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: Delmar Nursing and Rehabilitation Center **DATE SURVEY COMPLETED:** September 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. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found to not be in substantial compliance with 42 CFR 483. Survey Dates: 09/07/26 to 09/10/26 Survey Census: 90 Sample Size: 31 Supplemental Residents: 20		
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 September 10, 2026: cross refer: F600, F628, F689, F695, F801, and F812		

Provider's Signature _____ Title VHA Date 9/23/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR NURSING & REHABILITATION CENTER	**101 DELAWARE AVE., DELMAR, DE. 19940-1110 , DELMAR, Delaware, 19940**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality on 09/07/26 – 09/10/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		
F0000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 09/07/26 to 09/10/26 Survey Census: 90 Sample Size: 31 Supplemental Residents: 20	F0000		
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition	F0801	Corrective Measures for Residents Affected: Unable to correct deficiency from 8/29-9/23/26 Immediately hired, 9/24/26, a Delaware-licensed Registered Dietician to assess high risk residents, review nutritional status, and address any identified risks (e.g., weight loss, pressure ulcers, tube feedings). Registered Dietician to work 3 days a week remotely/in facility on alternating days. Registered Dietician completed comprehensive nutritional assessments for high-risk residents. Identification of Others with Potential to be Affected:	10/07/2026

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

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F0801 SS = F	Continued from page 1 professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications- (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later	F0801	Continued from page 1 All new admissions and current residents were reviewed by Director of Nursing to ensure no one was missed. Director of Nursing to review resident census to identify any resident requiring Registered Dietician services. Systematic changes and Measures to Prevent Recurrence: Dietary and nursing staff re-educated by Trisha Vazquez, RN, staff educator, on the requirement for Registered Dietician oversight and licensure. Policy updated to require immediate notification to administration if Registered Dietician coverage lapses. Root Cause analysis- we were in the process of recruiting either a permanent or temporary replacement and our previous Registered Dietician was available remotely, which then caused a potential gap. Monitoring and Quality Assurance: Registered Dietician service logs and resident nutrition assessments will be reviewed weekly for 4 weeks, then monthly for 2 months until 100% compliance is achieved. Results of audits will be reviewed in Quality Assurance Performance Improvement meetings for three months until 100% compliance is achieved.	10/07/2026

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F0801 SS = F	Continued from page 2 than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Based on Registered Dietitian (RD) job description review, education and competency documentation review, and interview, the facility failed to ensure a qualified RD was employed at the facility for 90 of 90 census residents. This failure had the potential to affect nutritional status, weight losses, pressure ulcers, tube feedings, and over nutritional assessments and evaluations. (CROSS REFERENCE F812) Findings include: Review of the most recent "Employee Education Attendance Record" titled, "Food safety and Sanitation," provided by the facility, revealed it was conducted on 04/30/26 by the Dietary Manager (DM) and the RD. Review of the most recent "Food & Nutrition Services Competency Validation" for Cook1 for safe food handling, revealed it was conducted on 04/30/26 by DM and RD. During an interview on 09/08/26 at 8:59 AM, the Administrator stated they did not have an RD, since 08/28/26. During an interview on 09/08/26 at 9:14 AM, the DM stated the RD left on the 28th. He stated she used to be here Tuesdays and Fridays and would talk with the residents. During an interview on 09/09/26 at 9:07 AM, the Administration stated the RD left the facility at end of last month and that they did not have a current RD to assess residents or oversee weight losses. She stated the Speech Therapist, and nursing staff were available right now. She confirmed she was aware they were not meeting the regulatory requirements for RD. She stated they could reach	F0801		10/07/2026

