 10, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 111. The investigative sample totaled 44 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; Anxiety- general term for several disorders that cause nervousness, fear, apprehension and worrying or Anxiety is an unpleasant state of inner turmoil, often accompanied by nervous behavior, such as pacing back and forth; Antipsychotic- class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; CNA - Certified Nurse's Aide; DON - Director of Nursing; EMR - Electronic medical record; LPN - Licensed Practical Nurse; Mg-milligrams- unit of weight;	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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 NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; SW - Social Worker;	F0000		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for two (R9 and R34) out of five residents sampled for medication review, the facility failed to discuss the risk and benefits of proposed care. Findings include: 1. Review of R9's clinical record revealed: 4/17/26 - R9 was admitted to the facility. 4/20/26 - An admission MDS documented that R9 had a BIMs score of 11 indicating moderate cognitive impairment. 4/20/26 untimed - An informed consent for psychotropic medication was signed by R9's legal representative. The form lacked documentation of the resident's condition requiring treatment, the	F0552	R9's legal representative was provided information by the unit manager regarding quetiapine fumarate and trazadone, including the risks and benefits of these medications, and the clinical indication of the medications. The legal representative was given the opportunity to consent or decline these medications. R34 has discharged from the facility with the quetiapine fumarate order discontinued so facility unable to correct deficient practice. All residents currently at the facility had their anti-psychotic and anti-depressant orders reviewed for documented informed consent that included risks and benefits and clinical indication for the medication(s). A root cause analysis identified a knowledge gap with admission nurses on the purpose of the informed consent and the information needed for a resident or legal representative to make a decision regarding anti-psychotic or anti-depressant medications. The Staff Educator will educate all licensed staff about the informed consent form, when to fill it out, what information is required to include and obtaining a signature from the resident or legal representative consenting to or declining the medication. The Staff Educator will also add education regarding the informed consent expectation and process to all licensed staff during onboarding/orientation as a pro active new hire process change. The DON, or designee, will complete an audit of all residents admitting with, or with newly ordered, anti-psychotic and anti-depressant medications weekly times four weeks or until 100% compliance, then a random audit of 10 residents with admitting or newly ordered ant-psychotic or anti-depressant medications monthly for two months or until 100% compliance achieved with results reported in QAPI for review and recommendations. Compliance date: August 11, 2026	08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	**110 W. NORTH STREET , GEORGETOWN, Delaware, 19947**

(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
F0552 SS = D	Continued from page 2 clinical indication for the medication, the expected benefits, the medication being proposed, the potential risks and side effects, and the representative's informed consent based upon this information. 4/29/26 4:30 PM - A physician's order documented quetiapine fumarate (anti-psychotic) 25 mg give 0.5 tablet by mouth one time a day for mood. 5/23/26 6:00 PM - A physician's order documented trazadone hcl (anti-depressant) 50 mg give 0.5 tablet by mouth one time a day for dementia with anxiety. 7/8/26 9:06 AM - During an interview, E2 (DON) stated the expectation would be for the provider to discuss with resident's or the representative the risk versus benefits regarding the use of psychotropic medications and to document the discussion in the EMR (electronic medical record). E2 confirmed that the aforementioned form was signed by R9's representative but the form lacked evidence of the aforementioned data was indicated when completing the form. E2 further confirmed that the progress notes in the EMR lacked evidence of the risk versus benefit was completed with E9's representative prior to the provider ordering psychotropic medication. 2. R34's clinical record revealed: 6/9/26 – R34 was admitted to the facility with diagnoses including but not limited to dementia and major depressive disorder. 6/10/26 – R34's admission MDS documented a BIMS score of 15, indicating a fully intact cognitive status. 6/10/26 – R34's medication record included, "Quetiapine Fumarate Tablet 25 mg. [antipsychotic medication] give 1 tablet by mouth at bedtime for mood stabilizer." 7/4/26 8:00 PM – R34's medication record documented, "Quetiapine Fumarate Tablet 25 mg. give 1 tablet by mouth every 24 hours as needed for mood stabilizer." 7/9/26 12:00 PM - A review of R34's clinical record failed to failed to show evidence that R34 or her responsible party was informed of the risks and benefits associated with the change in the antipsychotic medication order prior to implementation.	F0552		08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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
