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: Wilmington Nursing and Rehabilitation **DATE SURVEY COMPLETED:** July 10, 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 follow up 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 residents' records and review of other facility documentation as indicated. The facility census on the first day of the survey was (131) one-hundred thirty-one. The investigative sample totaled (27) twenty-seven residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: This requirement was not met as evidenced by: Cross Refer to the CMS 2567 – L survey completed July 10, 2026: F550, F580, F583, F600, F609, F610, F656, F677, F684, F695, F761 and F777.	**3201.1.2** Cross Refer to the CMS 2567 – L survey completed July 10, 2026: F550, F580, F583, F600, F609, F610, F656, F677, F684, F695, F761 and F777. Date of compliance 8/26/2026	8/26/2026
3201.9.0	**Records and Reports**		

Provider's Signature *Renee Boyer* Title LNHA Date 8/17/2026

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3201.9.5	**Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate.** This requirement was not met as evidenced by: Based on interview and record review, it was determined that for two (R12 and R13) out of seven residents reviewed for abuse, the facility failed to have incident reports involving each resident. Findings include: 1. Review of R13's record revealed: 6/16/26 10:02 AM – The facility reported an allegation of abuse regarding R13 to the State Agency. 7/8/26 11:30 AM – Surveyor requested the facility's 6/16/26 incident report involving R13 and E8 (CNA). 7/9/26 10:20 AM – During an interview, E2 (DON) confirmed there was no facility incident report completed for the 6/16/26 staff to resident incident. 2. Review of R12's record revealed: 6/15/26 2:50 PM – The facility reported an allegation of abuse regarding R12 to the State Agency.	**Tag 3201 — Incident Reports** 1. Corrective Action: R12 and R13 no longer reside in the facility. The facility was unable to retroactively correct the failure to report the identified concern within the required timeframe. The concern will be reviewed, and any outstanding investigation, documentation, notification, or reporting requirements will be completed. 2. Identification of Other Residents: All residents have the potential to be affected. The Administrator and/or the Director of Nursing will complete an audit of all grievances and concerns from the previous 30 days to determine whether each concern was evaluated for reportability and reported in accordance with Delaware requirements. Any identified concerns will be investigated, documented, entered the Incident Management/Risk Management system, and reported as required. 3. Systemic Changes: System Change: The facility did not have a process in place to put grievance identified as a reportable into the Incident management (High Risk). During the new hire orientation this process will be reviewed with those that would be responsible for completing investigations or reportable events. Administrative staff will be educated by the Staff Development Coordinator or designee	8/26/2026

Provider's Signature Renee Boyer Title LNHA Date 8/17/2026

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	7/9/26 10:30 AM – During an interview, E2 (DON) was requested to provide copies of all facility incident reports regarding R12 dated 6/1/26 through 7/7/26. This request was repeated at 2:00 PM and 3:30 PM 7/10/26 10:20 AM – During an interview, E2 was requested to provide copies of all facility incident reports regarding R12 dated 6/1/26 through 7/7/26. 7/10/26 approximately 11:30 AM – E2 provided four handwritten witness statements related to the 6/15/26 alleged incident. 7/10/26 approximately 1:30 PM– During an interview, E2 confirmed that the facility did not have a completed incident report for the allegation related to R12 that was reported to the State Agency 6/15/26. E2 reported that the facility uses the incident investigation templates contained within their EHR (Electronic Health Record) system to manage internal incident investigations and reports. Since the system does not have a template for abuse/neglect allegations, the facility does not complete incident investigation reports for these allegations. 7/10/26 4:50 PM – Findings were reviewed during the exit conference with E1 (NHA), E2 and E3 (CRN).	on the facility's incident-reporting policy. Delaware incident-reporting requirements, identification and escalation of potentially reportable events, required administrative notification, and the process for entering reportable events into the Incident Management/Risk Management system. 4. Monitoring: The Director of Nursing and/or Administrator, will audit all grievances and concerns daily for two weeks, weekly for four weeks, and twice monthly for two months to verify that each concern was evaluated for reportability and that all reportable events were entered into the Incident Management/Risk Management system and reported as required. Identified concerns will be corrected immediately. Audit findings and trends will be reviewed through the Quality Assurance and Performance Improvement Committee to determine whether additional corrective action or monitoring is necessary. The Administrator and/or Director of Nursing are responsible for the corrective action. 5. Date of Compliance: 8/26/26	

Provider's Signature *Renee Boyer* Title LNHA Date 8/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(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
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD , WILMINGTON, Delaware, 19803

(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	INITIAL COMMENTS An unannounced follow up 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 residents' records and review of other facility documentation as indicated. The facility census on the first day of the survey was one hundred thirty-one (131). The investigative sample totaled twenty-seven (27) residents. Abbreviations/definitions used in this report are as follows: BOM - Business Office Manager; CNA - Certified Nursing Assistant; CRN - Corporate Regional Nurse; DON - Director of Nursing; IC - Infection Control; LPN - Licensed Practical Nurse; MAR - Medication Administration Record; NHA - Nursing Home Administrator; OT - Occupational Therapist; PRN - When necessary or as needed; RN - Registered Nurse; SPO2 - blood oxygen level, pulse ox; SSD - Social Services Director; STAT - At once; TAR - Treatment Administration Record; UM - Unit Manager; @ - at;	F0000		07/27/2026

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING B. WING	07/10/2026

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F0000	Continued from page 1 Acute respiratory failure - sudden condition that occurs when fluid builds up in the air sacs in the lungs, then lungs are unable to release oxygen into blood and organs; Activities of daily living (ADLs) – tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Anxiety - general term for disorders that cause nervousness, fear, apprehension and worrying; BIMS (Brief Interview for Mental Status) - assessment aimed at evaluating cognition in the elderly with scores ranging from 0 - 15. 13 -15: Cognitively intact. 8 - 12: Moderately impaired. 0 - 7: Severe impairment; Chronic Obstructive Pulmonary Disease - a chronic inflammatory lung disease that causes obstructed airflow from the lungs; Dehumanization – deprivation of human qualities or attributes such as individuality, compassion, or civility. Dehumanization is the outcome resulting from having been treated as an inanimate object or as having no emotions, feelings, or sensations; Dialysis – procedure that removes waste and extra fluid from the body through the blood; Diltiazem - medication used to treat high blood pressure; End-Stage Renal Disease (ESRD) - disease where the kidneys stop working; Hypertension - high blood pressure; Hypoxic - deficiency in amount of oxygen reaching body tissues; Incontinence – loss of control of bladder &/or bowel function; MDS assessment- federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs;	F0000		07/27/2026

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F0000	Continued from page 2 Milligram (mg) - unit of weight; Neglect – the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress; Perineal region – area that includes the external genitalia and the anal opening; PRN - as needed; Pulse oximeter - device used to measure blood oxygen saturation levels- desired range is 94% to 100%; Non-rebreather - device used to deliver high concentration oxygen to a person who can breathe unassisted; Santyl - ointment containing enzyme that helps remove dead tissue; Spironolactone - medication used to treat high blood pressure; Wellsky - Division of Health Care Quality's web-based portal to identify, track, investigate, and monitor critical incidents and their resolution.	F0000		07/27/2026
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of clinical and facility	F0600	F600 – Free from Abuse and Neglect 1. Corrective Action R13 and R16 no longer reside at the facility; therefore, no additional resident-specific assessment or intervention can be completed for these residents. R17 Following R13's allegation on June 16, 2026, the facility suspended E8 pending investigation, notified the State Agency and law enforcement, completed resident and family interviews, and initiated an investigation. The facility will reconcile the conflicting information contained in the Personnel Action Memo for E8 and the five-day investigation report. If required, the facility will submit corrected or supplemental information to the appropriate State Agency. The Director of Nursing obtained a statement from	08/26/2026

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F0600 SS = G	Continued from page 3 records, it was determined that for two (R13 and R16) out of seven residents reviewed for abuse, the facility failed to ensure each resident remained free from physical and emotional abuse. On the morning of 6/16/26, R13 was physically and emotionally abused by a staff person, resulting in dehumanization, a psychosocial harm. On 5/30/26, R16 was physically abused by another resident (R17) in the locked dementia unit. Findings include: 1. Review of R13 records revealed: 5/21/26 – R13 was admitted to the facility with diagnoses including, but were not limited to, end stage renal disease requiring renal dialysis, orthopedic aftercare following surgical amputations of the left leg below knee and toes on right foot and blindness in the right eye. 5/21/26 – R13 had two physician orders for wound treatments in the perineal region, one requiring a dressing and the other a non-sting skin barrier film to protect against moisture-associated skin damage. 5/27/26 – The admission MDS assessment documented that R13 had a BIMS of 15 (cognitively intact), required substantial/maximal staff assistance for toileting hygiene and dependent on staff for transfers. 6/16/26 – A grievance form was completed and stated: "Grievance Details: Resident reported that the night before a CNA came into his room to complete incontinence care. Resident asked CNA 'what was she doing' (sic) CNA then pulled his brief down to look for stool and/or urine… Summary of Findings: CNA report was obtained. The DON is currently completing an investigation. Summary of Actions Taken: The Director of Nursing met with the resident and obtained his statement. DON then reported the incident to the State Police and filed a report using Wellsky. When the police arrived, NHA went into the room with the resident and police. Resident had stated that he told the CNA that he didn't want care but she continued to proceed. He then slapped the bottle of spray out of her hand prior to being used as in the past it stung. CNA then left the room. Resolved Note: DON met with the resident to obtain his statement and reassured him that the matter would be looked into. DON will be completing an investigation into the incident. Police, NP [Nurse Practitioner] and a reportable completed. Satisfied at this time. No new concerns." 6/16/26 10:02 AM – The facility reported the following to the State Agency: "Resident stated CNA	F0600	Continued from page 3 E17 revealing that she observed R17 strike R16 with his walker and stayed in the room to keep R17 safe, she called for help another CNA redirected R17 out of the room and the nurse was in the room with the other resident. 2. Residents with Potential to Be Affected The Administrator and/or Director of Nursing or designee will audit grievances and risk management reports to identify any concerns or allegations involving abuse, neglect, inappropriate staff approach, failure to honor refusals of care, unwanted personal care, double briefing, resident-to-resident altercations, wandering into other residents' rooms, and aggressive behaviors, any identified issues will be reviewed to ensure reporting requirements have been followed. If any identified issues have not been reported per requirements, a report and investigation will be completed. The facility will review grievances, incident reports, behavior documentation, progress notes, and abuse investigation files from the preceding 30 days to identify concerns requiring additional investigation or protective action. Any concern identified will result in immediate resident protection, assessment, required notifications, investigation, care-plan review, and employee corrective action as indicated. 3. Systemic Changes The root cause analysis is related to the CNA's failure to follow abuse and neglect policy related to the allegation of physical and emotional abuse to R13, by failing to stop providing care when the resident expressed the desire not to receive care and misunderstanding that resident does not void. The Staff Development Coordinator/Director of Nursing and/or Nursing Supervisor will re-educate all licensed nurses, direct-care employees, agency staff, department managers, and other applicable employees regarding: Abuse, neglect, exploitation, and mistreatment	08/26/2026

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F0600 SS = G	Continued from page 4 came into his room at approximately 0230-0300am to give care to resident in the A bed, then approached his bed. He asked her, 'what are you doing' and she said I am going to check your brief. Stated he told her he did not want care from her, but she continued to attempt to provide care. Resident stated, 'she reached and pulled the front of my brief open to see if brief was soiled.' [R13] told her I have not urinated in 6 years, and she said that is impossible. At that time, she turned the resident to the side using her 'leg' for support and turned him on his left side. Resident also stated she sprayed him with the skin cleanser and he asked her not to use it because it stings his skin. At this point, he stated he slapped the container from out of her hand. Resident did not report this to anyone else on the night shift and wasn't until the beginning of this shift did he report to his nurse and his therapist who were in the room. Resident is legally blind, but can visualize images. Unable to give a specific description of the CNA but stated he has had her before." 6/16/26 – The facility's investigation included the following statements: -E12 (OT) documented, "Pt [Patient] made report to this therapist and RN [E13] in room. [R13] reported during therapy session a concern about PM aid (sic). Aid (sic) he did not know her name, but had a headband. Reports aid (sic) came in @ [at] 2:30 AM offering to clean [Room number beds A and B] up… [R13] reports aid (sic) then came to him to clean him up. Reports that aid (sic) ripped his diaper off moved his legs aggressively over, and used cleanser on his penis to clean aggressively. Pt noted having a… wound on his groin which is sensitive. Pt… told CNA that there is a wound and hurting him. [R13] reports throwing cleanser in CNA hand away from him asking her to stop. Patient did not report how the encounter ended." -E13 (RN) documented, "… Resident [R13] stated over 11-7 shift a 'wide bodied CNA' entered his room & [and] attempted to give him care. Resident stated he did not need anything & to please leave, CNA stated she needed to see if he was wet & tried to open his brief. At some point, she (CNA) attempted to apply wound cleanser to pt... & pt stated he hit the wound cleanser out of her hand & told her to leave. CNA still attempted to change pt & then left…". Identify any documentation you completed related to the incident: "Wrote note & notified DON of pts accusation…". -E8's (CNA) statement obtained on 6/16/26 via	F0600	Continued from page 4 prevention. Residents' right to refuse care and withdraw consent during care. The requirement to explain care and obtain resident cooperation before proceeding. Immediate cessation of nonemergency care when a resident refuses or asks the employee to stop. Appropriate response when refusal of care creates a clinical concern. Respectful communication and prohibited demeaning statements. Proper incontinence and wound care, including following physician orders and resident-specific sensitivities. Prohibition against double briefing. Immediate protection, reporting, investigation, and notification requirements. Prevention and management of resident-to-resident altercations. The Unit Managers, Staff Development Coordinator, and/or Nursing Supervisors will complete observation audits on 10% of residents' care during the scheduled audit period for the plan of correction. The facility will revise or reinforce its abuse-investigation process to require: Immediate protection and separation when indicated. Identification and interview of all witnesses. Documented attempts when a witness is unavailable	08/26/2026