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F0801 SS = F	Continued from page 3 out to the previous RD if they needed her for anything. Attempts to interview the previous RD were attempted on 09/09/26 at 8:48 AM and on 09/09/26 at 1:05 PM with no return call. Review of the undated job description for the "Clinical Dietitian," provided by the facility, revealed "The primary purpose of your job position is to assess diet therapies & instruct Residents on special diets according to physician's diet order or as deemed appropriate. Assists Food Service Director & Clinical Diet Technician in the total operation of the Dietary Department in accordance with current applicable federal, state, OSHA, & local standards, guidelines & regulations, & as directed by the Food Service Director to assure that quality food service & the highest degree of quality Resident care is maintained at all times."	F0801		10/07/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure proper glove use during food production and ensure foods were served at the proper temperature for 90 of 90 residents who consumed food in the kitchen. This	F0812	Corrective Measures for Residents Affected: All dietary staff retrained by Trisha Vazquez, RN, staff educator, on glove use and food temperature standards. Immediate correction of food handling practices; unsafe food discarded and replaced. Identification of Others with Potential to be Affected: All residents consuming facility-prepared food were considered potentially affected. Reeducation and competency will be completed with staff if this deficient practice occurs again. Systematic Changes and Measures to Prevent Recurrence: Cooks retrained by Trisha Vazquez, RN, staff educator on how to properly use temperature logs for all meals, reviewed daily by Dietary Manager. Cooks retrained by Trisha Vazquez, RN, staff educator on how to properly temperature food and drinks prior to meal service to ensure hot foods are at least 135 or above and cold foods are at 41 degrees or below.	10/07/2026

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F0812 SS = F	Continued from page 4 failure had the potential to lead to cross contamination and food borne illnesses. Findings include: 1. During an observation on 09/08/26 at 9:59 AM, Cook1 put on a pair of gloves. She cleaned the countertop with a wet towel from the cart. She grabbed a white cutting board and placed it on the counter. She cut tomatoes into slices and placed toasted bread onto the cutting board. She placed lettuce and tomato slices directly onto the toast, on plates, using the same pair of gloves. She lifted the metal lids off the steam table, filled the water pitcher while touching the faucet and poured the water into the steam table, using the same pair of gloves. She stirred the soup on the stove by the handle, placed a scoop of soup into a small disposable cup, for taste testing. She tasted the soup and took the disposable cup to the trash with the right hand, and the pitcher was in her left hand, using the same pair of gloves. She obtained more water from the 2-pan sink and placed the water into the pan of soup, on top of the stove. She grabbed the oven mitt and opened the oven doors with her right hand and moved the bacon around in the pan- using her gloved left hand. At 10:06 AM, she moved more metal lids from the steam table and grabbed the cream cheese container. She cut the cream cheese log into two sections, with the same gloved hands. She grabbed a metal bowl and placed the cream cheese- smaller half into the bowl. She placed the metal bowl into the oven after she took the bacon out of the oven, with the same pair of gloves. She grabbed some paper towels from the handwashing sink and took them to the cutting board and placed them onto a plate. She placed the bacon onto the paper towels, using the same pair of gloves. She placed the bacon onto the sandwich with lettuce and tomato slices using her gloved hands. She placed her hand on the top of the sandwiches with her same pair of gloves and cut the sandwiches in half. At 10:12 AM, she brought the sandwiches over and covered them with plastic wrap. She then proceeded to take her gloves off. No utensils were used with direct food contact. During an interview on 09/08/26 at 10:14 AM, Cook1 stated she put gloves on when she was using her hands and did not notice that she did not change her gloves out. During an interview on 09/08/26 at 10:41 AM, the Dietary Manager (DM) confirmed he noticed that she did not change her gloves. He stated he would provide education to the staff.	F0812	Continued from page 4 Staff retrained by Trisha Vazquez, RN, Staff educator on the proper use of gloves. New hire orientation for all dietary staff to include how to properly temperature food/drinks and the proper use of gloves. Food Service Director/designee will monitor the completion of meal temperature logs. Root Cause Analysis- The cook failed to follow policy for bare hand contact with food and use of plastic gloves. Cook failed to ensure internal temperatures were within guidelines for 135 degrees or higher for hot and or 41degrees or below for cold food. Monitoring and Quality Assurance: Dietary Manager reviews logs and conducts weekly audits for 4 weeks then, monthly for 2 months until 100% compliance is achieved. Dietary Manager/designee will do weekly audits, 1 meal a day to ensure proper glove use for 4 weeks, then, monthly for 2 months until 100% compliance is achieved. Results presented at Quality Assurance Performance Improvement meetings for three months until 100% compliance achieved.	10/07/2026

