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: Evergreen Post Acute LLC

DATE SURVEY COMPLETED: July 7, 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 Revisit and Complaint survey was conducted at this facility from June 30, 2026, through July 7, 2026, for the Annual and Complaint survey that ended May 11, 2026. The facility was found not to be in substantial compliance with 42 CFR Part 484, Subpart B, Requirements for Long Term Care Facilities. The facility census totaled one hundred and thirty-nine (139). The sample size totaled fifteen residents (15).	Please see EPOC -	
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:** Cross Refer to the CMS 2567-L survey completed July 7, 2026: F677, F686, F804 and F842.		

Provider's Signature [signature] Title Administrator Date 7.23.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD , SMYRNA, Delaware, 19977

(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 Revisit and Complaint survey was conducted at this facility from June 30, 2026, through July 7, 2026 for the Annual and Complaint survey that ended May 11, 2026. The facility was found not to be in substantial compliance with 42 CFR Part 484, Subpart B, Requirements for Long Term Care Facilities. The facility census totaled one hundred and thirty-nine (139). The sample size totaled fifteen residents (15). Abbreviations/definitions used in this report is a follows: CNA – Certified Nurse Aide; DON – Director of Nursing; HD – Housekeeping Director; LPN – Licensed Practical Nurse; NHA – Nursing Home Administrator; NP – Nurse Practitioner; RN – Registered Nurse; Braden Scale – an assessment tool for measuring risk of pressure ulcer development using the following scale. AT RISK 15 -18, MODERARE RISK 13-14, HIGH RISK 10 -12, VERY HIGH RISK 9 or below; Excoriation – areas of irritated, inflamed and missing skin; Heel Boots – cushioned heel covers to protect heels from pressure ulcer development; MASD – Moisture Associated Skin Damage - skin excoriation, inflammation and erosion caused by prolonged exposure to moisture from bodily fluids, leading to fragile, overhydrated skin prone to irritation and infection; Necrotizing Fasciitis - flesh eating bacterial disease;	F0000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD , SMYRNA, Delaware, 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	Continued from page 1 TAR - Treatment Administration Record;	F0000		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview it was determined that for one (R12) out of three residents reviewed for activities of daily living (ADL's) the facility failed to ensure that a resident received assistance with eating when R12 waited an estimated one hour and fifteen minutes for staff to begin feeding her breakfast. Findings include: Review of R12's clinical record revealed: 4/10/26 - A quarterly MDS assessment documented that R12 was dependent on staff assistance to eat meals. 6/30/26 – R12's care plan for inability to complete ADLs was reviewed. An intervention included in the care plan was for R12 to receive assistance with meals. 7/1/26 9:20 AM - As the surveyor entered R12's room the resident was laying on her side in bed. No breakfast tray was observed in the room. 7/1/26 9:29 AM - E8 (CNA) entered R12's room and began feeding R12 breakfast. 7/1/26 9:33 AM - E7 (FSD) reported that R12's breakfast was delivered to the unit at 8:15 AM an hour and fifteen minutes prior to R12 being fed. 7/1/26 11:00 AM - During an interview E4, (RN) provided the surveyor with a copy of the CNA assignments and reported that a change from E9 (CNA) to E8 (CNA) was reason for the delay in staff providing R12's breakfast.	F0677	F677 1. R12 was provided with a new meal and assisted with feeding timely. E8 and E9 were educated by DON on assuring dependent residents are assisted with meals. 2. All residents have the potential to be affected by this deficient practice. An observational audit was completed on 7/21/26 by Director of nursing of dependent residents requiring assistance with eating to ensure assistance with eating was provided timely, audit was 100% compliant. 3. Root cause analysis was conducted, and it was found that CNA assignments were unclear due to a change in staffing for unit, which led to a delay in resident being assisted with meal. Additionally, there was a lack of supervisory oversight of mealtime to ensure that residents requiring assistance with eating were helped in a timely manner. Unit Managers or designee will ensure CNA assignment sheets indicate residents who are dependent on staff for meal assistance to ensure if CNA assignment changes this information is readily available. Unit Manager or RN Supervisor will audit their unit during meal service to ensure all residents who are dependent on staff are receiving meal assistance. Staff Education Nurse/Designee will in service certified nursing aides on the importance of ensuring residents who require assistance with eating are helped in a timely manner. DON will educate all UMs, MDS Nurses, Staff Education RN, RN Supervisors, Infection Control and QAPI Nurse importance of rounding during mealtimes and ensuring that staff are providing assistance to all residents requiring assistance with eating timely. The Director of Nursing or designee is responsible for the corrective action.	08/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD , SMYRNA, Delaware, 19977