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F0600 SS = G	Continued from page 5 phone by E2 (DON): "[E8] had the resident on 11-7AM... assisted him and gave incontinent care. He [R13] did not complain to me. [E8] did not put... leg on his bed or on his back... He didn't say anything to me." A facility Corrective Action form, signed by E1 (NHA) and E2 and dated 6/16/26, documented, "CNA [E8] was suspended in regards to allegation from resident... Spoke with CNA over phone to inform her of the allegation and suspension." -E2's (DON) typed, undated statements: "[R13]... made a complaint to the oncoming nurse and CNA (sic) that he had been abused overnight by his SNA (sic). [Name of E8] was the CNA on this assignment. I spoke with the resident and his [FM1, family member] in regard to the complaint of abuse. During the visit, [FM1] wanted me to see the resident was doubled briefed. She also took pictures of the briefs. Both briefs were in place and fastened. [R13] also made complaints of abuse related to... approach with him. He stated, '... came in and pulled his brief forward to see if it was wet. [R13] explained to [E8, CNA] that I have not made urine in 6 years, but she did not believe that was possible'. [E8] then turned me on my side and used her leg to hold me in a side position. Also explained he does not like the spray, and she used it anyway. Complains it stings his peri area. Resident stated he attempted to 'slap' the container out of her hand. Resident is visually impaired and can only go by who was assigned to him. He stated, 'I would know her voice'. E2 also documented, "After receiving a complaint, I met with resident and [FM1]. After the meeting, I rounded with the CNAs and nurses and confirmed no other residents were doubled briefed at this time." 6/22/26 – The facility's Personnel Action Memo, signed by E1 (NHA) and E2 (DON), documented, "CNA brought in to complete reinstatement documents. Investigation completed... CNA refused to sign Personnel Action Memo and left building. Administrator present for meeting." 6/24/26 11:54 PM – The facility's 5-day follow-up investigation report to the State Agency submitted by E2 (DON) documented that there were "no s/s [signs or symptoms] of abuse; no physical harm... Patient told CNA he didn't want care from her, but she continued to attempt to provide care... CNA denied putting two briefs on the resident or demanding he receive care after he asked her to stop... Patient is a 1 person assist with bed mobility, requires mechanical lift for transfers, and 1 person assist w/ [with] toileting... 6/16 approximately 0830 AM... Resident stated to his nurse and therapist who was in the room at this time, that he did not report	F0600	Continued from page 5 or declines. Collection and preservation of relevant clinical and personnel records. Reconciliation of conflicting statements and documentation. Accurate documentation of employee suspension, reinstatement, education, corrective action, and employment status. Review of the investigation for completeness before submission of the five-day report. The abuse reporting process is reviewed during new hire orientation to include mandated reporting timeliness of reporting and investigation. The Administrator and/or Regional Director of Clinical Services will review abuse investigation files and State Agency submissions for completeness, consistency, and accuracy before final submission. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. 4. Monitoring Monitoring will evaluate: Immediate resident protection. Timely reporting and required notifications. Identification and interview of all witnesses. Documentation of attempts to obtain unavailable witness statements. Consistency between clinical records, personnel	08/26/2026

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F0600 SS = G	Continued from page 6 this incident to anyone until now. Approximately 0915am, DON and Administrator met with patient. Approximately 0930am, DON again met with patient and a [FM1, family member]. He was in agreement that she was present. [FM1] informed the DON that she was a CNA and works in LTC [long term care] in Delaware, explaining she is aware of what abuse is, and then alerted the DON that resident was wearing two briefs at this time. Resident stated, CNA from day shift had not provided a brief change prior to this discovery. Resident is alert and oriented, but has poor vision, and was not aware he was wearing two briefs… Resident stated to DON and NHA he felt safe in his environment but did not want the CNA to provide care to him. [Name] PD [police department] was notified and officer responded and spoke with patient… After investigation was completed, the allegation of abuse could not be substantiated. CNA was reinstated and DON gave 1:1 education… r/t [related to] incontinent care and customer service along with understanding what abuse looks like. CNA verbalized understanding and denied she had placed two briefs on the resident at anytime during her shift." It should be noted that conflicting information was reported to the State Agency as E8 (CNA) was not reinstated according to the Personnel Action Memo where she refused to sign it and left the building on 6/22/26. In addition, no evidence of E8's education was provided to the surveyor. 7/9/26 9:55 AM – During an interview with the surveyor, R13 stated that he can see forms with his left eye and blind in the right eye. R13 stated that he had recent surgical amputations and was here for therapy and wound care. Surveyor asked R13 about the night shift incident where a CNA came in and pulled down his briefs. R13 stated it was a female, heavy set aide. R13 asked [E8, CNA] what she was doing, and she said she was checking his brief for urine. R13 stated that he told [E8] that he hasn't urinated in 6 years and didn't need care. [E8's] reply to him was "that's the dumbest thing I ever heard." R13 stated that the aide was on one side of the bed and sprayed him in his wound area. R13 told E8 to stop because it stings. Then E8 came to the other side and sprayed him again and he knocked the cleanser spray away from him. During the interview, R13 was upset and angry when describing the incident. R13 stated that he felt the CNA was "aggressive, did not listen to him" and described the incident as an "assault." R13 stated that his family member [FM1] called the police to report the incident. R13 stated that if he needs staff assistance, he will use the call bell.	F0600	Continued from page 6 records, investigation findings, and State Agency reports. Evidence supporting employee education, suspension, reinstatement, or other corrective action. Assessment and care-plan revisions. Implementation of interventions for residents with wandering or aggressive behaviors. The Administrator and/or Director of Nursing will review 100% of new grievances and risk management reports to ensure the following allegations; resident-to-resident altercations, refusals resulting in unmet care needs, and related investigations daily for 14 days until 100% compliance, weekly for two weeks until 100% compliance, and monthly for two months until 100% compliance. The facility will present monitoring results and trends to the Quality Assurance and Performance Improvement Committee for review and determination of whether additional corrective action or extended monitoring is required. 5. Date of Compliance: 8/26/26	08/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING B. WING	07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0600 SS = G	Continued from page 7 7/9/26 12:59 PM – Surveyor left a voicemail for E8 (CNA) and asked for a return call. No return call was received by the surveyor as of the exit conference on 7/10/26 at 4:50 PM. 7/9/26 1:30 PM – During an interview, E12 (OT) stated that R13 was "agitated" and "very angry" when talking about the 6/16/26 incident with E8 (CNA). E12 stated that she immediately reported it. 7/9/26 1:45 PM – During an interview, E13 (RN) confirmed that he was present with E12 (OT) in the room when R13 made the allegation of being treated aggressively by the CNA. E13 stated that R13 was initially calm at first, but then he became very upset recalling the details. E13 stated that R13 was getting irritated when they asked additional questions. The facility failed to ensure R13 was free from physical and emotional abuse on 6/16/26 during early morning care by E8 (CNA) when: - R13 told E8 that he did not need care and she continued anyway; - R13 told E8 that he hasn't urinated in 6 years and E8's response to R13 was "that's the dumbest thing I ever heard"; - E8 sprayed skin cleanser on R13's peri-area that had wounds despite R13 telling her to not use it because the cleanser stings; and - R13 was found double briefed. 7/10/26 1:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (CRN). No further information was provided to the surveyor. 2. Review of R16's and R17's clinical records revealed: 5/30/26 8:30 PM – A facility incident report for R16 documented in the locked dementia unit, "Physical Aggression Received... Resident's [R16] Room... Resident [R16] was resting in bed, when staff called that another resident was hitting the one that is laying in bed with a walker. Upon entering the room found the male resident [R17] standing by the bed side trying to fight staff that were trying to redirect him. This nurse [E16, LPN] tried to redirect, unsuccessful. Other staffs including a male came to our aid for resident to be removed from the room. Resident [R16] in bed was crying... saying 'he hit me'. RN supervisor [E18] called and assessed.	F0600		08/26/2026

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F0600 SS = G	Continued from page 8 Bruise noticed (sic) back of right hand... Tylenol PRN [as needed] administered for pain...". 5/30/26 10:12 PM – A health status note by E10 (LPN) in R17's record documented, "Called to another resident's room [number], and was notified by aide resident hit the female resident resting in bed with a walker, on entering the room, witnessed resident [R17] fighting with staff members who were trying to redirect and yelling in [specific language] holding his walker and refusing to leave the room, managed to redirect him back to his room and he laid in bed." 6/2/26 11:40 AM – A psych progress note in R17's record documented, "... oriented to person... no verbal aggression, yes physical aggression... yes tangential thought process... yes delusions... behavioral symptoms (checked) restless... Severity of behaviors (checked) mild... Frequency of behaviors (checked) intermittent... Requested by staff due to recent physical aggression toward another resident and staff. Patient AAOX1, seen at bedside with staff present for monitoring. Hx [History] significant for chronic depression, anxiety, mood irritability, agitation, and exit-seeking behaviors. Patient unable to recall recent behavioral incident. Thought process tangential; thought content notable for delusional ideation. Insight and judgment severely impaired... Given recent escalation in aggression and mood dysregulation, recommendation made to restart Celexa to target depressive symptoms, irritability, and behavioral disturbance. Advanced major neurocognitive d/o [disorder] with behavioral disturbance continues to place patient at high risk for... aggression, impaired safety awareness... requiring ongoing supervision and behavioral monitoring... Continued psychiatric oversight remains medically necessary for medication management, behavioral stabilization, safety monitoring, and prevention of further decline... dementia-related behavioral disturbance with recent physical aggression, psych med management, and ongoing risk for harm to self/others requiring close mo (sic)." 6/5/26 – The facility's 5-day follow-up report to the State Agency documented: -R16's x-ray of right wrist was negative for acute fracture; -"Approximately 10:12 PM [5/30/26], CNA was giving care in another resident's room... when she heard a woman say "ouch" and raised her voice. CNA exited room and saw [R17] in room... [R16] was	F0600		08/26/2026

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F0600 SS = G	Continued from page 9 lying in her bed… when [R17] raised his walker and struck her with his walker as witnessed by CNA. [R17] was confused, yelling at [R16] to get 'out of his bed'." -Actions taken by the facility: For R16, "assess resident's emotional and mental health needs and update care plan accordingly; include resident in quarterly care plan meetings; maintain communication w/ [with] resident's RP [responsible party] to support emotional well-being; monitor for signs of depression or anxiety and refer to psychiatry/psychology as needed. For R17, "Psych consult; 1:1 observation until cleared by Psych; and medication review." -Conclusion: "Verified. [R17] has a history of wandering in other resident's rooms requiring redirection from staff back to his room and his surroundings. [R17] also has a history of being combative with staff. [R17] wandered into another resident's [R16] room, became disoriented and struck [R16] with his walker. CNA witnessed [R17] yelling… to [R16] to get out of his bed, then lifted his walker in the air and hit [R16] with the walker before the CNA could reach him." Review of the facility's investigation revealed written statements from E10 (LPN), E16 (LPN) and E18 (RN Supervisor). The facility lacked evidence of a statement from E17 (CNA) who witnessed R17 hit R16. 7/10/26 10:55 AM – During an interview, E10 (LPN) stated that R16 "looked scared" after the incident with R17. E10 stated that R16 had redness on her wrist. E10 stated that the CNAs told her that R16 was hit with R17's walker. E10 stated that on the following day, R16 was back to her normal baseline. 7/10/26 11:08 AM – During an interview, E11 (CNA) stated that she was on break and she was told about the incident when she returned. 7/10/26 4:50 PM – Findings were reviewed during the exit conference with E1, E2 and E3.	F0600		08/26/2026
F0677 SS = G	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 personal and oral hygiene;	F0677	F677 – ADL Care Provided for Dependent Residents 1. Corrective Action R13 no longer resides at the facility; therefore, no additional resident-specific intervention can be completed. R13 received incontinence care following identification of their needs; a shower was offered	08/26/2026