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F0812 SS = F	Continued from page 5 Review of the facility's 2017 policy titled, "Bare Hand Contact with Food and Use of Plastic Gloves," revealed "Gloved hands are considered a food contact surface that can get contaminated or soiled. If used, single use gloves shall be used for only one task (such as working with ready-to-eat food or with raw animal food), used for no other purpose, and discarded when damaged or soiled..." 2. During an observation of lunch tray line and interview on 09/08/26 at 12:00 PM, the DM took temperatures of the food at the start of tray line service. The pureed green bean mixture was 84 degrees Fahrenheit (F). The chicken salad sandwiches were 48 degrees F. The grilled cheese sandwiches were 129 degrees F. The green beans in the small bowls were 50 degrees F. At 12:14 PM, the DM stated that he preferred hot food at 135 degrees F and cold food at 41 degrees F. At 12:21 PM, the DM tested a third tray of green beans in small bowls, directly from the walk-in, and the temperature was 46.6 degrees F. These food items remained on the line and were served to the residents. During an interview on 09/09/26 at 1:36 PM, the Administrator stated she would have to look up the proper temperature for food and stated the staff should be changing gloves in between. Review of the facility's 2017 policy titled, "Food Temperatures," revealed "1. All hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 degrees F...2. All cold food items must be stored and served at a temperature of 41 degrees F or below."	F0812		10/07/2026
F0695 SS = E	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 observation, interview, record review and review of facility policy, the facility failed to ensure	F0695	Corrective Measures for Residents Affected: All respiratory equipment for affected residents was immediately cleaned or filters replaced as needed. Residents 2, R100, R23, R66, R8, R32 and R71 Oxygen therapy equipment has been cleaned and maintained and all other residents with oxygen therapy equipment will be cleaned and maintained as scheduled and as needed Residents assessed for any signs of infection or complications. Identification of Others with Potential to be Affected:	10/07/2026

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F0695 SS = E	Continued from page 6 respiratory equipment was maintained in a clean manner for seven of 10 (Residents (R) 2, R100, R23, R66, R8, R32, R71) sampled for respiratory care in a sample of 31 residents. Oxygen therapy equipment was not properly maintained. This had the potential to create health issues, including infections. Findings include: 1. Review of R2's undated "Admission Record" located in R2's electronic medical record (EMR) under the "Profile" tab revealed R2 was admitted to the facility on 05/21/26 with diagnoses which included diastolic heart failure, acute pulmonary edema. Review of R2's "Physician Order," dated 05/21/26, located in the resident's EMR under the "Orders" tab revealed "continuous O2 [oxygen] at 2 lpm (liters per minute)." Review of R2's quarterly "Minimum Data Set (MDS)," with an assessment reference date (ARD) of 08/28/26 and located in the resident's EMR under the "MDS" tab revealed, the facility assessed R2 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R2 was cognitively intact. The "MDS" documented R2 was receiving oxygen therapy. During an observation on 09/07/26 at 11:47 AM revealed R2's oxygen concentrator was located next to her bed. The oxygen concentrator had one dirty air intake filter and was missing a second intake filter with the area for the filter noted to be dirty and dusty. During an observation and interview on 09/10/26 at 12:10 PM, the Director of Nursing (DON) confirmed R2's concentrator had one air intake filter which was dirty, and one air intake filter was missing. The DON stated, "The intake filter is dirty and needs to be cleaned and the other one is missing and the area for it is also dirty." 2. Review of R100's undated "Admission Record" located in R100's EMR under the "Profile" tab revealed R100 was admitted to the facility on 09/08/26 with diagnoses which included chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease. Review of R100's "Physician Order," dated 09/08/26, located in the resident's EMR under the "Orders" tab revealed "continuous O2 at 2 lpm."	F0695	Continued from page 6 Audit all residents with respiratory equipment to ensure cleanliness of equipment, filters and proper maintenance. Will set up a monthly preventative maintenance program to monitor Respiratory equipment. Systematic Changes and Measures to Prevent Recurrence: Maintenance staff retrained by Tonya Burton, NHA, on cleaning and maintenance protocols for respiratory equipment. System change to include cleaning/maintenance to be completed by maintenance staff monthly or as needed based on manufacturer recommendation. A log to be maintained for each concentrator to keep track of its maintenance/cleaning that has been completed. Root Cause Analysis- Facility failed to ensure respiratory/oxygen equipment was not maintained in a clean manner and was not maintained properly. Monitoring and Quality Assurance: Director of Nursing conducts weekly audits for 4 weeks then, monthly, for 2 months until 100% compliance is achieved. Results presented at Quality Assurance Performance Improvement meetings for three months until 100% compliance achieved.	10/07/2026