(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
F0677 SS = D	Continued from page 2 7/7/26 2:00 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0677	Continued from page 2 4. DON/designee will audit 5 residents who require assistance with eating to ensure assistance with eating is provided timely. Audits will be completed on 5 residents daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee. The Director of Nursing or designee is responsible for the monitoring.	08/06/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review it was determined that for two (R12 and R14) out of four residents reviewed for pressure ulcers the facility failed to ensure measures to promote healing of pressure ulcers were in place. Findings include: 6/2026 – The facility policy on pressure ulcers indicated "To prevent the formation of pressure injuries it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. Individualized interventions will address specific factors identified in the resident's risk assessment, skin assessment, and any pressure	F0686	1. a. R12 ordered heel protection boot was immediately applied in accordance with the physician's order and the resident's individualized plan of care. b. The facility cannot retroactively correct this issue as R14 has discharged. 2. a. All residents with orders for heel boots have the potential to be affected by this deficient practice. An audit of all residents with physician orders for heel boots was completed by the Director of Nursing or designee to verify that ordered devices were present, properly applied, and documented. b. All residents receiving wound care services have the potential to be affected by this deficient practice. An audit was conducted of all current residents receiving wound care services to verify that wound care recommendations had corresponding physician orders. 3. a. Root cause analysis was conducted, and the review determined that the R12 had a physician order for bilateral heel protection boots as part of the facility's pressure injury prevention program. At the time of survey observation, only one of the bilateral ordered heel boots was in place. The boot was at bedside and available but not placed on resident.	08/06/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD , SMYRNA, Delaware, 19977

(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
F0686 SS = D	Continued from page 3 injury assessments. Interventions will be implemented in accordance with physicians' orders." 1. Review of R12's clinical record revealed: 8/1/25 – A physician's order was written for R12 to have heel boots applied while in bed. 6/30/26 – R12's care plan for skin integrity was reviewed. The care plan included the intervention for heel protection boots to be worn. 7/1/26 10:00 AM – R12 was observed in bed without a heel protection boot on the left foot, the boot was observed on the bedside table. 7/6/26 7:45 AM – R12 was observed in bed without a heel protection boot on the left foot, the boot was observed on the bedside table. 7/6/26 9:38 AM – During dressing change observation R12 was observed in bed without a heel boot protector on the left foot. E12 (RN) completed R12's dressing change and confirmed the absence of the heel protector pillow and applied it to R12 at that time. 2. Review of R14's clinical record revealed: 5/28/26 - R14 was admitted to the facility from the hospital with multiple diagnoses including diabetes, history of heart failure and a recent amputation of the right leg due to necrotizing fasciitis. 5/28/26 – An admission assessment was completed for R14 by E6 (RN) that documented R14 had "normal" skin. 5/29/26 – A physical therapy assessment documented that R14 was unable to walk due to medical condition and safety concerns. 6/1/26 - A care plan was created for R14's risk of altered skin integrity. The care plan lacked evidence of interventions to protect R14's heel from pressure ulcer development. 6/3/26 – An admission MDS assessment documented that R14 was required substantial maximum assistance to change position in the bed, was incontinent of bowel and bladder and dependent for toileting. R14's skin was assessed as at risk for pressure ulcers and had a surgical wound. Walking was not assessed due to R14's safety.	F0686	Continued from page 3 The Root Cause Analysis identified staff did not consistently verify that ordered heel boots remained in place. Existing rounds did not consistently include verification of heel boot placement as ordered. Nursing assistants were not consistently reapplying heel boots after providing resident care. Staff Education Nurse or designee will reeducate licensed nurses and certified nursing assistants regarding compliance with physician orders for heel protector boots. The wound nurse or designee will verify ordered heel protection boots are in place during routine skin rounds and treatment observations. The Director of Nursing or designee are responsible for the corrective action. b. A root cause analysis determined that the deficiency resulted from a breakdown in communication and order reconciliation following the wound nurse assessment. Although the wound nurse documented the recommendation for heel offloading boots, there was no standardized process requiring verification that the recommendation had been converted into a physician order before completion of wound rounds. As a result, the intervention was not implemented. The facility determined this was a process failure rather than a lack of clinical knowledge. Facility implemented a standardized wound recommendation tracking system to ensure timely ordering, implementation, and monitoring of all wound care recommendations. Upon completion of weekly wound rounds a thorough report is generated by the Wound Care Nurse Practitioner, the report consists of the patient's name, status of wound, new orders/recommendations. Upon receiving this report, the Wound Care Nurse and Unit Manager will complete a same day reconciliation of wound recommendations and physician orders. Staff Education Nurse/ Designee will educate licensed nurses on the importance of timely transcription and implementation of all physician orders related to pressure injury prevention and treatment. The wound nurse or designee will verify ordered heel protection boots are in place during routine skin rounds and treatment observations. The Director of Nursing or designee are responsible for the corrective action.	08/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD , SMYRNA, Delaware, 19977