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F0677 SS = G	Continued from page 10 This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for three (R11, R13 and R26) out of eight residents reviewed for activities of daily living (ADLs), the facility failed to provide necessary services for personal hygiene care of dependent residents. R13, who had a perineal wound, returned from dialysis incontinent of bowel and requested to be changed. As a result of R13's toileting hygiene care request being deferred by staff until after dinner, R13 sat in a soiled incontinence brief for an additional two hours, resulting in dehumanization, a psychosocial harm. R26 was left soiled for four hours after requesting staff assistance. In addition, the facility failed to ensure that R11, a dependent resident, received the necessary services to maintain grooming and personal hygiene. Findings include: 1. Cross refer F609 Review of R13's record revealed: 5/21/26 – R13 was admitted to the facility for short-term rehabilitation with diagnoses including, but were not limited to, end stage renal disease requiring renal dialysis, orthopedic aftercare following surgical amputation of the left leg below knee and toes on right foot and blindness in the right eye. 5/27/26 – The admission MDS assessment documented that R13 had a BIMS of 15 (cognitively intact), required substantial/maximal staff assistance for toileting hygiene and dependent on staff for transfers. 6/22/26 – A wound assessment report revealed that R13 had an abrasion in the perineal region that was receiving daily and PRN Santyl ointment treatment with no dressing. 7/1/26 – A grievance form was completed and stated: "Grievance Details: Resident upset with the timeliness of being changed… Summary of Findings: Resident reported that he had a bowel movement while at dialysis. He returned approximately 5:10 [PM]. Trays for dinner started to come out and resident then pressed call bell. CNA attempted to explain to resident that she will be back to chang (sic) him once the trays are passed. Resident	F0677	Continued from page 10 which he declined. R13 was evaluated by the Physician Assistant on 7/2/2026 and 7/3/2026. R13's care plan and toileting needs were reviewed, care plan and interventions were determined to be appropriate. The investigation was completed on 6/24/2026. The investigation was reviewed by the Administrator and it was determined and clarified that all statements were noted to be collected prior to the completion of the investigation, it was determined that a CNA statement was collected for the investigation but had been misfiled, it is now with the completed investigation. R11 received hygiene and incontinence care following identification of their needs. A skin observation tool was completed on 6/25/2026. During the investigation the Director of Nursing reviewed R11's care plan and toileting needs; care plan and interventions determined to be appropriate. R11 was evaluated by the physician on 6/25/2026. An investigation was completed on 7/1/2026, and the facility was unable to identify the staff responsible for the improper incontinence care was provided. Staff that were suspended were reinstated and received education regarding proper incontinence care. (E29 and E30) R26 received hygiene and incontinence care following identification of their needs. A skin observation tool was completed on 6/8/2026. R26's care plan and toileting needs were reviewed by the Director of Nursing, care plan and interventions determined to be appropriate. R26 was evaluated on 6/8/2026, 6/9/2026 and 6/10/2026 by either the Physician Assistant or the Physician. Investigation was completed on 8/7/2026. 2. Residents with Potential to Be Affected The Director of Nursing and/or Assistance Director of Nursing will audit residents requiring staff assistance with ADLs, toileting, or incontinence care. The audit will include observations related to call-bell response time, timely care, appropriate brief/incontinent product use, care-plan accuracy, ADL documentation, and resident interviews when appropriate. The facility will immediately address identified concerns. 3. Systemic Changes	08/26/2026

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F0677 SS = G	Continued from page 11 became angry and stated he should be able to be changed whenever he needs to be. Summary of Actions Taken: Director of Nursing [DON] attempted to explain the (sic) due to infection control, the CNA will pass out all meal trays then return to provide care. CNA who had resident did report to DON that she did try to explain to resident, but he became angry. Resident stated that once he was changed the stool was dry and hard to get off, so the CNA was a (sic) rough. A PRN [as needed] shower was offered but was declined. Resolved Note: DON, NHA and evening supervisor met with resident and [family member]. Educated resident on the process of passing meals. Resident not satisfied...". 7/1/26 6:59 PM – The facility's Documentation Survey Report revealed that E6 (CNA) documented that R13 ate 0-25% of meal intake for dinner. 7/9/26 9:55 AM – During an interview with the surveyor, R13 stated that he can see forms with his left eye, while he was blind in the right eye. R13 stated that he had a bowel movement when he was at dialysis on Wednesday, 7/1/26. R13 explained that he was unable to use the bathroom at dialysis because of his inability to walk due to recent surgical amputations. R13 stated that he arrived back to the facility around 4:45 PM. R13 stated that he was told by staff upon arrival back to the facility that they do not change residents during mealtimes. During the interview with the surveyor, R13 became very emotional from being tearful to becoming angry as he recalled what occurred on 7/1/26. R13 stated that he was not changed until after 7:00 PM despite having had a bowel movement at dialysis earlier that day. When asked about the time he was changed, R13 stated he remembered that Jeopardy was on the TV at the time. R13 stated that the staff need more training because they keep saying, "I'll be back and they never come back." R13 stated that he knows there are other residents who have needs and he understands that, but he "felt ignored" and did not understand why he could not get changed when he asked during a mealtime. 7/9/26 11:10 AM – During an interview, the surveyor asked E5 (SSD) about R13. E5 stated that R13 has a BIMS of 15 (cognitively intact), receiving short-term rehabilitation, a man of good faith, and cares about his family. E5 stated that she spoke to R13 several times, including on 7/2/26. When asked about R13's return from dialysis on 7/1/26 and his request to be changed, E5 stated that she was aware of the delay	F0677	Continued from page 11 The root cause analysis for R13 is related to the facility staff's failure to provide incontinence care in a timely manner upon resident request by failing to understand that it was permissible to stop passing meal trays to provide incontinence care. The root cause analysis for R11 is related to the facility staff's failure to provide incontinence care using the appropriate products and/or using the products improperly. The assigned CNAs from 3-11 and 11-7 shift were suspended pending investigation, both the 3-11 and 11-7 assigned CNAs were interviewed as well as another 11-7 CNA that was assisting the assigned CNA with care, all deny using two briefs or a plastic liner being placed under the resident. The facility was unable to determine which staff member was involved; the assigned CNAs were educated related to proper use of incontinence products. The root cause analysis for R26 is related to a delay in incontinence care, related to R26's call bell being turned off by "a tall light skinned" girl at approximately 10:10, stating that said she would get help but did not return. The resident stated she put her call bell back on later, which was at 2:00 am per the grievance log, and care was provided at that time. The DON or designee will re-educate licensed nurses, CNAs, supervisors, and agency staff regarding timely ADL and incontinence of care, call-bell response and follow-through, staff assistance across assignments, resident dignity, and supervisory escalation. The education will specifically address that care may not be delayed during meal service; employees may not turn off a call bell without providing or securing assistance, and double briefing and unauthorized plastic barriers are prohibited. The Unit Managers, Staff Development Coordinator, and/or Nursing Supervisors will complete observation audits on 10% of residents' care during the scheduled audit period for the plan of correction random audits will be completed monthly if to ensure continued compliance if issues are noted it will be brought through QAPI for review and follow up.	08/26/2026

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F0677 SS = G	Continued from page 12 in changing. When asked how would she feel if she was told that she had to wait for toileting care, she responded "frustrated." Surveyor asked E5 for a copy of the facility's policy and procedure that stated staff were not to provide toileting care for residents during mealtimes. 7/9/26 11:46 AM – During a follow-up interview, E1 (NHA) and E5 (SSD) stated that the facility does not have a policy about not changing a resident during meals. E1 stated it is a resident's right to be changed at any time. E1 stated that they will educate all staff that residents have a right to be changed at any time. 7/10/26 9:35 AM – During an interview, E6 (CNA) confirmed that she was R13's assigned CNA on 7/1/26 from 3 PM to 11 PM, and it was her first time she provided care to R13. E6 stated that R13 returned from dialysis, and he rang his call bell and asked to be changed. E6 stated that she told him that she would change him after dinner. E6 stated that during the meal she had to pass the meal trays in the hallway, retrieve missing meal items for residents from the kitchen, feed another resident across the hall from R13, and then she was asked at the end of dinner to supervise another resident, R27, in the nursing station as E7 (RN Supervisor) was called to the 1st floor for a resident who fell. E6 stated about 30-40 minutes after dinner, R13 started yelling to be changed to the nurse, E9 (LPN). E6 stated that she explained to the nurse that she would change R13 after dinner. E6 was asked by the surveyor if E9 (LPN) offered to change R13, E6 stated, "no." E6 stated that after she changed R13, a family member and E2 (DON) were present in his room. When asked by the surveyor if R13 ate dinner on 7/1/26, E6 stated "no." E6 stated that she was told in orientation to not change residents during mealtimes and that "pretty much everyone does that." When asked who told her not to change residents during mealtimes, E6 could not recall. When asked if the facility was short-staffed on that shift, she replied "I can't say short-staffed." 7/10/26 8:30 AM – During a follow-up interview, R13 stated that E2 (DON) and E5 (SSD) came back into his room recently and E2 told him that she was wrong and he can get changed during meals. R13 stated in an upset and angry tone that E2 lied to me and that he did not receive an apology for sitting soiled after using his call bell and asking to be changed on 7/1/26.	F0677	Continued from page 12 New hire orientation will include specific education that addresses that care may not be delayed during meal service; employees may not turn off a call bell without providing or securing assistance, and double briefing and unauthorized plastic barriers are prohibited The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. 4. Monitoring The facility will immediately correct negative findings and report results to the Quality Assurance and Performance Improvement Committee. The Director of Nursing/Assistant Director of Nursing and/or Unit Managers/Nursing Supervisors or designee will audit 10% of residents requiring ADL, toileting, or incontinence assistance across all shifts, including meal periods, daily for 14 days until 100% compliance, weekly for two weeks until 100% compliance, and monthly for two months until 100% compliance. Results will be reviewed through the Quality Assurance and Performance Improvement Committee to determine whether additional corrective action, education, or extended monitoring is required. 5. Date of Compliance: 8/26/26	08/26/2026

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F0677 SS = G	Continued from page 13 7/10/26 9:45 AM – During an interview, E9 (LPN) stated that she could not remember R13 asking to be changed on 7/1/26. However, E9 said "if he needs to be changed, then we will change him." 7/10/26 1:24 PM – During an interview, E7 (RN Supervisor) stated that the CNA [E6] was assisting with dinner and she went in to change R13 after dinner. E7 stated that he apologized to R13 that all CNAs were in the process of dinner and no one was available. E7 confirmed that R13 was "upset." 7/10/26 1:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (CRN). No further information was provided to the surveyor. 1. Cross refer F550 Review of R11's clinical record revealed: 9/25/19 - R11 was admitted to the facility with diagnosis including stroke and dementia. 2/20/23 – R11 was care planned for requiring assistance with ADLS related to physical limitation... weakness with interventions including one person staff assist with bed mobility. 6/8/23 (revised 12/20/23) – R11 was care planned for bowel and bladder incontinence and interventions included one person staff assist with… toileting hygiene as needed for incontinent episodes and providing toileting hygiene with brief exchanges. 5/18/26 – R11's quarterly MDS assessment revealed R11's cognition was severely impaired and was totally dependent with toileting, and personal hygiene. R11 required partial to moderate assistance with bed mobility and was always incontinent with bladder and bowel. R11 was also receiving hospice services during the review period. 6/24/26 1:04 PM – A facility incident report submitted to the state reporting agency documented that on 6/24/26 at 11:15 AM, "…During rounds at approximately 1100 (11:00 AM), [P1 Hospice RN] and [E29 CNA] were giving care to [R11]. During care, it was discovered [R11] was briefed, with another brief under him and also a plastic trash can liner was underneath a drawsheet…"	F0677		08/26/2026