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F0695 SS = E	Continued from page 7 Review of R100's admission "MDS," with an ARD of 09/14/26 and located in the resident's EMR under the "MDS" tab revealed, the facility had not yet completed the MDS by the end of the survey due to the recent admission of R100. During an observation and interview on 09/10/26 at 12:10 PM, the DON confirmed R100's concentrator had a dirty air intake filter. The DON stated, "The intake filter is dirty." 3. Review of R23's undated "Admission Record" located in R23's EMR under the "Profile" tab revealed R23 was admitted to the facility on 10/08/25 and then was readmitted on 05/13/26 with diagnoses which included chronic obstructive pulmonary disease, chronic diastolic heart failure, Alzheimer's disease. Review of R23's "Physician Order," dated 05/13/26, located in the resident's EMR under the "Orders" tab revealed "continuous O2 at 2 lpm via." Review of R23's quarterly "MDS," with an ARD of 08/20/26 and located in the resident's EMR under the "MDS" tab revealed, the facility assessed R23 to have a BIMS score of 12 out of 15 which indicated R23 was moderately impaired cognitively. The "MDS" documented R23 was receiving oxygen therapy. During an observation and interview on 09/10/26 at 12:15 PM, the DON confirmed R23's concentrator had a dirty air intake filter. The DON stated, "The intake filter is dirty and needs to be cleaned." 4. Review of R66's undated "Admission Record" located in R66's EMR under the "Profile" tab revealed R66 was admitted to the facility on 06/20/25 with diagnoses which included chronic obstructive pulmonary disease, unspecified asthma. Review of R66's "Physician Order," dated 06/20/25, located in the resident's EMR under the "Orders" tab revealed "continuous O2 at 2 lpm." Review of R66's annual "MDS," with an ARD of 06/28/26 and located in the resident's EMR under the "MDS" tab revealed, the facility assessed R66 to have a BIMS score of 15 out of 15 which indicated R66 was cognitively intact. The "MDS" documented R66 was receiving oxygen therapy. During an observation and interview on 09/10/26 at 12:22 PM, the DON confirmed R66's concentrator had a dirty air intake filter. The DON stated, "The	F0695		10/07/2026

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F0695 SS = E	Continued from page 8 intake filter is dirty and needs to be cleaned." 5. Review of R8's undated "Admission Record" located in R8's EMR under the "Profile" tab revealed R8 was admitted to the facility on 02/28/25 with diagnoses which included anxiety, Alzheimer's disease, angina pectoris. Review of R8's "Physician Order," dated 08/14/26, located in the resident's EMR under the "Orders" tab revealed "continuous O2 at 2 lpm as needed." Review of R8's 5-Day "MDS," with an ARD of 08/16/26 and located in the resident's EMR under the "MDS" tab revealed, the facility assessed R8 to have a BIMS score of 11 out of 15 which indicated R8 was moderately impaired cognitively. The "MDS" documented R8 was receiving oxygen therapy. During an observation and interview on 09/10/26 at 12:22 PM, the DON confirmed R8's concentrator had a dirty air intake filter. The DON stated, "The intake filter is dirty and needs to be cleaned." 6. Review of R32's undated "Admission Record" located in R32's EMR under the "Profile" tab revealed R32 was admitted to the facility on 07/01/24 and was readmitted on 05/07/25 with diagnoses which included heart failure, atrial fibrillation. Review of R32's "Physician Order," dated 05/30/26, located in the resident's EMR under the "Orders" tab revealed "O2 at 3 lpm as needed." Review of R32's 5-Day "MDS," with an ARD of 09/01/26 and located in the resident's EMR under the "MDS" tab revealed, the facility assessed R32 to have a BIMS score of nine out of 15 which indicated R32 was moderately impaired cognitively. The "MDS" did not indicate oxygen use. During an observation and interview on 09/10/26 at 12:25 PM, the DON confirmed R66's concentrator had a dirty air intake filter. The DON stated, "The intake filter is dirty." 7. Review of R71's undated "Admission Record" located in R71's EMR under the "Profile" tab revealed R71 was admitted to the facility on 08/28/26 with diagnoses which included heart failure, atrial fibrillation, history of pulmonary embolism. Review of R71's "Physician Order," dated 06/20/25, located in the resident's EMR under the "Orders"	F0695		10/07/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0695 SS = E	Continued from page 9 tab revealed "O2 at 2 lpm as needed." Review of R71's admission "MDS," with an ARD of 09/04/26 and located in the resident's EMR under the "MDS" tab revealed, the facility assessed R71 to have a BIMS score of 10 out of 15 which indicated R71 was moderately impaired cognitively. The "MDS" did not indicate oxygen use. During an observation and interview on 09/10/26 at 12:30 PM, the DON confirmed R66's concentrator had a dirty air intake filter. The DON stated, "The intake filter is dirty and needs to be cleaned." Review of the facility's undated policy titled, "Oxygen Use," revealed, "Policy Statement: The administration of supplemental oxygen is an essential element of appropriate management for a wide range of clinical conditions. However, oxygen should be regarded as a drug and therefore, requires prescribing in all but emergency situations. Failure to administer oxygen appropriately can result in serious harm to the patient. The safe implementation of oxygen therapy with appropriate monitoring is an integral component of the Healthcare Professional's role…Set Up: Check to be sure foam filters are free of dust and debris…"	F0695		10/07/2026
F0600 SS = D	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 record review, review of facility documentation, interview, and facility policy review,	F0600	"Past Noncompliance - no plan of correction required"	12/16/2025