F0552 SS = D	Continued from page 3 7/9/26 1:30 PM - E2 confirmed there was no documentation demonstrating that R34 or the responsible party had been informed of the risks and benefits associated with the medication order change. 7/10/26 2:45 PM - Findings were reviewed the E1 (NHA) and E2 (DON) during the exit conference	F0552		08/11/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.	F0605	R9's quetiapine fumarate order was updated by the ADON to include side effect monitoring at the time of survey. R34 has discharged so facility unable to update the quetiapine fumarate order to add side effect monitoring. All residents currently at the facility with an anti-psychotic medication order were reviewed for side effect monitoring. If any were found without side effect monitoring, the side effect monitoring was added to the order. A root cause analysis was completed and revealed not all nurses were aware of how to implement side effect monitoring for anti-psychotic medications. The Staff Educator will provide education to all licensed staff on how to add side effect monitoring for anti-psychotic medications. The Staff Educator will also add education about adding side effect monitoring to anti-psychotic medications to all licensed staff during onboarding/orientation as a proactive new hire process change. The DON, or designee, will complete an audit of all residents admitting with, or with newly ordered, anti-psychotic medication to ensure side effect monitoring is in place weekly times four or until 100% compliance then monthly times two or until 100% compliance achievec with results reported in QAPI for review and recommendations. Compliance date: August 11, 2026	08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	**110 W. NORTH STREET , GEORGETOWN, Delaware, 19947**

(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
F0605 SS = D	Continued from page 4 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §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- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that	F0605		08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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
F0605 SS = D	Continued from page 5 medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that for two (R9 and R34) of five residents sampled for unnecessary medications, the facility failed to ensure residents receiving psychotropic medications therapy were monitored for targeted behaviors and adverse consequences (side effects) following initiation and during continued use of the medications. Findings include: 1. Review of R9's clinical record revealed: 4/17/26 – R9 was admitted to the facility. 4/29/26 4:30 PM – A physician's order was written for quetiapine fumarate (antipsychotic medication) 25 mg, give 0.5 tablet by mouth once daily. 5/5/26 – A care plan identified that R9 was receiving psychotropic medications related to mood disorder and included the intervention to monitor, document, and report adverse side effects such as unsteady gait, involuntary movements (tardive dyskinesia), shuffling gait, refusing to eat, fatigue, and insomnia 7/8/26 8:50 AM - A review of the Medication Administration Record (MAR) from 4/29/26 through 7/8/26 lacked evidence that staff monitored or documented adverse side effects following the initiation of quetiapine fumarate. 7/8/26 9:06 AM – During an interview, E2 (Director of Nursing) stated nursing staff were expected to	F0605		08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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
F0605 SS = D	Continued from page 6 monitor residents for adverse effects of psychotropic medications. E2 confirmed the facility failed to monitor and document adverse effects or adverse outcomes for the aforementioned medication. 2. R34's clinical record revealed: 6/9/26 – R34 was admitted to the facility. 6/10/26 – R34's admission MDS documented a BIMS score of 15, indicating a fully intact cognitive status. 6/10/26 – R34's medication record included, "Quetiapine Fumarate Tablet 25 mg. [antipsychotic medication] give 1 tablet by mouth at bedtime for mood stabilizer, Duloxetine HCl Capsule Delayed Release Particles 90 mg. [antidepressant medication] give 1 capsule by mouth one time a day for depression and Buspirone HCl Tablet 15 mg. [antianxiety medication] give 1 tablet by mouth three times a day for anxiety. 6/19/26 – R34's care plan included, "I am prescribed anti-anxiety medications … I will be free from discomfort or adverse reactions related to anti-anxiety therapy. Monitor for side effects and effectiveness Q-SHIFT [every shift.] Monitor … if I exhibit … drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion … I am prescribed antipsychotic medication. be/remain free of psychotropic drug related complications…" 7/9/26 1:00 PM – A review of R34's medication record from 6/10/26 through 7/8/26 lacked evidence of the targeted behaviors that R34 was being monitored for, and the effectiveness or adverse effects of the medications. 7/9/26 2:00 PM – During an interview, E2 (DON) stated, "Yes, staff should have been monitoring the resident to ensure that the medications are working, and to determine whether she was experiencing any side effects from them." 7/9/26 2:15 PM – Findings were confirmed with E1 (NHA) and E2. 7/10/26 2:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference	F0605		08/11/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F0658	A Nurse Practitioner completed a post fall assessment for R83 which was documented in the resident's chart at the time of the incident. An RN was present and completed a post fall assessment	08/11/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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