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F0677 SS = G	Continued from page 14 6/24/26 – A written statement by P1 documented, "... [R11] was observed to be briefed with another brief inside of it. [R11] was lying on drawsheet with a trash bag smoothed out under the draw sheet. [R11] was saturated in urine, significant loos (sic) stool noted and redness to sacral area and down to left leg..." 6/25/26 – A written statement by E29 (CNA) documented, "I arrived late for my shift, then I started passing trays. I was checking my residents for safety and took care of immediate care. [P1] asked me to help her with [R11's] care. When we moved sheet (sic) we saw two briefs & the plastic liner." 7/1/26 – A facility 5 Day Follow Up Report documented, "... CNA from the 11p-7a [E30 CNA] and 7a-3p shift [E29] were interviewed and denied knowledge of the 2nd brief and/or liner... " 7/9/26 11:39 AM – In an interview, P1 stated, "... Both incontinence briefs were soaked with significant amount of urine and loose stools... it looked like it's been there for quite some time... longer than that of morning start of shift..." 7/9/26 12:21 PM – During an interview, E2 stated that E30 was the CNA who worked the previous night shift and she just came off from orientation. E2 stated that E30 was suspended along with E29 at that time when investigation was ongoing. 7/9/26 4:35 PM – In a telephone interview, E29 stated that on 6/24/26, she reported late for work and at around 10 or close to 11 AM she and P1 went to R11's room to do R11's incontinent care. P1 pulled the blanket and found trash bag underneath the blanket. E29 stated, "We took off two adult briefs that were on [R11] and it was soaked with urine and stool." The facility failed to ensure R11, a dependent resident, received hygiene/toileting care on 6/24/26. Care was not provided to R11 until 11:00 AM. 7/10/26 10:35 PM – Findings were discussed with E1 (NHA) and E2 (DON). 7/10/26 10:40 PM – Findings were reviewed with E2 and E2 during the Exit Conference. 3. Cross refer F610 Review of R26's clinical record revealed:	F0677		08/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(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
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F0677 SS = G	Continued from page 15 5/2/26 – R26 was admitted to the facility with diagnoses including polyneuropathy. 5/2/26 – A care plan documented that R26 required the assistance of one staff member for toileting, toileting hygiene and brief changes. 5/8/26 – An admission MDS assessment for R26 documented a BIMS score of 15, indicating intact cognition. The assessment also documented that R26 was frequently incontinent of bowels, was dependent for transferring to the toilet and required supervision or touching assistance for toileting hygiene. 6/7/26 8:23 PM- A facility document entitled, "Documentation Survey Report" E14 (CNA) documented that R26 did not have a bowel movement and was assisted after being incontinent of urine. 6/8/26 3:28 AM – A facility document entitled, "Documentation Survey Report" E25 (CNA) documented that R26 was incontinent of bowels and was dependent for assistance after having a large bowel movement. 6/8/26 – A facility document entitled, "Grievance Summaries" documented, "…Grievance Details: [R26] complained that she did not receive adequate care over the weekend. [R26] stated she stayed in bed all weekend and that she turned on her call light at 10:10 pm [6/7/26 10:10 PM]; an aide came and said she will be back but did not return after being informed that she needed to be changed…Summary of Investigation…[R26] reported a delay in being care [sic]…aide came in but didn't return to change her until hours later…". The grievance summary also documented that a CNA and Nursing Supervisor on duty received education. 7/9/26 10:35 AM – During an interview, E14 stated that she did not know of any incident where R26 was not changed after a bowel movement. E14 also denied receiving any education regarding this incident. 7/6/26 3:36 PM – During an interview, R26 stated, "Three or four weeks ago I put on my call bell. I had a BM [bowel movement] and needed to be changed. It was 10:30 [PM] and I did not get help until 2:30 [AM]. I was told there were no aides. At 11:30 [PM], I told the aide I needed to be changed and was told, 'I'll be back'. One hour later, another aide came with wipes and a brief and said, 'I'll be back'…I filed	F0677		08/26/2026

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F0677 SS = G	Continued from page 16 a report…I sat there for hours in feces…I reported it to [E1, NHA], [E2, DON] and [E4 RN, UM]. 7/7/26 10:52 AM – During an observation, R26's call light was on. E26 (CNA) entered R26's room turned off the call light and stated, "I will get your aide." 7/7/26 1:35 PM – During an interview, E26 stated, "If a resident puts on their call light I will help them." The Surveyor asked E26 why R26 was not assisted when entering room. E26 stated, "I did not help [R26] because I was busy." 7/7/26 2:30 PM – During an interview, E27 (CNA) stated, "I told [R26] I would her get up at 10:00 AM. My assignment got changed at 9:00 AM and I had to give two other residents showers." The Surveyor asked E27 if anyone informed her that R26 needed assistance. E27 stated, "The nurse (E23, RN) told me when I was finished that [R26] was waiting for me. [R26] needed to be changed; she had a massive bowel movement. I assist with other CNAs' residents and I helped other CNAs' residents this morning. They don't help with other CNAs' residents here." 7/7/26 4:16 PM – During an interview, R26 stated, "I told the aide [E26] I needed to be changed. She told me that I have [E27] and that she would go get her. I was sitting here for over an hour." 7/10/26 2:00 PM – Findings were reviewed with E1 (NHA) and E2 (DON). 7/10/26 4:50 PM – Findings were reviewed with E1, E2 and E3 (CRN) during the exit conference.	F0677		08/26/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the	F0550	F550 – Resident Rights/Exercise of Rights 1. Corrective Action R11 a certified nursing assistant provided incontinence care at approximately 11:15 am and a licensed LPN completed and documented in the clinical record, a skin observation tool on 6/25/2026 at 2:41 pm. The facility has completed an investigation in which the employee who provided R11's care on the date the concern was identified. CNA received individualized re-education by the Director of Nursing, regarding dignified incontinence care.	08/26/2026

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F0550 SS = D	Continued from page 17 resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for two (R11 and R26) out of eight residents reviewed for activities of daily living, the facility failed to ensure that the residents were treated with dignity. For R11, the facility failed to promote respect and dignity when he was found lying in bed on top of a plastic trash bag wearing two incontinence briefs. R26 was left unchanged and soiled after requesting assistance from staff. Findings include: 1. Cross refer F677 Review of R11's clinical record revealed: 9/25/19 - R11 was admitted to the facility with diagnosis including stroke and dementia. 6/24/26 1:04 PM – A facility incident report submitted to the state reporting agency documented that on 6/24/26 at 11:15 AM, "…During rounds at approximately 1100 (11:00 AM), [P1 Hospice RN] and [E29 CNA] were giving care to [R11]. During care, it	F0550	Continued from page 17 A registered nurse followed up with R26 regarding the delayed incontinence care and assured R26 that staff would be reeducated regarding providing incontinence care, call bell accessibility was verified, R26's incontinence care plan and toileting needs were reviewed and interventions determined to be appropriate, R26 was satisfied with follow-up and had no further concerns at the time. A licensed practical nurse completed a skin observation tool on 6/8/2026 at 2:38 pm. The CNAs who responded to R26's request but did not provide timely care and the nursing supervisor responsible for shift oversight received individualized corrective action, education, and competency validation regarding timely incontinence care, call-bell response, escalation, and supervisory oversight. Each corrective action will include the applicable completion date. 2. Identification of Other Residents Who Could Be Affected The Regional Director of Clinical Reimbursement has completed an initial audit related to residents that require assistance with incontinence care to verify that care is provided timely and in a manner that preserves dignity. The ongoing audit will include resident observation, skin condition, use of briefs and protective barriers, and call-bell accessibility and response, The Administrator will review grievances and complaints from the preceding 30 days involving delayed care, unanswered call bells, toileting, incontinence care, or dignity. If any concerns are identified, an investigation with appropriate follow-up will be completed. 3. Systemic Changes Root cause analysis is related to assigned CNAs, not providing appropriate incontinence of care to the	08/26/2026

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F0550 SS = D	Continued from page 18 was discovered [R11] was briefed, with another brief under him and also a plastic trash can liner was underneath a drawsheet..." 7/9/26 11:08 AM – In an interview, E21 (LPN, UM) stated that she was notified by E20 regarding R11 and E21 notified E2 (DON). E21 stated, "I went and checked the other residents in the unit to make sure no other residents where double briefed. I spoke with aids and nurse about proper care, dignity and safety of residents." 7/9/26 11:13 AM – During an interview, E20 (LPN) stated that she didn't have R11 on the assignment on that day (6/24/26). E20 stated she was called by P1 to check on R11 in his room. E20 stated, "I went in there and saw a plastic trash bag... when I walked in I saw [R11] with two incontinent briefs on and was fastened... I reported this to [R11's] nurse, [E10 LPN] and [E21, LPN UM] ... skin check was done. 7/9/26 11:39 AM – In an interview, P1 stated, "... I checked in with [E29] and we helped clean [R11] up. We saw two briefs on [R11] one was fastened, I can't remember if the inner brief was fastened as well... we turned [R11] to his side of the bed facing [E29], I saw a large trash bag underneath the folded blanket which served as a drawsheet..." 7/10/26 10:35 PM – Findings were discussed with E1 (NHA) and E2 (DON). 2. Review of R26's clinical record revealed: 5/2/26 – R26 was admitted to the facility with diagnoses including polyneuropathy. 5/2/26 – A care plan documented that R26 required the assistance of one staff member for toileting hygiene, including incontinence care. 5/8/26 – An admission MDS assessment for R26 documented a BIMS score of 15, indicating an intact cognition. The assessment also documented that R26 was frequently incontinent of bowels, was dependent for transferring to the toilet and required supervision or touching assistance for toileting hygiene. 6/8/26 3:28 AM – A facility document entitled, "Documentation Survey Report" documented that R26 was incontinent of bowels and was dependent on the assistance of one staff member after having a large bowel movement.	F0550	Continued from page 18 resident in a timely manner and also related to the use of improper incontinence products and CNAs "rounding" on residents without providing incontinence care during "rounds". Licensed nurses, CNAs, agency staff, and other direct-care employees will be educated by the DON or designee regarding resident rights and dignity; timely toileting and incontinence care; call-bell response; prohibition against double briefing and unauthorized plastic barriers; reporting and escalation of unmet care needs; and licensed-nurse supervisory responsibilities. During daily rounds, the unit managers/nursing supervisors will ensure residents are receiving incontinence care timely. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. 4. Monitoring The DON/ADON/Unit Managers and/or Nursing Supervisors will complete observation audits of residents requiring toileting or incontinence assistance across all units and shifts daily for 14 days until 100% compliance, weekly for two weeks until 100% compliance, and monthly for two months until 100% compliance. Audits will evaluate timely responses to requests, resident cleanliness and dryness, appropriate brief use, absence of unauthorized barriers, call-bell accessibility, resident dignity, care-plan implementation, and supervisory follow-up. Results and trends will be reported to the Quality Assurance and Performance Improvement Committee for review and determination of whether additional monitoring or corrective action is required. 5. Date of Compliance 8/26/2026	08/26/2026

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F0550 SS = D	Continued from page 19 6/8/26 – A facility document entitled, "Grievance Summaries", documented, "…Summary of Investigation…[R26] reported a delay in being care [sic] as she initiated the call bell at 10:10 [6/7/26 10:10 PM], aide came in but didn't return to change her until hours later…". The grievance summary also documented that a CNA and Nursing Supervisor on duty received education. 7/6/26 3:36 PM – During an interview, R26 stated, "Three or four weeks ago I put on my call bell. I had a BM [bowel movement] and needed to be changed. It was 10:30 [PM] and did not get help until 2:30 [AM]. I was told there were no aides. At 11:30 [PM], I told the aide I needed to be changed and was told 'I'll be back'. One hour later another aide came with wipes and a brief and said 'I'll be back'. I filed a report. I sat there for hours in feces. It really affected my self-esteem to be left there like that." The facility failed to ensure R26 was treated with dignity when requested incontinence care was not provided, leaving the resident soiled for four hours. 7/10/26 2:00 PM – Findings were confirmed with E1 (NHA) and E2 (DON). 7/10/26 4:50 PM – Findings were reviewed with E1, E2 and E3 (CRN) during the exit conference.	F0550		08/26/2026
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	F0580	F580 – Notification of Changes Corrective Action Resident R9 no longer resides in the facility we are unable to correct the identified concern. Residents with Potential to be Affected An audit of diagnostic testing results, and physician notifications from the previous 30 days will be completed by the Director of Nursing or Designee. Any identified concerns will be addressed with the provider and follow up completed per the provider's recommendations. Systemic Changes The root cause analysis is related to the licensed nurses' failure to follow notification requirements of	08/26/2026

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F0580 SS = D	Continued from page 20 (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 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 interview and record review, it was determined that for one (R9) out of four residents reviewed for change in condition, the facility failed to ensure that the physician was immediately consulted when R9's stat chest x-ray report revealed significant results. Findings include: Cross refer F684, F695 and F777 Review of R9's clinical record revealed: 6/5/26 – A physician note by P2 (NP) documented that per nursing report, R9 had increased congestion and, "… will check stat (at once) chest x-ray..." 6/5/26 9:21 AM – A nurse progress note	F0580	Continued from page 20 abnormal results to the physician in a timely manner related to the licensed nurse placing the results in the physician's box instead of calling the provider for abnormal results. X-ray results are electronically uploaded into Point Click Care from PDI Radiology Services for review, Point Click care does not creat an alert when a new radiology results has been entered into the residents clinical record. The licensed nurse placed the results in the physician box for review instead of calling the provider with the abnormal results and did not communicate to the Nursing Supervisor regarding the results received. The Nursing Supervisor did not communicate with the nurse regarding the pending results and did not review Point Click Care regarding the x-ray results to ensure the provider was notified. The Unit Manager reviews the clinical record for pending results and communicates in the scheduled daily morning clinical meeting and schedule daily afternoon clinical meeting, if results are not received during that time the homework sheet is utilized to communicate with the off- shift nursing supervisors related to pending results and follow-up needed. The Staff Development Coordinator, Director of Nursing, Assistant Director of Nursing, Unit Managers, and Infection Preventionist will be educated by the Regional Director of Clinical Services and the Staff Development Coordinator/Assistant Director of Nursing and/or Unit Managers will educate the Nursing Supervisors and licensed nurses regarding the use of the homework sheet to communicate regarding x-ray results to ensure they are reported to the provider timely. The licensed nurses will be re-educated by the Director of Nursing or Designee on physician notification requirements, documentation, communication of diagnostic results, and notification of timeframes. The use of the homework sheet was implemented to prevent this deficient practice from reoccurring. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. Monitoring The Director of Nursing/Assistance Director of Nursing and/or Unit Managers will audit physician notifications of x-ray results daily for 14 days until 100% compliance, then weekly for 2 weeks until 100%	08/26/2026