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F0600 SS = D	Continued from page 10 the facility failed to protect Resident (R) 3 and keep her free from verbal abuse by Certified Nursing Assistant (CNA) 7. She was one of five residents reviewed for abuse out of a sample of 31 residents. Failing to protect a resident from verbal abuse can result in serious emotional and psychological harm. The deficient practice was determined to be past noncompliance related to facility identifying the staff to resident verbal abuse and implementing interventions to prevent reoccurrence of the situation, completed on 12/16/25. The facility's actions included the following: 1.CNA7 was initially removed from the schedule and facility pending the facility investigation. 2.Staff were in-serviced on abuse prevention. 3.The police department was notified, and the situation was investigated. 4.Staff interviews were completed. 5.Resident interviews were completed. 6.Care plan was revised with interventions. 7.Incident taken to QAPI (Quality, Assessment, and Improvement) for review. 8.CNA7 was terminated. Findings include: Review of R3's "Admission Record," located in R3's electronic medical record (EMR) under the profile tab, revealed a facility admission date of 02/08/22, with medical diagnoses that included dementia, atrial fibrillation, anxiety disorder. Review of R3's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/20/25, revealed the facility assessed R3 to have a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15 which indicated R3 was cognitively intact. Review of R3's Care Plan located under the Care Plan tab in the EMR revealed R3 has a behavior problem: A. Making false allegations. B. Cursing/yelling at staff. Date initiated 07/11/25, revision dated 08/13/26. Interventions: Explain all procedures to the resident before starting and allow the resident to adjust to changes. Date Initiated:	F0600		12/16/2025

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F0600 SS = D	Continued from page 11 07/11/2025. Follow up with psych as needed Date Initiated: 07/11/2025. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 07/11/2025 Review of R3's "Progress Notes" located in the EMR under the "Progress Notes" tab revealed a "Social Services" note dated 12/19/25, "Social Services Director (SSD) followed up with R3 regarding a state reportable incident that occurred on 12/14/2025. SSD notified R3 that the staff member involved in the incident was no longer employed by the facility. She was relieved and thanked SSD for notifying her of the outcome. R3 reported no other issues or concerns. SW will continue to assist as needed." Review of the facility investigation revealed, "Description of incident: On 12/14/25 it was reported that R3 felt threatened (kill her) by CNA7. CNA7 admitted that R3 asked her to push her in wheelchair. CNA7 commented "God blessed you with two good legs and we would like you to use them." R3 then raised her fist to CNA7 and CNA7 stated do not do that. R3 then stated she is threatening me. It was reported that CNA7 stated it would be her last time. Statements obtained and verified statement." Facility conclusion: Verified. During an interview on 09/07/2026 at 2:16 PM, R3 stated, "I had an incident with CNA7 a few months ago when she threatened to kill me. She was terminated for making verbal threats." During an interview on 09/09/26 at 3:00 PM, the Director of Nursing (DON) stated, "R3 requested to be pushed in her wheelchair, CNA7 made statement to R3 and R3 shook her fist at CNA7 and then CNA7 responded with statement that it would be her last or something along that line. Facility investigation confirmed the event and terminated the CNA for abuse." On 09/09/26 at 3:35 PM, an attempt was made to complete a phone interview with CNA7, and she refused to have a conversation. During an interview on 09/09/26 at 3:40 PM, the Administrator stated, "CNA7 was terminated, we could not confirm it did not happen. CNA7 had additional customer service issues so we terminated her. CNA7 was terminated for making a threating	F0600		12/16/2025