F0658 SS = D	Continued from page 7 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of facility documentation, it was determined that for two (R83 and R118) of nine residents reviewed for falls and accidents, the facility failed to provide treatment and services in accordance with professional standards of practice by failing to ensure that a Registered Nurse (RN) completed the required post-fall assessment following each resident's fall. "Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024... RN... Post Fall Assessment & Documentation... updated 10/11/24." 1. Review of R83's clinical record revealed: 4/15/22 - R83 was admitted to the facility. 1/1/26 7:30 AM - R83 had a witnessed fall during a transfer, resulting in staff lowering R83 to the floor. 1/1/26 9:35 PM - A post fall assessment was completed by E9 (LPN). 7/9/26 10:30 AM - During an interview, E9 stated the expectation was for an RN to complete post fall assessments. E9 stated that she did complete the post fall assessment and the RN was also in the room at that time. E9 confirmed that she did complete the assessment. Review of the EMR failed to show evidence that a Registered Nurse completed or documented the required post-fall assessment following the resident's fall on 1/1/26. 2. R118 clinical record revealed: 10/1/25 – R118 was admitted to the facility. 3/23/26 at 10:59 AM – Documentation of assessment completed by E11 (Licensed Practical Nurse (LPN)) in R118's clinical record indicated,	F0658	Continued from page 7 on R118 at the time of the fall. A statement was obtained from the RN attesting to their assessment. Education was provided by the Staff Educator to the RN to complete documentation in the chart of their assessment rather than relying on the LPN note. All residents with a fall in the last 30 days were reviewed for RN post fall assessment documentation. If the documentation was missing, the RN who assessed post fall wrote a late entry note documenting the assessment. A root cause analysis identified a gap in understanding the RN must complete the documentation of their assessment; it isn't enough for the LPN to say an RN was in to assess in the LPN note. The Staff Educator will educate all licensed staff on completing documentation per their own assessment and at the time of the assessment. The Staff Educator will also add education about RN documentation of post fall assessments to all licensed staff during onboarding/orientation as a proactive new hire process change. The DON, or designee, will complete an audit of all residents with a fall for a post fall RN assessment weekly times four or until 100% compliance then monthly times two or until 100% compliance achieved with results reported in QAPI for review and recommendations. Compliance date: August 11, 2026	08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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
F0658 SS = D	Continued from page 8 "Staff notified this nurse that resident [R118] had fallen in the satellite common area. Resident lying face down in the prone position with blood noted to the facial area... Resident noted to have a laceration to the right side of the forehead. Pressure dressing applied. Unresponsive to tactile or verbal stimuli... Resident to be sent out via 911 at this time. 911 notified. Resident left the facility via stretcher with EMS with a cervical collar in place and pressure dressing intact..." 7/9/26 10:00 AM – A review of R118's clinical record revealed that the post fall documentation was completed by E11 (LPN). During an interview, E11 stated, "I was the nurse when the resident fell. Other nurses came into the room, but I did the documentation." 7/9/26 at 11:00 AM – During an interview, E2 (Director of Nursing) confirmed that the post-fall documentation for R118 had been completed by the LPN and acknowledged there was no documentation that an RN completed the required post-fall assessment. 7/10/26 2:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference	F0658		08/11/2026
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 §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	F0757	R9's anti-coagulant order had side effect monitoring added by the ADON at the time of survey. All residents currently in the facility with anti-coagulant orders were reviewed for side effect monitoring. Any anti-coagulant orders found without side effect monitoring had the monitoring added. A root cause analysis revealed not all licensed staff were familiar with the process of adding monitoring to anti-coagulant medications. The Staff Educator will provide education to all licensed staff on why and how to add side effect monitoring for anti-coagulant medications. The Staff Educator will also add education about adding side effect monitoring to anti-coagulant medications to all licensed staff during onboarding/orientation as a proactive new hire process change. The DON, or designee, will complete an audit of all new admissions on an anti-coagulant medication for side effect monitoring weekly times four or until 100% compliance then monthly times two or until 100% compliance achieved with results reported in QAPI for review and recommendations.	08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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