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F0580 SS = D	Continued from page 21 documented, "... [P2] made aware (sic) she went to see [R9] ... gave verbal order for STAT chest x-ray..." 6/5/26 3:00 PM – R9 had a physician's order for chest x-ray two views for cough and congestion. 6/6/26 9:07 PM – A radiology results report documented R9's chest x-ray result was reported on this date and time revealing, "moderate congestive heart failure...moderate interstitial edema, cardiomegaly and pulmonary vascular redistribution. There is peri bronchial cuffing (hazy appearance around the airways which occurs when excess fluid, mucus, or inflammation builds up in the surrounding lung tissue) ... There is (sic) bibasilar infiltrates (shadows or haziness in the lowest sections of both lungs) right greater than left..." The record lacked evidence that the physician was consulted about the abnormal chest x-ray result. 6/6/26 10:31 PM – A nurse progress note documented that R9's chest x-ray was done with pending result. R9 was noted with occasional dry, non-productive cough..." 6/7/26 6:13 AM - A nurse progress note documented, "...CXR (chest x-ray) results are back and MD (physician) will review them and give further instructions..." 6/7/26 9:43 AM – A nurse progress note documented that R9's chest x-ray result was reported to the on-call physician. This was two days after the STAT chest x-ray order. 7/9/26 12:39 PM – During interview, E16 (LPN) stated that R9's chest x-ray result was reported to the on-call physician on the morning of 6/7/26. E16 stated that R9 had new orders including guaifenesin for cough, azithromycin for pneumonia and Lasix (water pill). 7/10/26 6:29 PM – In an interview, E2 (DON) confirmed that the nurse who received the report from the x-ray company that evening or night shift did not immediately call the physician but left it in the MD (physician's) book. 7/10/26 7:51 PM – In a telephone interview, E31 (LPN) stated "I can't remember exactly what [E28 RN Supervisor] told me that night when she received [R9's] results... she must have said, '...done and reviewed' and put in the box for the MD (physician) to read."	F0580	Continued from page 21 compliance, then monthly for 2 months until 100% compliance. Results will be reviewed through the Quality Assurance and Improvement committee. 5. Date of Compliance: 8/26/26	08/26/2026

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F0580 SS = D	Continued from page 22 Attempts to contact E28 were unsuccessful. 7/10/26 10:35 PM – Findings were discussed with E1 (NHA) and E2 (DON). 7/10/26 10:40 PM – Findings were reviewed with E1 and E2 during the Exit Conference.	F0580		08/26/2026
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that for two (R4 and R13) out of 27 sampled residents, the facility failed to respect each	F0583	F583 – Personal Privacy/Confidentiality 1. Corrective Action On July 9, 2026, the handwritten notes containing information regarding R4's and R13's toileting and incontinence-care status were immediately removed from the residents' doors and enhanced barrier precaution signage by E24. R4 and R13 no longer reside at the facility; therefore, no additional resident-specific intervention can be completed. The facility identified who wrote and posted the handwritten notes. The identified employee did receive individualized re-education and was placed on suspension regarding resident privacy, confidentiality of personal care, appropriate documentation, and the prohibition against posting residents' toileting or incontinence status outside their rooms. Toileting and incontinence-care documentation will be entered only in the facility-approved clinical record, EMR, and TAR in accordance with facility policy. 2. Residents with Potential to Be Affected The DON or designee will complete a facility-wide audit of all resident-room doors, precaution signage, hallways, nursing work areas, assignment sheets, communication tools, and other publicly visible locations to identify handwritten notes or other postings containing confidential resident information. The audit will specifically identify postings related to toileting, incontinence of care, wet/dry checks, personal care, diagnoses, treatments, behaviors, or	08/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(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
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD , WILMINGTON, Delaware, 19803

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F0583 SS = D	Continued from page 23 residents' right to personal privacy and confidentiality of personal care. Findings include: 1. 7/9/26 9:14 AM - An observation in the hallway outside of R13's room revealed a ripped piece of white paper thumbtacked on top of the enhanced barrier precaution sign with the following handwritten: "NOT WET @ 5:55 AM 07/09/26". 7/9/26 9:20 AM – During an interview, E24 (RN/IC) confirmed the observation and removed the piece of ripped paper. 2. 7/9/26 9:15 AM – An observation in the hallway outside of R4's room revealed a ripped piece of white paper thumbtacked on top of the enhanced barrier precaution sign with the following handwritten: "CHANGED @ 4:50 CHECKED AGAIN @ 6:03 AM NOT WET 07/09/26". 7/9/26 9:20 AM – During an interview, E24 confirmed the observation and removed the piece of ripped paper. 7/9/26 9:25 AM – During a combined interview, surveyor was present when E24 reviewed the two observations with E2 (DON) and E3 (CRN). 7/10/26 4:50 PM – Findings were reviewed during the exit conference with E1 (NHA), E2 and E3.	F0583	Continued from page 23 other confidential information. Any inappropriate posting will be removed immediately. The affected resident privacy will be addressed, and the responsible employee will receive follow-up education and corrective action as indicated. Approved clinical signs necessary for resident care and safety will also be reviewed to ensure they contain only the minimum information permitted by facility policy. 3. Systemic Changes Root Cause analysis was related to the employee did not following proper policy protocol for documenting ADL care in the electronic record; DON spoke with CNA who took no ownership or regard in her role of posting the notes outside the door and her lack of consideration for providing dignified care to the resident. All facility and agency employees will be educated by the DON or designee regarding: Resident privacy and confidentiality during personal care. The prohibition against posting handwritten personal care or toileting information outside resident rooms. Appropriate use of precaution signage. Approved methods for documenting and communicating toileting, incontinence of care, and resident-care checks. The requirement to document such care in the facility-approved clinical record, EMR, TAR, or authorized communication system. The responsibility to immediately remove and report inappropriate postings.	08/26/2026

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F0583 SS = D		F0583	Continued from page 24 In addition to education facility leadership will visually monitor the facility during angel rounds, unit rounds, and environmental rounds, to ensure there is no posted information related to residents' personal and confidential care the rounds described will continue to be completed beyond the monitoring time of this POC. Angel rounds are completed daily Monday through Friday by assigned staff members; unit rounds are completed daily by Unit Managers/Nursing Supervisors and/or Manager on Duty and Environmental Rounds and completed a minimum of 5 times per week. Angel round forms are utilized, and the grievance process will be utilized to report any HIPPA violations. HIPPA training is completed during new hire orientation and yearly on Relias training. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. 4.Monitoring Audits will include resident-room doors, precaution signage, hallways, nursing stations, assignment sheets, communication tools, and other areas where confidential information can be publicly displayed. The Administrator and/or Interdisciplinary team will conduct privacy and confidentiality audits in the facility units and shifts daily for 14 days until 100 % compliance, weekly for two weeks until 100% compliance, and monthly for two months until 100% compliance. Audit results and trends will be presented to the Quality Assurance and Performance Improvement Committee for review and determination of whether additional monitoring or corrective action is necessary. 5. Date of Compliance: 8/26/26	08/26/2026
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	F0609	F609 – Reporting of Alleged Violations Corrective Action R13 no longer resides at the facility; therefore, no additional resident-specific intervention can be completed. The employee identified has been terminated from the facility.	08/26/2026

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F0609 SS = D	Continued from page 25 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of clinical and facility records, it was determined that for one (R13) out of eight residents reviewed for activities of daily living (ADLs), the facility failed report R13's allegation of neglect to the State Agency. Findings include: Cross refer F677 example 1 Review of R13's record revealed: 7/1/26 – A grievance form was completed and stated: "Grievance Details: Resident upset with the timeliness of being changed… Summary of Findings: Resident reported that he had a bowel movement while at dialysis. He returned approximately 5:10 [PM]. Trays for dinner started to come out and resident then pressed call bell. CNA attempted to explain to resident that she will be back to chang (sic) him once the trays are passed. Resident became angry and stated he should be able to be changed whenever he needs to be… Resident stated that once he was changed the stool was dry and hard to get off, so the CNA was a (sic) rough… Resident not satisfied…". The facility lacked evidence that R13's 7/1/26	F0609	Continued from page 25 Residents with Potential to be Affected The Nursing Home Administrator or designee will audit all grievances, complaints, allegations of abuse, neglect, exploitation or mistreatment, injuries of unknown source, resident-to-resident incidents, and other alleged violations from the preceding 30 days to verify appropriate investigation, protection, notification, and timely State Agency reporting. The facility will immediately address any identified concern, including completing late reports or supplemental submissions when required. Systemic Changes Root cause analysis is the facility failed to identify that a reported grievance should have been elevated as an allegation of neglect due to the a delay in incontinence care. The Administrator and/or Staff Development Coordinator will re-educate licensed nurses, department managers, direct-care staff, agency staff, and administrative leadership regarding recognition of potential neglect, immediate resident protection, mandatory reporting requirements, applicable reporting timeframes, chain of command, grievance escalation, and documentation expectations, education will also include will be that if there is a care concern that is being reported as grievance, the Administrator and/or Director of Nursing will be notified when it is received and not just being documented in the electronic grievance log. The Nursing Home Administrator and/or Director of Nursing is responsible to review all grievances filed in the electronic grievance log at the facility. The System change will be that if there is a care concern that is being reported as a grievance, the Administrator and/or Director of Nursing will be notified either in person or by telephone when it is received and not just being documented in the electronic grievance log. The abuse reporting process is reviewed during new hire orientation to include mandated reporting timeliness of reporting and investigation.	08/26/2026

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F0609 SS = D	Continued from page 26 grievance was reported to the State Agency as an allegation of neglect. 7/10/26 4:50 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (CRN).	F0609	Continued from page 26 The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. Monitoring The Director of Nursing, Assistance Director of Nursing, and/or Unit Manager/Nursing Supervisors will audit 10% of residents requiring ADL, toileting, or incontinence care assistance across all shifts, including meal periods, daily for 14 days until 100% compliance, weekly for two weeks until 100% compliance, and monthly for two months until 100% compliance. Results will be reviewed through the Quality Assurance and Performance Improvement Committee to determine whether additional corrective action, education, or extended monitoring is required. The Administrator and/or Director of Nursing will review 100% of grievances and risk management reports, complaints, allegations, and potentially reportable incidents to ensure reporting requirements have been met and investigations have been completed daily for 14 days until 100% completed, weekly for two weeks, until 100% completed and monthly for two months until 100% completed. Results will be reviewed through the Quality Assurance and Performance Improvement Committee to determine whether additional corrective action, education, or extended monitoring is required. Audits will verify immediate protection, appropriate investigation, required notifications, accurate classification, timely State Agency reporting, and completion of follow-up reports. Any negative findings will be corrected immediately. Date of Compliance: 8/26/26	08/26/2026
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	F0610	F610 – Investigate Alleged Violations Corrective Action The Director of Nursing will investigation the allegation for R26 for the deficient practice and the Administrator will review the investigation. All required statements will be collected, and the initial education and signature sheets will be placed in the	08/26/2026