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F0600 SS = D	Continued from page 12 statement. Staff should not threaten, disrespect residents, they should always be respectful." Review of the facility policy, "Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property," dated 12/23/25, revealed, " It is the policy of Delmar Nursing and Rehabilitation Center that each resident will be free from "Abuse". Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion… Additionally, residents will be protected from abuse, neglect, and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for Protection… C. Prevention: Procedure:…6. Supervision of Staff: staff will be supervised to identify inappropriate behaviors while caring for or in attendance with residents."	F0600		12/16/2025
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F0628	Corrective Measures for Residents Affected: Provided written notification to affected residents and their representatives as soon as identified. R17 and R81 have been provided proper written notification as identified. Ensured documentation of notification of Transfer/Discharge is maintain in the medical record. Identification of Others with Potential to be Affected: Audit of all transfers/discharges in the past 90 days to ensure written notification was provided. All residents who were impacted by the deficient practice received the new transfer/discharge form by mail. Systematic Changes and Measures to Prevent Recurrence: Educated Social Services, Nursing, Medical Records, and Admissions staff on Delaware's written notice requirements and created a form.	10/07/2026

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F0628 SS = D	Continued from page 13 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:	F0628	Continued from page 13 Nurses to be educated that when sending out a resident, copies of all Discharge/Transfer paperwork must be retained by the facility. Implemented a Discharge/Transfer form and updated the policy. Root Cause Analysis- Upon discharge/transfer the nurse sending out the resident did not make a copy of the discharge/transfer paperwork that she sent to the hospital. The facility did not utilize a form with the updated transfer/discharge requirements as noted by the State of Delaware. Monitoring and Quality Assurance: Social Services Director/ Medical Records conducts weekly audits of all transfers/discharges for 4 weeks, then monthly, for 2 months until 100% compliance is achieved. Audit results presented at Quality Assurance Performance Improvement meetings for 3 months until 100% compliance is achieved.	10/07/2026

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F0628 SS = D	Continued from page 14 (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).	F0628		10/07/2026

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F0628 SS = D	Continued from page 15 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter).	F0628		10/07/2026

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F0628 SS = D	Continued from page 16 This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and policy review, the facility failed to provide a written notification of transfer to the hospital to the resident and resident representative (RR) for three residents (Resident (R)17, R81, and R86) reviewed for hospital transfer out of a total sample of 31 residents. This failed practice had the potential to affect the resident and their RR by not having the knowledge of where and why a resident was transferred and/or how to appeal the transfer, if desired. Findings include: 1.Review of R17's electronic medical record (EMR) located under the "Census" tab revealed that R17 was discharged to the hospital on 07/20/26 and returned to the facility on 07/24/26. There was no record in the EMR of the facility providing a written notice of transfer to the resident or the RR. 2.Review of R86's EMR located under the "Profile" tab revealed an admission record that revealed an admission date of 06/16/26. Review of R86's EMR located under the "Census" tab revealed that R86 was discharged to the hospital on 07/30/26 and did not returned to the facility. There was no record in the EMR of the facility providing a written notice of transfer to the resident or the RR. During an interview on 09/08/26 at10:53 AM, the Director of Nursing (DON) stated that we call the family and note it in the chart. The DON stated that we don't send anything in writing to the residents or the family. During an interview on 09/08/26 at 11:15 AM, the Social Services Director (SSD) stated that she was not sure about written transfer notice being sent to the family, but she does send a list of residents transferred to the ombudsman. During an interview on 09/08/26 at 1:28 PM, the Admissions Director (AD) stated she sends the bed hold notice to the resident's representative. The AD stated she did not send a transfer form or notice. 3.Review of R81's "Admission Record" located under the "Profile" tab of the EMR revealed R81 was originally admitted to the facility on 03/24/25 and readmitted on 02/08/26 with diagnoses paranoid schizophrenia, chronic kidney disease, stage 4 (severe), type 2 diabetes mellitus, acquired absence	F0628		10/07/2026