(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
F0686 SS = D	Continued from page 4 6/3/26 – A wound care progress note written by E5 (NP) documented, "float left heel while in bed with use of heel boots." 6/5/26 – A Braden assessment documented that R14 "walked occasionally". R14 was scored a "14" that indicated moderate risk of pressure ulcer development. 6/10/26 – A wound care progress note written by E5 (NP) documented, "float left heel while in bed with use of heel boots." June 2026 – Review of R14's physicians orders lacked evidence of an order for heel protection boots. June 2026 – Review of R14's TAR lacked evidence of application of heel protection boots to protect R14's heel from pressure ulcer development. June 2026 – Review of R14's CNA record of care provided lacked evidence of application of heel protection boots to protect R14's heel from pressure ulcer development. 6/13/26 – R14 was admitted to the hospital. A wound care assessment documented the presence of a Stage I pressure ulcer to R14's left heel. 7/7/26 12:44 PM – During an interview, E5 (NP) confirmed that R14's treatment plan for pressure ulcer prevention was to have heel boots applied. 7/7/26 1:29 PM – During an interview, E13 (DR) confirmed that R14 could not walk due to the recent amputation. 7/7/26 1:32 PM – During an interview, E2 (DON) confirmed that the Braden assessment completed on 6/5/26 was inaccurate and that the facility did not apply heel protection boots to R14. E2 stated, "we did have the intervention to float the heels". 7/7/26 2:00 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0686	Continued from page 4 4. a. DON/designee will audit 5 residents who have orders for heel boots. Audits will be completed on 5 residents daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee. The Director of Nursing or Designee are responsible for the monitoring. b. DON/designee will audit 5 residents receiving wound care to verify wound care recommendations match physician orders. Audits will be completed on 5 residents daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee. The Director of Nursing or Designee are responsible for the monitoring.	08/06/2026
F0804 SS = D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F0804	1. R12 was immediately provided with a replacement meal that met the resident's prescribed diet, was served at an appropriate temperature, and was determined to be palatable. 2.	08/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD , SMYRNA, Delaware, 19977

(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
F0804 SS = D	Continued from page 5 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that for one (R12) out of three residents reviewed for nutrition/hydration the facility failed to ensure that R12 received a meal that was palatable and at an appetizing temperature when R12 was served breakfast greater than one hour after it's delivery. Findings include: 7/1/26 9:29 AM - E8 (CNA) entered R'12's room and began feeding R12 pureed eggs. The Surveyor observed that there was no steam, and the pureed oatmeal, sausage and eggs had a film across the top that appeared to indicate the meal was no longer warm. E8 confirmed that the bowls containing R12's eggs was not warm too touch. 7/1/26 9:33 AM - E7 (FSD) reported that R12's breakfast was delivered to the unit at 8:15 AM an hour and fifteen minutes prior to R12 being fed. E7 then obtained temperatures of R12's breakfast as follows; eggs 86.7 degrees Fahrenheit, sausage 110 degrees Fahrenheit, oatmeal 83.1 degrees Fahrenheit. E7 then ordered a replacement tray for R12. Review of the facility's food temperature logs revealed R12's meal was originally prepared at a temperature of 186 degrees Fahrenheit and had cooled between 76 – 102 degrees Fahrenheit when served by E8. 7/1/26 10:00 AM – A replacement tray arrived for R12 and E4 (RN) confirmed the prior breakfast tray was served at a temperature that that was no longer palatable. 7/7/26 2:00 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0804	Continued from page 5 All residents receiving meals have the potential to be affected, an audit of meal service will be conducted by Food Services Director/Designee to ensure residents meals are palatable and at an appropriate temperature at tray assembly and upon arrival to the resident care units. Additional audit will be conducted to review the timing of when staff assist a dependent resident to eat, after the trays are delivered to the floor. 3. A root cause analysis was conducted and determined that deficiency resulted due to delays between tray line assembly and meal delivery, allowing food temperatures to decrease before reaching resident, inconsistent communication between dietary and nursing departments regarding meal delivery timing and service expectations and opportunities to reinforce staff accountability for promptly identifying and replacing meals that were no longer served at acceptable temperatures or quality. The facility determined that these process gaps created the potential for meals to be served below acceptable standards for temperature and palatability. The Food Services Director/Designee will re-educate all dietary staff regarding CMS requirements for food quality, palatability, appearance, portioning, and temperature. The Staff Education Nurse/Designee re-educated Certified Nursing Aides regarding prompt meal distribution upon receipt from the kitchen and notification of dietary when alternative tray should be requested. Additionally, facility implemented routine supervisory observations of meal service to be completed by the Nurse Unit Manager or designee and reinforced the use of insulated meal delivery equipment and proper holding techniques to maintain appropriate food temperatures. The goal of the supervisory observations is to ensure that all residents require assistance at mealtime receive a meal that is palatable and served at an appetizing temperature. This will be a daily responsibility for Unit Manager or designee to include weekends and holidays and will be ongoing. The QAPI Nurse or designee will be responsible for the corrective actions. 4.	08/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING B. WING	07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD , SMYRNA, Delaware, 19977