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F0610 SS = D	Continued from page 27 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. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R26) out of eight residents reviewed for activities of daily living, the facility failed to have evidence of a thorough investigation of a neglect allegation when R26 complained to staff that she had been left incontinent of feces for four hours after requesting assistance. Findings include: Cross refer F677 Review of R26's clinical record revealed: 5/2/26 – R26 was admitted to the facility with diagnoses including polyneuropathy. 5/2/26 – A care plan documented that R26 required the assistance of one staff member for toileting, toileting hygiene and brief changes. 5/8/26 – An admission MDS assessment for R26 documented a BIMS score of 15, indicating an intact cognition. The assessment also documented that R26 was frequently incontinent of bowels, was dependent for transferring to the toilet and required supervision or touching assistance for toileting hygiene. 6/7/26 - A facility document entitled, "Daily Nurse Assignment", documented that E7 (RN Supervisor) and E14 (CNA) were assigned to R26 during the 3:00 PM to 11:00 PM shift on 6/7/26. 6/7/26 – A facility document entitled, "Daily Nurse Assignment", documented that E28 (RN Supervisor) and E25 (CNA) were assigned to R26 during the 11:00 PM to 7:00 AM shift from 6/7/26 to 6/8/26. 6/8/26 3:28 AM – A facility document entitled,	F0610	Continued from page 27 investigation file. Residents with Potential to be Affected The Administrator or Designee will audit all abuse and neglect investigations for the previous 30 days to verify complete investigations, supporting documentation, and timely follow-up. Any identified concerns were corrected immediately. Systemic Changes Root cause analysis was identified that the employee did not follow the policy and procedure for reporting allegations of neglect due to the E4's misunderstanding that a delay in care could possibly be considered neglect. The Administrator will re-educate the licensed nurses, department managers, and leadership on abuse investigation requirements, collection of witness statements, documentation standards, evidence preservation, and completion of thorough investigations. Grievances and Risk Management reports will be reviewed in the scheduled morning and afternoon clinical meetings. The system change will be that any grievances that are documented in the electronic grievance log that are related to care concerns will be immediately reported to the Administrator and/or Director of Nursing. All investigations will be stored in the Director of Nursing office in a designated file drawer. Monitoring The Administrator and/or Director of Nursing will audit grievances and risk management reports to ensure any allegations of abuse or neglect are reported per the reporting requirements and investigations are completed daily for 14 days until 100% compliance, then weekly for 2 weeks, until 100% compliance, monthly for 2 months until 100% compliance. Results will be reviewed through the Quality Assurance and Performance Improvement Committee to determine whether additional corrective action, education, or extended monitoring is required. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective	08/26/2026

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F0610 SS = D	Continued from page 28 "Documentation Survey Report" documented that between 11:00 PM on 6/7/26 and 7:00 AM on 6/8/26, R26 was assisted by staff after having a large bowel movement. 6/8/26 – A facility document entitled, "Grievance Summaries" documented, "…Reported Date: 6/8/26…Reported By: [R26]…Reported To: [R26]…Resolved Date – Resolved By: 6/8/26 – [E1, NHA]…Grievance Details:…[R26] stated she remained in bed all weekend… [R26] turned her light on at 10:10 [6/7/26 10:10 PM], an aide came and said she will be back but did not return after being informed that [R26] needed to be changed. [R26] stated she did not get changed until 2 am [2:00 AM]…Summary of Investigation: [R26] reported a delay in being care [sic]…aide came in and did not return to change her until hours later…Summary of Findings: [R26] reported a delay…Summary of Actions Taken:…Education completed with CNA and supervisor on duty." The grievance summary did not indicate who R26 reported her concern to or a result of the findings. The grievance summary also documented that E1 resolved R26's grievance on 6/8/26 and a CNA and Nursing Supervisor on duty received education following the incident. 7/6/26 3:36 PM – During an interview, R26 stated, "…Three or four weeks ago I put on my call bell. I had a BM [bowel movement] and needed to be changed. It was 10:30 [PM] and did not get help until 2:30 [AM]. I was told there were no aides. At 11:30 [PM], I told the aide I needed to be changed and was told, 'I'll be back'. One hour later, another aide came with wipes and a brief and said, 'I'll be back'. I filed a report…". 7/7/26 11:00 AM – During a joint interview, the Surveyor requested all facility investigation documents and evidence of education provided to staff that were involved in the incident resulting in R26's grievance from E1(NHA), E2 (DON) and E3 (CRN). 7/8/26 12:10 PM – During an interview, E2 stated, "E1 [NHA] just updated the grievance status to resolved… [E4, RN UM] did the investigation and education for the CNA and Nursing Supervisor on duty…". The Surveyor again requested all investigation documents. E2 stated, "I don't know where those documents are. [E4] is out of the country. I cannot reach her." The Surveyor asked, "What are the names the CNA and the supervisor that were educated as stated on the grievance?" E2	F0610	Continued from page 28 action. 5. Date of compliance: 8/26/2026	08/26/2026

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F0610 SS = D	Continued from page 29 stated, "I do not know who the CNA or supervisor was. It is either [E7] and [E14] or [E28] or [E25]." 7/9/26 10:35 AM – During an interview, E14 stated, "I don't know of any incident when [R26] did not get changed. I know when [R26]'s light goes on, she needs to be changed. "The Surveyor asked E14 if education was provided on responding to residents requesting assistance or providing timely incontinence care. E14 stated, "No". 7/9/26 4:23 PM – During an interview, E7 stated that he did not remember any incidents where R26 was not changed after requesting assistance. The Surveyor asked E7 if education was provided or was made aware of R26's complaint. E7 stated, "No one talked to me about it." 7/10/26 2:00 PM – Findings were confirmed with E1 (NHA) and E2 (DON). 7/10/26 4:50 PM – Findings were reviewed with E1, E2 and E3 (CRN) during the exit conference.	F0610		08/26/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical	F0656	F656 – Develop and Implement Comprehensive Care Plans Corrective Action R10's continues to reside within the facility. R10's plan of care has been reviewed and updated by the Assistant Director of Nursing to address the identified concern and reflect the resident's current needs, interventions, goals, and responsible disciplines. Residents with Potential to be Affected The Director of Nursing and/or Unit Managers will complete an initial audit to ensure all residents with orders for oxygen have a person-centered comprehensive care plan in place to reflect the residents' current needs, interventions goals and responsible disciplines. Systemic Changes Root cause analysis is related to the facilities failure to ensure the care plan was updated to address noncompliance with continuously wearing an oxygen	08/26/2026

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F0656 SS = D	Continued from page 30 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 interview and record review, it was determined that for one (R10) out of three residents sampled for care plan revision, the facility failed to ensure that R10's care plan was updated to address noncompliance with continuously wearing an oxygen nasal cannula for ordered oxygen therapy and to implement the care plan when R10's documented oxygen levels fell below provider-issued parameters. Findings include: Review of R10's clinical record revealed: 5/28/26 – R10 was admitted to the facility with diagnoses including COPD (Chronic Obstructive Pulmonary Disease) and acute respiratory failure. 5/28/26 – R10's care plan documented, "[R10] is at risk for respiratory complications secondary to COPD, lung cancer and respiratory failure...Interventions: administer oxygen as ordered...pulse ox [oximeter] and alert clinician per parameters...". 7/6/26 11:56 AM – During an observation, R10 ambulated out of her room into the hallway. R10's O2 nasal cannula was pulled away from her face. E19 (RN) placed R11's O2 nasal cannula onto her nostrils.	F0656	Continued from page 30 nasal cannula for ordered oxygen therapy and to implement the care plan when R10's documented oxygen levels fell below provider-issued parameters. The root cause is also related to incomplete documentation in the R10's clinical record regarding the resident removing her oxygen cannula. Due to the incomplete documentation, the care plan was not updated. The Staff Development Coordinator/Director of Nursing/Assistance Director of Nursing and/or Unit Managers/Nursing Supervisors will educate licensed nurses and C.N.A.s regarding reporting and the licensed nurses' documenting in the electronic clinical records when a resident removes any medical equipment, including oxygen, and the care plan is updated as indicated. The prior education for the previous corrective action was not specific to residents removing medical devices/equipment or for the licensed nurses to document residents' behaviors of removing medical devices/equipment resulting in the failure of licensed nurses to document that R10 was removing the nasal cannula, resulting in the failure to update the care plan. The Director of Nursing, Assistant Director of Nursing and/or Unit Managers run the 24 hour progress notes report and review the progress notes in Point Click Care prior to the daily scheduled clinical meeting, documentation that refers to residents' removal of any medical equipment, including oxygen, will be discussed in the clinical meeting and the care plan will be updated by the clinical reimbursement nurse and/or nursing leadership to ensure a person centered comprehensive care plan. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. Monitoring The MDS Coordinator and/or Unit Managers/Nursing Supervisor will audit residents with oxygen orders to ensure the resident is complaint with wearing their nasal cannula, if resident is non-complaint ensure there is documentation in the electronic clinical	08/26/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD , WILMINGTON, Delaware, 19803

(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 31 7/7/26 1:15 PM – During an observation, R10 was lying in bed not wearing an O2 nasal cannula. E22 (LPN) placed R10's O2 nasal cannula onto her nostrils. 7/8/26 1:23 PM – During an interview, E19 stated, "I was not assigned to [R10]. I don't know if [R10] removes her oxygen [nasal cannula]. I put it back on her." 7/8/26 2:00 PM – During an interview, E22 stated, "I know that [R10] takes her oxygen [nasal cannula] off. I don't know if anyone else knows that." 7/8/26 2:30 PM – Review of R10's care plan revealed no interventions for noncompliance with continuously wearing an O2 nasal cannula. 7/9/26 10:18 AM – The Surveyor asked E15 if R10 was known to remove her oxygen nasal cannula. E15 stated, "I don't know. That was the first day I worked with her." 7/9/26 10:39 AM – During an observation, R10 was lying in bed not wearing an O2 nasal cannula. The surveyor notified E23 (LPN) that R10 was not wearing an O2 nasal cannula. 7/9/26 10:40 AM – During an interview, E23 stated, "I just put it [nasal cannula] on R10 when I gave her meds [medications]." The surveyor observed E23 place R11's nasal cannula onto her nostrils. 7/9/26 10:45 AM – During an interview, the Surveyor asked E23 if she knew that R10 removes her nasal cannula. E23 stated, "I don't know. This is my first time working with [R10]." The facility failed to update R26's care plan with interventions for repeatedly removing the oxygen nasal cannula. 7/10/26 2:00 PM – Findings were confirmed with E1 (NHA) and E2 (DON). 7/10/26 4:30 PM – Findings were reviewed with E1, E2 and E3 (CRN) during the exit conference.	F0656	Continued from page 31 record and the care plan reflects or is updated to address the non-compliance, goals and interventions as needed these audits will be completed daily for 14 days until 100% compliance, weekly for two weeks until 100% compliance, and monthly for two months until 100% compliance. Results will be reviewed through the Quality Assurance and Performance Improvement Committee to determine whether additional corrective action or extended monitoring is required. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. 5. Date of Compliance: 8/26/2026	08/26/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility	F0684	F684 – Quality of Care Corrective Action R9 no longer resides at the facility; therefore, no additional resident-specific assessment or	08/26/2026

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F0684 SS = D	Continued from page 32 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 interview and record review, it was determined that for one (R9) out of four residents reviewed for change in condition, the facility failed to ensure that R9's plan of care was implemented for monitoring of blood oxygen levels and constipation. Findings include: Review of R9's clinical record revealed: Cross refer F580 and F777 A. SPO2/BLOOD OXYGEN MONITORING 10/9/24 – R9 was admitted to the facility with diagnoses including but not limited to diabetes, chronic kidney disease, essential hypertension, bifascicular block (two of the three main electrical pathways in the lower chambers of the heart are blocked), anxiety and dementia. A. SPO2/BLOOD OXYGEN MONITORING 6/5/26 – R9 was care planned for cough and congestion and interventions included diagnostics and labs as ordered, auscultate lung sounds as needed and elevating head of bed to prevent shortness of breath as tolerated. 6/5/26 – A physician note by P2 (NP) documented, "…Vital Signs… O2 Sat (blood oxygen level/ SPO2) 97 RA (room air) 6/2/26 6:52 PM… continue to monitor lung sounds and pulse ox (SPO2)." 6/6/26 10:31 PM – A nurse progress note by E32 (LPN) documented, "…lungs are clear, diminished (decreased breath sound), SPO2 96% on room air…". 6/7/26 6:13 AM - A nurse progress note documented that R9 had productive cough and rhonchi (low pitched rattling or snoring) lung sounds... "HOB (head of bed) elevated to improve his SATS (SPO2, O2 sats, pulse ox or blood oxygen level). There was no documented check of SPO2. 6/7/26 9:43 AM - A nurse progress note	F0684	Continued from page 32 intervention can be completed. The Director of Nursing/Assistant Director and/or Staff Development Coordinator will identify and review the actions of the licensed nurses responsible for R9's care from 6/5/26 through 6/7/26, including E16, E31, E32, E28, and any other identified nurses, to determine why SpO_2 monitoring was not completed for six of seven shifts. Individualized education and corrective action will be provided as indicated. The Director of Nursing/Assistant Director and/or Staff Development Coordinator will identify and review the actions of the licensed nurses responsible for reviewing R9's bowel records from 5/22/26 through 5/25/26 to determine why the constipation protocol was not initiated after nine shifts without a bowel movement. Individualized education and corrective action will be provided as indicated. Residents with Potential to be Affected The Director of Nursing/Assistant Director of Nursing and/or Unit Managers will review the electronic clinical record prior to the daily scheduled clinical meetings to identify residents with respiratory changes in condition or provider-directed SpO_2 or vital-sign monitoring. The audit will verify that monitoring orders or treatment plans identify the required frequency and duration, are accurately transcribed, and are completed and documented as directed. The audit will also verify assessment, provider notification, and implementation of new orders when abnormal findings are identified. The Director of Nursing, Assistant Director of Nursing and/or Unit Managers will audit all residents with changes in condition, new or revised orders, incidents, falls, wounds, infections, hospital returns, significant weight changes, behavioral changes, and changes in ADL or functional status during the preceding 14 days, issues identified will be reviewed with the physician and follow-up will be completed as required. Pulse oximetry monitoring will be ordered on admission as clinically indicated.	08/26/2026