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F0628 SS = D	Continued from page 17 of right leg below knee, and acquired absence of left leg above knee. Review of R81's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab of the EMR revealed R81 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R81 was cognitively intact. Review of R81's "Progress Note," dated 08/15/26, and located under the "Progress Notes" tab of the EMR revealed R81 was sent to the hospital for vomiting. Review of R81's entire medical record revealed no documented evidence of written notice of transfer to R81 and/or their responsible party. Review of R81's "Hospital records" dated 08/15/26, located under the "Misc" tab of the EMR, revealed diagnoses of poor renal function. The record indicated R81 arrived at the hospital on 08/11/26 at 9:39 AM, with a chief complaint of fatigue. During an interview on 09/10/26 at 9:29 AM, R81 stated she remembered that she went to the hospital. R81 said she was throwing up. She said she was given paperwork from the hospital and was diagnosed with a kidney infection but was not given any paperwork from the facility. During an interview on 09/10/26 12:01 PM, the DON confirmed R81 went to the hospital on 08/11/26 for emesis. The DON stated, "There was no transfer form completed. We did not provide a written notice of transfer to the resident or resident/representative." Review of the facility's undated policy titled "Transfer and Discharge Process Policy" ...The policy is intended to ensure that residents and resident representatives receive appropriate written notice, appeal information, transition planning, bed-hold information, and discharge summary documentation when transfer or discharge occurs.	F0628		10/07/2026
F0689 SS = D	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	F0689	Corrective Measures for Residents Affected: Immediate cleanup of the spill. Staff involved counseled and retrained by Tonya Burton, NHA, on prompt response to spills and ensure the environment is clean and safe.	10/07/2026