(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
F0804 SS = D		F0804	Continued from page 6 Food Services Director/designee will audit 5 meals for hot and cold food temperatures, meal palatability and timeliness of meal delivery. Audits will be completed daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee. The Director of Nursing or designee will conduct an audit that reviews the timing of when staff assist a dependent resident to eat, after the trays are delivered to the floor. Audits will be completed on all units where residents that need staff assistance to eat reside. Audits will be completed on 10 residents that need assistance residents daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee. The QAPI nurse or designee will be responsible for the monitoring.	08/07/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F0842	F842 1. The facility cannot retroactively correct this issue as R14 has discharged. 2. An audit of 7 days of admission assessments will be conducted of residents admitted with skin alteration to assure that skin assessments accurately reflect each resident's skin condition. 3. A Root Cause Analysis was conducted and the investigation determined that the inaccurate Braden Scale assessment resulted from inconsistent application of the Braden Scale criteria by licensed nursing staff due to clinician rushing to complete tasks, a limited secondary review of Braden scores for accuracy and overall opportunities to strengthen communication between bedside nursing staff, the wound care nurse, and the interdisciplinary team regarding residents' pressure injury risk. Staff Education Nurse/ Designee will ensure licensed	08/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD , SMYRNA, Delaware, 19977

(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
F0842 SS = D	Continued from page 7 (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations	F0842	Continued from page 7 nurses receive education on the importance of documentation of skin alterations on new admissions. The facility revised its skin integrity review process to require Wound Care Nurse or Unit Manager review of newly completed Braden assessments. To ensure no assessments are missed the agenda for the daily interdisciplinary team meetings has been updated to review of the newly completed Braden Assessments by the Wound Care Nurse or Unit Manager at the meeting. Any missing sections will be reviewed and updated accordingly by Wound Care Nurse or Unit Manager conducting the review. The Director of Nursing or designee is responsible for the corrective actions. 4. DON/designee will audit 5 Braden Assessments for completion of form and accuracy of each section of the assessment. Audits will be completed on 5 residents daily for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee. The Director of Nursing or designee is responsible for the monitoring.	08/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD , SMYRNA, Delaware, 19977

(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
F0842 SS = D	Continued from page 8 conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R14) out of fifteen residents sampled the facility failed to ensure resident records were accurately completed. Findings include: Review of R14's clinical record revealed: 5/28/26 – An admission assessment was completed for R14 by E6 (RN) that documented R14 had "normal" skin. The skin assessment was incomplete with blank areas of missed documentation in the heel problems, preventative foot care, and skin plan sections. 6/3/26 – A wound care progress note documented that R14 had excoriation to the sacrum and a wound to the left arm were present on admission to the facility. 7/7/25 12:25 PM - During an interview E6 (RN) reported that during the admission assessment it was observed that R14 had MASD to the sacrum and a wound to the left arm that E6 did not document in R14's admission skin assessment. Additionally, E6 confirmed that the admission skin assessment was completed mistakenly with the heel assessment, foot care and skin care plan sections left blank. E6 stated, "these are clerical errors, I did the assessment but missed documenting everything." 7/7/26 2:00 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0842		08/06/2026