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F0684 SS = D	Continued from page 33 documented that R9 had continuing cough and rhonchi lungs. There was no documented check of SPO2. 6/7/26 10:29 AM – A facility respiratory change in condition report completed by E16 (LPN) documented that at the time of the evaluation, R9's vital signs, specifically his blood oxygen level, was 97% via room air on 6/2/26 6:52 PM. This report did not include the SPO2 at the time of the report. 6/7/26 3:30 PM – A nurse progress note documented that R9 was sent out to the hospital for evaluation and treatment. 7/8/26 9:10 AM – During an interview, FM2 (wife) stated that she was surprised to see that R9 was not on oxygen therapy while at the facility. FM2 further stated, "It was only when the EMT arrived when they hooked him on the oxygen". 7/9/26 12:45 PM – In an interview, E16 (LPN) stated that she was not aware if R9's blood oxygen level was monitored every shift after he was seen by P2 (NP) on 6/5/25 for cough and congestion. When asked if she obtained R9's blood oxygen level on 6/7/26, E16 stated she could not remember who took R9's vital signs including blood oxygen level. E16 further stated that another nurse (E32) helped her prepare and complete R9's transfer paperwork and notified FM2. Despite R9's treatment plan by P2 to continue blood oxygen level monitoring, in six out of the seven shifts from 6/5/26 day shift through 6/7/26 day shift, the facility failed to assess R9's SPO2 or blood oxygen level. It was noted that only on 6/6/26 at 10:31 PM, was R9's SPO2 assessed and recorded at 96% on room air. 7/10/26 7:51 PM – In a telephone interview with E31 (LPN), when asked if she completed a respiratory assessment for R9, stated that when she worked on 6/6/26, Saturday night into Sunday, 6/7/26, she saw R9, adjusted and elevated his head of bed. E31 also stated, "I called [E28, RN, Supervisor] to come down as R9's rhonchi lung sound was not normal. I was not aware of any O2 saturation/blood oxygen level monitoring for [R9]." Attempts to contact E28 were unsuccessful. 7/10/26 8:25 PM – During a telephone interview, E32	F0684	Continued from page 33 The Director of Nursing or designee will audit all current residents' bowel-movement records to identify residents without a documented bowel movement for three days or nine shifts. The audit will verify that licensed nurses reviewed the bowel records, assessed the residents, implemented the ordered constipation protocol, documented the intervention and effectiveness, and notified the provider when indicated. The facility will immediately address identified concerns. Systemic Changes The root cause analysis is related to the facility failure to ensure R9's care plan was implemented for monitoring of blood oxygen levels per the provider's progress note in the electronic clinical record, chart review revealed that the provider did not enter an order for pulse oximetry monitoring or for oxygen as well nursing not monitoring resident related to antibiotic and diuretic use for his acute condition change as per facility. The Director of Nursing/Assistant Director of Nursing and/or Staff Development Coordinator will re-educate licensed nurses regarding respiratory change-in-condition assessments, obtaining current vital signs and SpO_2 readings, clarifying provider monitoring directions, transcribing monitoring orders with the required frequency and duration, completing monitoring as directed, reporting abnormal findings, and documenting interventions and resident response. The Medical Director will review with P2 (Nurse Practitioner) regarding the need to initiate orders related treatment plans documented in the clinical record The root cause analysis is related to the facility failure to ensure R9's care plan was implemented for monitoring constipation and to initiate the intervention related to constipation, R9's electronic clinical record was reviewed and it was determined that the resident has a bowel movement documented on 6/5/2026 at 4:55 am and then again on 6/7/2026 at 4:48 am, which is 7 shifts, indicating that the initiation of the bowel regimen was not indicated at that time.	08/26/2026

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F0684 SS = D	Continued from page 34 (LPN) was asked if he monitored R9's blood oxygen level, he stated that he checked R9's SPO2 and it was at 96% on room air when he worked on the 3-11 shift on Saturday, 6/6/26 and documented in the nurse progress notes. E32 further stated that, "...When a resident has a change of condition, we should always get a doctor's order for vital signs monitoring including SPO2 monitoring. I don't recall if [R9] had a specific physician's order for SPO2 monitoring." The facility failed to assess R9's blood oxygen level despite P2's treatment plan on 6/5/26, for R9's continued SPO2 monitoring. 7/10/26 10:35 PM – Findings were discussed with E1 (NHA) and E2 (DON). B. BOWEL MANAGEMENT The facility's policy titled, "Constipation Prevention" dated 1/29/24, documented, "Patients will be monitored for regular bowel elimination as evidenced by a bowel movement (BM) every three days (nine shifts) or as determined by individual assessment, medical condition or functional status. Procedure: 1. The licensed nurse will routinely review documentation to determine patients in need of intervention to facilitate bowel movement. 2. Initiate nursing interventions as needed and document in medical record. 3. Notify provider for medication orders, if necessary...". 10/9/24 – R9 had a physician's order for docusate sodium 100 mg take two capsules by mouth every 24 hours as needed for constipation, defined as 3 days/nine shifts. 10/9/24 (revised 10/21/24) – R9's care plan for at risk for constipation or impaired hydration related to having reduced mobility and medication side effects had interventions including to administer medications as ordered, to observed for signs and symptoms of constipation or extended abdomen that may indicate constipation and to track and record bowel movements. A review of R9's May 2026 CNA flowsheet revealed that R9 did not have a bowel movement for 11 shifts starting 5/22/26 dayshift until 5/25/26 evening shift. A review of R9's May 2026 MARs (Medication Administration Records) and progress notes lacked evidence that R9 was assessed for the need to administer docusate sodium.	F0684	Continued from page 34 Point Click Care provides an alert on the clinical dashboard if a resident does not have a documented bowel movement in 9 shifts. The Director of Nursing or designee will re-educate licensed nurses and CNAs regarding accurate bowel-movement documentation, licensed-nurse review of bowel records each shift, initiation of the constipation protocol after three days or nine shifts without a bowel movement, resident assessment, medication administration, provider notification, documentation of intervention effectiveness, and escalation when constipation remains unresolved. The Unit Managers/Supervisor will be educated to print the BM alerts daily and distribute to the licensed nurses for follow up for residents requiring initiation of the bowel regimen as indicated, the Unit Manager/Nursing Supervisor will review the alerts after follow up is completed for any additional follow up required. This information is brought through the scheduled daily clinical meeting. The electronic clinical record is reviewed prior to the daily scheduled clinical meeting to assess the need to initiate the bowel regimen for residents not having a bowel movement in 9 shifts. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. Monitoring The Director of Nursing/Assistant Director of Nursing and/or Nursing Supervisor will audit residents with respiratory changes in condition or provider-directed SpO_2 or vital-sign monitoring daily for 14 days until 100% compliance, then weekly for two weeks until 100% compliance, then monthly for two months until 100% compliance. Audits will verify that the ordered monitoring frequency and duration are accurately transcribed, completed, documented, and acted upon. The Director of Nursing/Assistant Director of Nursing and/or Nursing Supervisor will audit bowel-movement records daily for 14 days until 100%	08/26/2026

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F0684 SS = D	Continued from page 35 7/9/26 12:40 PM – In an interview, E16 (LPN) stated that R9 had a physician's order for docusate sodium, a stool softener, every 24 hours as needed for constipation. E16 stated that she was not aware of R9's bowel movement issues. 7/10/26 7:30 PM – When asked for the facility's bowel movement protocol in reference to R9's no bowel movement for more than 3 days, E2 (DON) stated that R9 followed the facility's standing order of administering milk of magnesia as needed if no BM for three days. 7/10/26 7:55 PM – When asked if R9 had regular bowel movements and if R9 was constipated, E31 (LPN) stated, "I am not aware of [R9's] bowel movement issues." 7/10/26 10:35 PM – Findings were discussed with E1 (NHA) and E2. 7/10/26 10:40 PM – Findings were reviewed with E1 and E2 during the Exit Conference.	F0684	Continued from page 35 compliance, weekly for two weeks until 100% compliance, and monthly for two months until 100% completed. Audits will verify that residents without a bowel movement for three days or nine shifts are assessed and receive timely intervention, documentation, effectiveness monitoring, and provider notification as indicated. 5. Date of Compliance 8/26/2026	08/26/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview and observation, it was determined that for one (R10) out of five residents sampled for resident records, the facility lacked evidence that oxygen therapy was administered as stated in the care plan and as ordered by the provider. Findings include: Cross refer F656 Review of R10's clinical record revealed: 5/28/26 – R10 was admitted to the facility with diagnoses including COPD (Chronic Obstructive Pulmonary Disease) and acute respiratory failure.	F0695	F695 – Respiratory/Tracheostomy Care Corrective Action R10 continues to reside in the facility. R10 was assessed, oxygen was provided as ordered, the physician was notified, and the plan of care was updated. The Director of Nursing completed individualized education and competency validation related to obtaining pulse oximetry readings for E15 and E23. The Infection Preventionist RN will inspect and test the pulse oximeters to verify proper function and accuracy. Any device that does not function properly will be removed from service until repaired or replaced. Residents with Potential to be Affected The Director of Nursing or designee will audit all residents with active oxygen and oxygen-saturation orders. The audit will verify that oxygen is administered at the ordered flow rate and frequency, oxygen-delivery devices are properly positioned, saturation readings are obtained and documented as ordered, and abnormal readings receive immediate	08/26/2026

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F0695 SS = D	Continued from page 36 5/28/26 – R10's care plan documented, "[R10] is at risk for respiratory complications secondary to COPD, lung cancer and respiratory failure…Interventions: administer oxygen as ordered…pulse ox [oximeter] and alert clinician per parameters…". 6/4/26 – A facility document entitled "Order Summary Report", documented, "O2 [oxygen] at 2 LPM [liters per minute] via NC [nasal cannula] every shift for COPD…monitor O2 sat [saturation] to maintain oxygen at or above 92%...". 6/29/26 9:43 AM – E15 (LPN) documented in R10's clinical record an O2 reading of 78% on RA (room air). 6/29/26 11:58 AM – E15 documented in R10's clinical record an O2 reading of 78% on RA. 7/9/26 10:18 AM – During an interview, the surveyor asked E15 if the physician was notified of R10's consecutive low oxygen readings on 6/29/26. E15 stated, "…if I entered 78% for R10's oxygen readings it was a mistake." The surveyor asked E15 if these oxygen readings were errors, how would that be documented. E15 stated, "I would have entered a note." The surveyor asked E15 what you would do if a resident has a pulse oximeter reading of 78%. E15 stated, "I would've called the provider, put on a non-rebreather, called 911 to send her out to the hospital, but [R11] was never at 78%". "The surveyor asked E15 why it was documented that R11 was on room air if she is ordered to receive oxygen therapy every shift. E15 stated, "I can't remember if [R10] was on room air or not. That was the first day I worked with [R10]. It might have been an error." 7/9/26 11:00 AM - Review of R10's clinical record revealed no documentation that the two oxygen readings of 78% on 6/29/26 were entered in error or documentation of physician notification of R10's low oxygen reading levels. Review of R10's oxygen reading levels entered in the vitals section of the clinical record from 6/1/26 to 6/30/26 revealed eleven oxygen saturation readings that documented room air as the method of oxygen delivery. 7/9/26 10:39 AM – During an observation, R10 was lying in bed not wearing an O2 nasal cannula. The surveyor asked R10 if she could place the nasal cannula back into her nostrils. R11 was unable to replace the nasal cannula. The surveyor notified E23 (LPN) that R10 was not wearing an O2 nasal cannula.	F0695	Continued from page 36 assessment, validation, intervention, and provider notification. The facility will identify residents unable to independently replace or adjust their oxygen-delivery devices and will revise their care plans and monitor interventions as indicated. The facility will immediately address identified concerns. Systemic Changes The root cause analysis is related to the licensed nurse not administering oxygen therapy as ordered and stated in the care plan, as well as the licensed nurse's inaccurate documentation in the resident's clinical record related to pulse oximetry readings and method of oxygen administration; documenting room air in error, and the nurses failure to check the resident's pulse oximetry when nasal cannula was found off the resident, resulting in the resident's pulse oximetry reading of 82%, this occurred due to the nurse not following the facility respiratory care and oxygen equipment policy. The Director of Nursing or designee will re-educate licensed nurses regarding respiratory assessment, oxygen administration, pulse-oximetry technique, physician notification, order implementation, and documentation. Education will address equipment and probe checks, correct placement, factors affecting readings, validation of unexpected results, and required assessment, intervention, notification, and documentation for abnormal readings. The Staff Development Coordinator and/or Unit Managers/Nursing Supervisors will complete competency validation for all licensed nurses related to obtaining pulse oximetry readings on residents. We will have a competency validation record completed for licensed nurses, this will be included in new hire orientation for licensed. This The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective	08/26/2026

