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

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

STATE SURVEY REPORT

NAME OF FACILITY: Encore at Parkside

DATE SURVEY COMPLETED: June 25, 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 complaint survey was conducted at this facility from June 24, 2026, through June 25. 2026. The deficiencies contained in this report are based on interviews, observations, and record review. The facility census on the first day of the survey was seventy-eight (78).		6/16/2026
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 June 25, 2026: cross refer: F689.		

Provider's Signature Folarin Osundina Title Director of Nursing Date 9/1/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. BUILDING B. WING	06/25/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from June 24, 2026, through June 25. 2026. The deficiencies contained in this report are based on interviews, observations, and record review. The facility census on the first day of the survey was seventy-eight (78). Abbreviations/definitions used in this report are as follows: Elopement: Leaving a safe area without permission; Subarachnoid hemorrhage: A bump or blow to the head that caused bleeding near the brain. Wanderguard: a tool that helps stop patients from leaving a safe area without staff knowing.	F0000		07/14/2026
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that one (R1) of three residents sampled did not receive adequate supervision and assistive devices to prevent elopement, as R1 is a newly admitted resident identified as an elopement risk. This failure resulted in R1 eloping from the facility to a busy road between approximately 5:00 PM and 5:20 PM without supervision or intervention. An Immediate Jeopardy was identified to the facility	F0689	"Past Noncompliance - no plan of correction required"	07/14/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/25/2026

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F0689 SS = SQC-J	Continued from page 1 on 6/25/26 at 10:00 AM and was determined to be past noncompliance as of 6/16/26. Findings include: Review of R1's clinical record revealed: 6/12/26- R1 was admitted to the facility for short-term rehab with diagnoses that included, but were not limited to, traumatic subarachnoid hemorrhage (a bump or blow to the head that caused bleeding near the brain). 6/12/26- The admission elopement evaluation documented that R1 was a risk for elopement. 6/12/26 10:22 PM- A progress note documented "Resident noted independently ambulatory with baseline confusion. Wander risk. Reported to NP (nurse practitioner), via Team Health. Order for Wanderguard (requested)." 6/12/26 11:23 PM- An order note documented "Wanderguard (ordered). Check placement and function q (every) shift". 6/13/26 10:36 AM- A progress note documented that the Wanderguard was placed on the resident's left ankle. 6/15/26 approximately 5:00 PM- Video surveillance revealed that R1 eloped from the healthcare facility through a set of double doors and that the Wanderguard alarm was not activated, and R1 was able to walk out the doors unattended, 6/15/26 5:56 PM- A progress note documented "Resident (R1) was found outside the building by the road by (E3 [COTA-L]) without supervision around 1500 (should be 5 PM) on 6/15/26. Resident has baseline confusion, poor safety awareness. BIMS score of 6. Wanderguard had been placed around the Resident's left ankle. Wanderguard failed. Resident brought back into the building." 6/15/26- R1, who was assessed as independent but at increased risk for elopement, was observed leaving the facility through the exit double doors without staff knowledge. Despite being seen exiting the building, the wander management system did not activate or alert staff. R1 continued ambulating along a main traffic roadway with a posted speed limit of 45 miles per hour for approximately 0.5 to 1 mile. At approximately 5:20 PM, E3 identified R1 walking along the roadway and returned the resident to the facility. Facility staff was unaware that R1 had exited	F0689		07/14/2026

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F0689 SS = SQC-J	Continued from page 2 the building. 6/24/26 12:00 PM- During an interview, E3 stated, "I was driving home from work when I noticed (R1) walking on the side of the road towards Wendy's. I recognized him as a resident because I worked with him earlier that same day. I pulled over and asked (R1) where he was going, and he said he was going to see his son at college. I was able to get him into my vehicle and brought him back to the facility and back to the unit, where nobody realized he was gone." 6/24/26 12:30 PM- During an interview, E1 (ADON) stated, "We realized that (R1) eloped from the facility when (E3) brought him back into the building and let the unit manager know. (R1) was fully assessed and no injuries occurred during the elopement. His Wanderguard was immediately replaced, and we moved him to the second floor of the facility." Following the elopement incident, the facility took the following immediate actions: A head-to-toe assessment was completed upon the resident's return, and vital signs were obtained and monitored. The malfunctioning Wanderguard was removed and replaced with a functioning device. The incident was reported to the State in accordance with reporting requirements The resident's attending physician and responsible party were notified of the incident. The resident was relocated to the second floor to provide an additional layer of protection, as the Wanderguard system deactivates elevator access when functioning properly. The resident was placed on increased monitoring for elopement risk and related behaviors. The resident was placed in the facility's "At Risk for Elopement" binder, including a current photograph for staff identification. The resident's elopement assessment was reviewed and updated. The resident's care plan was revised to reflect the elopement incident and include individualized interventions to address elopement risk.	F0689		07/14/2026

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F0689 SS = SQC-J	Continued from page 3 An audit was conducted of all residents identified as being at risk for elopement who were wearing wanderguards. Placement and functionality of each device were verified, and any malfunctioning devices were immediately replaced. The wanderguard system, including door alarms and elevator controls, was evaluated to ensure proper operation. Staff education and systemic corrective actions include (completed on 6/16/26): Education was provided to all staff regarding Identification of residents at risk for elopement; Daily monitoring and verification of Wanderguard placement and functionality; Immediate intervention when a resident identified as being at risk for elopement is observed approaching or exiting a secured area; The requirement for nursing staff to notify the Director of Nursing (DON) or Assistant Director of Nursing (ADON) immediately if Wanderguard placement or functionality cannot be confirmed. Staff competency regarding elopement prevention procedures and Wanderguard monitoring will be validated through observation and follow-up education as needed 6/25/26 10:00 AM- An immediate jeopardy was called in the presence of E1 (ADON), and E2 (MDS Coordinator) regarding the 6/12/26 elopement of R1. Based on the immediate actions taken by the facility, no further elopements occurred, and interventions were verified by the surveyor onsite during the survey; this incident was past non-compliance. 6/25/26 - Findings were reviewed during exit conference with E1 and E2.	F0689		07/14/2026