F0757 SS = D	Continued from page 9 §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, record review, and review of other facility documentation, it was determined that for one (R9) of five residents sampled for unnecessary medications, the facility failed to ensure residents receiving anticoagulant therapy were monitored for side effects. Findings include: 1. Review of R9's clinical record revealed: 4/17/26 – R9 was admitted to the facility. 4/29/26 8:00 PM – A physician's order was written for Eliquis (anticoagulant medication) 5 mg, give two tablets by mouth twice daily for three days, then one tablet by mouth twice daily. 5/5/26 – A care plan identified that R9 was receiving anticoagulant medications which included interventions to monitor for the following adverse side effects: blood-tinged urine, black tarry stools, dark red or bright red blood in stool, bruising, blurred vision, lethargy, fatigue, or sudden change in mental status. 7/8/26 8:50 AM – A review of the Medication Administration Record (MAR) from 4/29/26 through 7/8/26 lacked evidence that staff monitored or documented adverse outcomes following the initiation of Eliquis. 7/8/26 9:06 AM – During an interview, E2 (Director of Nursing) stated nursing staff were expected to monitor residents for adverse effects of anticoagulant medication. E2 confirmed the facility failed to monitor and document adverse effects or adverse outcomes for the aforementioned medications. 7/10/26 2:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0757	Continued from page 9 Compliance date: August 11, 2026	08/11/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Contro The facility must establish and maintain an infection prevention and control program designed to provide	F0880	The CNA was educated by the DON on EBP and proper PPE at the time of survey. All EBP rooms were reviewed to ensure PPE was available in or near the room.	08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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 = D	Continued from page 10 a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (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.	F0880	Continued from page 10 A root cause analysis identified the CNA wasn't aware to use a gown in addition to gloves as soon as she began preparing the resident for care. The DON provided education to the CNA regarding EBP and when to use the appropriate EPP. The Staff Educator will provide education to all staff regarding EBP, why EBP is necessary, when to use the precautions, and to restock supplies when PPE is low. The Staff Educator will include in depth education during orientation training for new hires about EBP to include why EBP is necessary, when to use it, and the importance of restocking EPP supplies for EBP rooms. The DON, or designee, will complete a random audit of 10 residents on EBP for appropriate EBP use and sufficient supply of PPE weekly times four weeks or until 100% compliance then monthly times two or until 100% compliance achieved with results reported to QAPI for review and recommendations. Compliance date: August 11, 2026	08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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 = D	Continued from page 11 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: F880- Based on interview, observation, and record review, it was determined that for one (R40) out of five residents sampled for infection control intervention, the facility failed to ensure that appropriate Enhanced Barrier Protection (EBP) equipment was utilized during high contact resident care activity. Findings include: R40's clinical record revealed: 5/30/26 - R40 was admitted to the facility with diagnoses including, but not limited to right great toe ulcer, and end stage renal disease which required dialysis treatments three times a week. 6/3/26 – R40's admission MDS documented a BIMS score of 15, indicating a completely intact cognitive status. The MDS also documented that R40 was dependent on the staff for all personal hygiene, turning and repositioning and transfers. 6/4/26 – R40's physician s orders included, "Enhanced Barrier Precautions for wound every shift." 6/23/26 – R40's physician's orders included, "Wound treatment: Right great toe arterial ulcer. Cleanse with NSS [normal sterile saline], apply Betadine liberally and leave OTA [open to air.] 7/1/26 – R40's care plan documented, "The resident is on enhanced barrier precautions (EBP) r/t [related to] covered wound." The interventions included, "Direct care staff to utilize gowns and gloves for all personal care."	F0880		08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085029	A. BUILDING B. WING	07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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 = D	Continued from page 12 7/6/26 11:30 AM – During an observation, R40 was laying unclothed in his bed. E7 (CNA) was observed washing him up using a wet washcloth. E7 stated that she was getting R40 cleaned up and ready for his appointment. E7 was wearing gloves but no gown. The Surveyor asked E7 if she was aware that R40 was care-planned for enhanced barrier precautions. E7 stated, "No, I was not aware of that." The Surveyor observed that there were no enhanced barrier precautions supplies inside or outside of the room. During an interview, E6 (LPN) stated, "Gowns and gloves were supposed to be in the cart outside of the room. And the aide was supposed to be using it when care was given." The facility failed to ensure that enhanced barrier precautions were utilized when care was provided to R40. I would be more specific? below The facility failed to ensure staff implemented Enhanced Barrier Precautions by wearing both gowns and gloves during high-contact personal care provided to R40. 7/10/26 2:45 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0880		08/11/2026