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F0695 SS = D	Continued from page 37 7/9/26 10:40 AM – During an interview, E23 stated, "I just put it [nasal cannula] on R10 when I gave her meds [medications]." The surveyor observed E23 place R10's nasal cannula onto her nostrils. The surveyor then requested E23 to obtain R10's oxygen level. R10's oxygen saturation reading was 82%. 7/9/26 10:41 AM – During an observation, E23 left R10's room to get another pulse oximeter. E23 placed the new pulse oximeter onto R10's finger, which gave a reading of 95%. The surveyor then requested that E23 obtain R10's oxygen level with the first pulse oximeter used, which gave a reading of 98%. R10's oxygen level reading at 82% was accurate at the time it was taken. 7/10/26 2:00 PM – Findings were reviewed with E1 (NHA) and E2 (DON). 7/10/26 4:50 PM – Findings were reviewed with E1, E2 and E3 (CRN) during the exit conference.	F0695	Continued from page 37 action. Monitoring The Director of Nursing or designee will audit 5 residents on each nursing unit with orders for oxygen to ensure oxygen administration, oxygen-device placement, saturation monitoring, documentation, and follow-up daily for 14 days until 100% compliance, then weekly for two weeks until 100% compliance, and monthly for two months until 100% compliance. Audits will verify compliance with the ordered oxygen flow rate, delivery method, monitoring frequency, response to abnormal readings, physician notification, and care-plan interventions. Results will be reviewed through the Quality Assurance and Performance Improvement Committee. Date of Compliance: 8/26/2026.	08/26/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit	F0761	F761 – Label/Store Drugs and Biologicals Corrective Action The Unit Manager removed the expired medications for R15 and R24 from the medication cart and unsecured closet and disposed of according to facility policy. The Unit Manager removed the nystatin powder from R14's bedside drawer. The facility will secure the unlocked closet and determine whether it will be appropriately labeled and approved for medication storage or removed from medication-storage use. Residents with Potential to be Affected The Director of Nursing or designee will complete a facility-wide audit of medication carts, treatment carts, medication rooms, closets, refrigerators, backup-medication supplies, discontinued	08/26/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(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
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD , WILMINGTON, Delaware, 19803

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F0761 SS = D	Continued from page 38 package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that for three (R14, R15 and R24) out of three residents sampled for medication storage, the facility failed to ensure each resident's medications were safely stored in a secured area and under direct observation of authorized staff. Additionally, the facility failed to properly dispose of each residents' expired medications. Findings include: 1. 7/6/26 10:32 AM – An observation of an unlocked and unlabeled closet door at the end of the locked dementia unit revealed a large brown box on the bottom shelf filled with blister packs of residents' medication. 7/6/26 10:39 AM – Surveyor asked the two nurses, E10 (LPN) and E20 (LPN), in the locked dementia dining/activity room around the corner to have E21 (LPN/UM) to meet the surveyor in the hallway. 7/6/26 10:47 AM – Surveyor and E21 observed the unlocked closet and E21 stated that they do not use this closet. Further observation revealed a brown box on the bottom shelf filled with residents' blister packs of medications with the following handwritten on the top of the box "Backup meds Arcadia Front". E21 could not explain why there were medications stored in the closet. The following residents' medications were in the box and immediately confirmed with E21: -R24's medication labels stated, "Spironolactone 25mg tab. Give 50mg by mouth one time a day related to hypertension. 2 tablets = 50mg. Hazardous Group 2 Drug. HD Caution: Hazardous Drug. Observe Special Handling, Administration and Disposal Requirements." Out of twenty-nine (29) blister packs accounted and prescribed to R24, twenty-four (24) blister packs containing either 7 tablets or 14 tablets had expired "use by" dates. -R15's medication labels stated, "Diltiazem 60mg	F0761	Continued from page 38 medication areas, and resident rooms. The audit will verify medication security, labeling, expiration dates, storage requirements, hazardous drug handling, medication reconciliation, and timely disposal. Systemic Change The root cause analysis is related to the facilities' failure to follow the policy regarding proper medication storage; this failure was related to the surplus of medications not being stored in a designated secured area. The Director of Nursing/Assistant Director of Nursing and/or Nursing Supervisors will re-educate licensed nurses regarding medication and treatment storage, labeling, security, expiration-date checks, backup-medication management, medication reconciliation, hazardous-drug handling and disposal, removal of discontinued or expired medications, this education will be incorporated into new hire orientation for licensed nurses. The surplus of medications will be stored in the secure medication room located near the nursing station on the New Castle nursing unit. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. Monitoring The Director of Nursing/Assisted Director of Nursing and/or Unit Managers/Nursing Supervisors will audit all medication carts, treatment carts, medication rooms, approved medication closets, backup supplies, and 5 resident rooms per day of resident rooms daily for 14 days until 100% compliance, then weekly for two weeks until 100% compliance, and monthly for two months until 100% compliance. Audits will verify security, labeling, expiration dates, medication accountability, hazardous-drug requirements, proper disposal, and consistency between available medications and MAR/TAR documentation. Results will be reviewed through the Quality	08/26/2026

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F0761 SS = D	Continued from page 39 tab. Give 1 tablet by mouth every 8 hrs [hours] for HTN [hypertension]. Recommend monitor BP [blood pressure] & [and] pulse wkly [weekly] or per policy. May cause photosensitivity or dizziness." Out of forty (40) blister packs accounted and prescribed to R15, twenty-seven (27) blister packs containing 14 tablets had expired "use by" dates with one blister pack missing 2 tablets. 7/6/26 12:05 PM – During an interview, E21 stated that R24 and R15's medications are kept in the "front" medication cart. A follow-up interview after reviewing the contents of the box with E21 confirmed the following: -the residents' medications should not be stored in an unlocked, unsupervised closet; and -expired medications should have been properly disposed. 2. 7/6/26 – Observations of the front medication cart assigned to E10 (LPN) revealed the following: -at 12:12 PM, R24 had two Aldactone 25mg medication blister packs containing 14 tablets with expired "use by" dates of 10/8/25 and 2/4/26. -at 12:19 PM, R15 had one Diltiazem 60mg medication blister pack containing 14 tablets with expired "use by" date of 12/14/25. Observations immediately confirmed with E10 and in the presence of E21 (LPN/UM). 7/6/26 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (CRN). 3. Review of R14's clinical record revealed: 6/27/25 – R14 was admitted to the facility with diagnoses including dementia. 4/5/26 – R14's quarterly MDS assessment revealed that R14's cognition was severely impaired. 7/7/26 2:02 PM – During an interview, FM4 (friend) stated that she visits R14 in the facility regularly. FM4 indicated stated that she noticed a bottle of medicated powder left inside the drawer of R14 bedside table. FM4 motioned the surveyor to examine the contents of the drawer.	F0761	Continued from page 39 Assurance and Performance Improvement Committee. 5. Date of Compliance 8/26/2026	08/26/2026

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F0761 SS = D	Continued from page 40 7/7/26 2:20 PM – An observation in R14's drawer revealed an unused bottle of nystatin powder prescribed for R14 on 6/11/26 with directions to apply to groin topically two times a day for rash for 10 days. 7/7/26 2:25 PM - When interviewed, R14 stated, "They (nursing staff) never put them on me". 7/7/26 2:34 PM – E21 (LPN UM) entered R14's room to deliver incontinence briefs. Surveyor showed E21 the bottle of nystatin powder inside R14's drawer. 7/7/26 2:36 PM – In an interview, E21 confirmed that the nystatin powder should be kept in the treatment cart and not inside R14's drawer. E21 further stated that the nurses apply the powder on R14 and that she will check R14's treatment orders if R14 was to continue using it or to discontinue. 7/10/26 10:35 PM – Findings were discussed with E1 (NHA) and E2 (DON). 7/10/26 10:40 PM – Findings were reviewed with E1 and E2 during the Exit Conference.	F0761		08/26/2026
F0777 SS = D	Radiology/Diag Srvcs Ordered/Notify Results CFR(s): 483.50(b)(2)(i)(ii) §483.50(b)(2) The facility must- (i) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. 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) out of four residents reviewed for change in condition, the facility failed to ensure that a stat (at once) ordered chest x-ray was completed until 31 hours after it was ordered. In addition, the facility failed to ensure that R9's STAT chest x-ray result was reported to the physician in a timely	F0777	F777 – Radiology/Other Diagnostic Services Corrective Action R9 no longer resides at the facility and the deficient practice is unable to be corrected; therefore, no additional resident-specific intervention can be completed. Residents with Potential to be Affected The Director of Nursing or designee will audit all STAT diagnostic orders from the preceding 30 days to verify that each order was accurately transcribed, transmitted, acknowledged by the diagnostic provider, completed within the facility's expected STAT turnaround time, and escalated when delayed. The Director of Nursing or designee will separately audit diagnostic results from the preceding 30 days to verify that significant or abnormal findings were promptly reported to the physician, required interventions were implemented, and the notification and follow-up were documented. The facility will	08/26/2026

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F0777 SS = D	Continued from page 41 manner. Findings include: Cross refer F580 and F684 Review of R9's clinical record revealed: 6/5/26 9:21 AM – A nurse progress note documented, "... [P2 NP] made aware (sic) she went to see [R9] ... gave verbal order for STAT chest x-ray..." 6/5/26 3:00 PM – R9 had a physician's order for chest x-ray two views for cough and congestion. 6/6/25 4:54 PM – A radiology results report documented R9's chest x-ray examination was done on this date and time. 6/6/26 9:07 PM – A radiology results report documented R9's chest x-ray result with significant findings. 6/7/26 6:13 AM - A nurse progress note documented, "...CXR (chest x-ray) results are back and MD (physician) will review them and give further instructions..." 6/7/26 9:43 AM – A nurse progress note documented that R9's chest x-ray result was reported to the on-call physician. 7/10/26 6:29 PM – In an interview, E2 (DON) confirmed that R9's stat chest x-ray ordered on 6/5/26 at 9:21 AM was not done until the next day, 6/6/26 after 4:00 PM. E2 also confirmed that the nurse who received the report from the x-ray company that evening or night shift did not immediately call the physician but left it in the MD (physician's) book. 7/10/26 7:51 PM – In a telephone interview, E31 (LPN) stated "... The evening nurse told me it was just a regular chest x-ray order, and not stat." When asked if she received the report of R9's chest x-ray result on Saturday evening, E31 stated that she did not see the actual copy of the report..." 7/10/26 8:17 PM – During a telephone interview, E32 (LPN) stated that he worked on 6/6/26 on the 3-11 shift. E32 further stated, "... I was told by the outgoing day nurse of R9's delayed chest x-ray... The nurse working before my shift should have notified the on call NP or MD when R9's chest x-ray was not completed right away." 7/10/26 10:35 PM – Findings were discussed with	F0777	Continued from page 41 immediately address identified concerns. A homework sheet will be utilized for each shift by the Unit Managers/Nursing Supervisors to communicate pending diagnostic test results to be communicated to the provider when received. Systemic Changes The root cause analysis is related to the licensed nurses' failure to follow notification requirements of abnormal results to the physician in a timely manner related to not following the facility Laboratory/Diagnostic Testing Policy. The Director of Nursing/Assistant Director of Nursing and/or Staff Development Coordinator/Nursing Supervisors will re-educate licensed nurses regarding transcription and transmission of diagnostic orders, identification of STAT priority, confirmation that the diagnostic provider received the order, tracking through completion, shift-to-shift communication, and escalation when a STAT test is delayed. Education will also address timely review of diagnostic reports, immediate physician notification of significant or abnormal findings, implementation of new orders, documentation, and the prohibition against leaving a significant result in the physician communication book without direct notification, this education will be incorporated into new hire orientation for licensed nurses. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. Monitoring The Director of Nursing/Assistant Director of Nursing and/or Unit Managers/Nursing Supervisors or designee will audit diagnostic orders and significant or abnormal diagnostic results daily for 14 days until 100% compliance, then weekly for two weeks until 100% compliance, then monthly for two months until 100% compliance. Audits will separately verify timely completion of STAT orders and timely	08/26/2026

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F0777 SS = D	Continued from page 42 E1 (NHA) and E2 (DON). 7/10/26 10:40 PM – Findings were reviewed with E2 and E2 during the Exit Conference.	F0777	Continued from page 42 physician notification and follow-up once results are received. Results will be reviewed through the Quality Assurance and Performance Improvement Committee. Date of Compliance 8/26/2026	08/26/2026