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F0689 SS = D	Continued from page 18 §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 policy review, the facility failed to ensure a urine spill was cleaned up timely for one resident (Resident (R) 41), out of 31 sampled residents. The deficient practice had the potential for creating an accident hazard or a fall. Findings include: Review of R41's "Admission Record" located under the "Profile" tab of the electronic medical record (EMR) revealed R41 was originally admitted to the facility on 03/28/25 with diagnoses of major depressive disorder, hemiplegia and hemiparesis following cerebral infarction, and anxiety disorder. Review of R41's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab of the EMR with an Assessment Reference Date of 07/06/26, revealed R41 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R41 was cognitively intact. The resident was noted to be able to transfer himself between his bed and his wheelchair. Review of R41's "Care plan" located under the "Care plan" tab of the EMR and dated 08/13/25, revealed R41 was at risk for falls with interventions that included staff were to promptly respond for all requests for assistance and provide a safe environment with floors free from spills. During an interview and observation on 09/10/26 at 10:21 AM, R41 was in the hallway outside of the conference room and Director of Nursing's (DON) office. R41 was upset and stated he was mad because he put his call light on because he had spilled his urinal. He stated "[The Licensed Practical Nurse Unit Manager (LPNUM)] came in and told me, It's the housekeeper's job. No one cleaned up the spill." R41 continued to speak with the DON. During an observation on 9/10/26 at 10:27 AM, R41's room's door was open, water was running in the sink, and a large puddle of fluid was on the floor next to the bed as well as a urinal.	F0689	Continued from page 18 Identification of Others with Potential to be Affected: Audit of incident reports and environmental rounds to identify any similar hazards or delays in response. Re*education and competency will be completed with staff if this deficient practice occurs again. Systematic Changes and Measures to Prevent Recurrence: Trisha Vazquez, RN, staff educator, retrained all staff on prompt response to spills and environmental hazards and informed them that they are responsible for ensuring that the spill is promptly cleaned up. Policy reinforced that all staff are responsible for maintaining a safe environment. As part of new hire orientation all newly hired staff will be educated that they are responsible for the prompt response to spills/environmental hazards. Supervisors conduct random spot checks for environmental hazards. Root Cause Analysis- Staff failed to clean up a spill in a timely manner as a result of poor communication. Monitoring and QA: Administrator will audit weekly 8 spot checks (2 per unit) for 4 weeks then monthly for 2 months until 100% substantial compliance is achieved. Audit results presented at Quality Assurance Performance Improvement meetings for 3 months until 100% compliance is achieved.	10/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = D	Continued from page 19 During an interview on 9/10/26 at 10:35 AM, Certified Nurse Aide (CNA) 6 stated she did not see R41's call light on earlier. During an interview on 9/10/26 at 10:40 AM, the Housekeeping Aide (HA) stated she had not been informed of anything spilled in any room this morning. During an observation on 09/10/26 at 10:41 AM, CNA6 walked down the hall passed R41's room, looked in and kept walking. The water was still running in the sink, and the puddle was still on floor, as well as the urinal. During an observation on 09/10/26 at 10:42 AM, CNA6 entered R41's room, donned gloves, noted water was running in the sink and left the water running, removed sheets from the bed, picked up a soaked towel off floor, placed them in a bag, and took it to the soiled utility room, leaving a puddle and urinal on the floor next to the bed. During an observation on 09/10/26 at 10:44 AM, water was still running in the sink and the puddle on the floor with urinal next to R41's bed. During an interview on 09/10/26 at 10:46 AM, LPN3 stated "[R41's] call light was on about a half-hour ago. [LPNUM] answered the light. During an observation on 09/10/26 at 10:47 AM, CNA6 entered R41's room, pulled the bed out from the wall and made the bed. There was still a puddle on the floor next to and under the bed and the urinal was on the floor. During an observation on 09/10/26 at 10:50 AM, CNA6 left R41's room. The puddle was still on floor next to and under bed, urinal on the floor, and water still running in the sink. CNA6 sanitized her hands and entered another resident room. During an interview and observation on 09/10/26 at 10:55 AM, the Administrator observed R41's room. The Administrator immediately turned off the running water in the sink upon entering the room. The Administrator stated she observed the wet floor and a puddle under R41's bed, and a urinal sitting on floor. The Administrator immediately pulled CNA6 into the room to clean up the spill and the urinal. The Administrator also had the HA come in to clean the floor. During an interview on 09/10/26 at 11:18 AM, the Administrator stated "Anybody and everybody is	F0689		10/07/2026

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F0689 SS = D	Continued from page 20 responsible to answer call lights. The CNA or nurse is to wipe up any spills and housekeeping goes behind to clean. Spills can't be left there. The expectation is that any nurse is to answer call lights and take care of resident needs. Residents should not have to wait for a CNA if the nurse or unit manager answers the call light. The resident could have slipped and fell." During an interview on 09/10/26 at 11:33 AM, the LPNUM stated she answered R41's call light. "[R41] said 'I spilled my urinal.' I told him, 'I got ya.' [The Maintenance Director (MD)] said he would take care of it. I did not ask him to. That was about 10:20 AM."I told him that we would clean it up and get housekeeping too. No, I did not clean up the spill. I thought housekeeping would clean it up." During an interview on 09/10/26 at 11:41 AM, the MD stated, "I was doing water temps. I saw [LPNUM] talking with [R41]. She said something about a spill, and she said I'll get someone when I was walking by and said 'I would take care of it' but I didn't. I was looking for the housekeeper, and my phone rang to go up front to meet the contractor and forgot about it. Normally if I see a spill, I won't just leave it there." During an interview on 09/10/26 at 11:47 AM, the DON stated, "Everyone is responsible for answering call lights. Anybody that is capable of cleaning up spilled urine is responsible to clean it up. I would expect the nurse who answered the call light to wipe up the spill to eliminate the safety issue." Review of the facility's undated policy titled, "Resident Rights Policy and Procedure," indicated "Safe environment. Each resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely. The facility shall provide: . . . Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. . ."	F0689		10/07/2026