



**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

Page 1 of 1

NAME OF FACILITY: Ocean Grove Post Acute LLC

DATE SURVEY COMPLETED: July 30, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint survey was conducted at this facility from July 20, 2026, through July 30, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records, and other facility documentation as indicated. The facility census on the first day of the survey was (one-hundred sixty) 160. The investigative sample totaled (seventy-four) 74 residents. Regulations for Skilled and Intermediate Care Facilities Scope 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 30, 2026: cross refer: F550, F551, F552, F584, F603, F605, F609, F641, F657, F677, F684, F695, F842, F908 and F921.		

Provider's Signature Tommy Hardy-Fauler Title Administrator Date 8/18/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER OCEAN GROVE POST ACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET , MILLSBORO, Delaware, 19966	
(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 37 8/8/25 9:20 AM - A progress note in R180's clinical record documented, "Staff reporting they are concerned for their safety related to resident's behavior of verbally harassing staff and threatening comments." 8/20/25 4:13 PM - A progress note in R180's clinical record documented, "Staff report resident witnessed cursing at and threatening female resident...resident began making false accusations against staff." 8/21/25 11:12 AM - A progress note in R180's clinical record documented, "Resident with re-occurring behaviors of verbal aggression towards staff." August 2025 - Review of R180's behavior monitoring sheet lacked evidence documentation of any behaviors. 7/28/26 12:10 PM - During an interview E2 (DON) confirmed that R180's behavior monitoring was incomplete as evidenced by lack of documentation in the point of care task sheets to reflect R180s' episodes of behaviors. 7/30/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0842		09/14/2026

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F0842 SS = D	Continued from page 36 §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 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 interview and record review it was determined that for one (R180) out of seventy-four residents reviewed the facility failed to ensure resident records were complete and accurately documented. Findings include: Review of R180's clinical record revealed: 7/24/25 12:15 PM - A progress note in R180's clinical record documented, "Resident verbally agitated yelling ...staff report concerns related to residents' anger towards them and felt threatened by his tone." July 2025 - Review of R180's behavior monitoring sheet lacked evidence documentation of any behaviors.	F0842				09/14/2026	

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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 (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.	F0842	PLAN OF CORRECTION — F-842 ===== Immediate Action Taken: The facility is unable to correct the deficiency. The resident R#180 was discharged from the facility on 4/22/2026. Scope and Impact Assessment: The Director of Nursing/Unit Managers will review clinical records for the last 7 days for all residents with identified behaviors and ensure behavior is documented for completeness and accuracy. Education and Prevention Measures: The Staff Development Coordinator/Nursing Supervisors conducted training for nursing staff on the importance of accurate documentation of resident behaviors and the completion of behavior monitoring sheets. System Change: Unit Managers/Nurse Supervisor will review C.N.A. behavior documentation daily during the afternoon stand down meeting to ensure completeness of documentation on behaviors. Root cause, failure of staff to ensure behavioral documentation was completed accurately. Ongoing Monitoring Plan: The Director of Nurses/Asst Director of Nurses will conduct 5 audits per unit of clinical documentation and behavior monitoring sheets to ensure ongoing compliance with documentation standards. Daily for 5 Days until 100% compliance is achieved, Audits will then be completed weekly for 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X3 months.			09/14/2026	

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F0695 SS = D	Continued from page 34 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, and record review, it was determined that for one (R84) out of three residents reviewed for respiratory care, the facility failed to clean R84's oxygen concentrator filter weekly as ordered. Findings include: R84's clinical record revealed: 6/30/25 - R84 was readmitted to the facility with diagnoses to include, but not be limited to, chronic respiratory failure and chronic obstructive pulmonary disease. 6/30/26 - An annual Minimum Data Set (MDS) for R84 documented an intact cognitive status with a BIMS score of 15. 10/25/25 11:00 PM - A physician's order for R84 documented to clean filter weekly and as needed. 7/20/26 7:02 AM - During an observation, R84 was resting in bed while receiving oxygen via nasal cannula. The oxygen concentrator's external filter was observed covered with thick layers of gray dust. 7/20/26 9:40 AM - During an interview, E15 (Respiratory Therapist) stated that the external filter on the oxygen concentrator is supposed to be cleaned every week, and the nursing staff on the floor are able to perform the cleaning. E15 asked R84 if someone cleaned the filter recently and R84 replied that it has been a long time since it was cleaned and only E15 cleans it. E15 immediately cleaned the external filter. 7/30/26 2:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0695	Continued from page 34 On 7/20/26, The Respiratory Therapist immediately cleaned the external filter of R84's oxygen concentrator upon observation of its condition. Additionally, nursing staff were informed to ensure that R84's oxygen concentrator filter is cleaned weekly as per the physician's order. Scope and Impact Assessment: Asst Director of Nursing/Unit Managers will review residents receiving oxygen care with oxygen concentrators. Oxygen concentrator filters will be checked, and filters cleaned as applicable. Education and Prevention Measures: The Staff Development Coordinator/Nursing Supervisors conducted an in-service training for nursing staff on the importance of maintaining oxygen concentrators, including the requirement to clean filters weekly. Staff will be educated on the specific cleaning procedures and documentation requirements. System Change: Unit Managers will conduct weekly audits to ensure oxygen concentrators' filters are clean. Respiratory Therapist, during her weekly visit will check oxygen concentrators' filters for cleanliness. Root cause failure of staff to ensure the oxygen concentrators filters were cleaned as per physician orders. Ongoing Monitoring Plan: The Director of Nursing/Asst Director of Nursing, will conduct visual inspections of cleanliness of 4 oxygen concentrator filters from 4 Units to ensure compliance with cleaning protocols, daily for 5 Days until 100% compliance is achieved, Audits will then be completed weekly for 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. Audits will be focusing on the completeness of informed consent discussions and associated documentation. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X3 months.	09/14/2026

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F0684 SS = D	Continued from page 33 medication system) transcript documented that E24 removed 1 tablet of Augmentin 875/125 mg from the machine. 5/10/26 9:13 PM - A physician's order documented Augmentin 875/125 mg give one tablet by mouth every 12 hours for 10 days. The order was scheduled for a one-time administration and was documented as administered at 10:36 PM. 5/10/26 11:00 PM - A physician's order documented to obtain a wound culture of the right upper extremity abscess. 5/11/26 7:51 PM - An Omnicell (emergency medication system) transcript documented that E25 (LPN) removed 1 tablet of Augmentin 875/125 mg from the machine. 5/11/26 9:00 PM - A physician's order documented Augmentin 875/125 mg give one tablet by mouth every 12 hours for 10 days. 7/24/26 10:48 AM - During an interview, E26 (CNO) confirmed that the antibiotic was to be started after culture was obtained and that it was ordered for twice a day for 10 days. 7/24/26 1:46 PM - During an interview, E27 (LPN) stated the expectation when a nurse receives a verbal order to input the order as soon as possible into the EMR. 7/29/26 12:24 PM - During an interview, E24 stated that she was unable to recall if she was present on 5/10/26 during the telehealth visit for E3 and could not recall if she received the verbal order for the antibiotic. E24 stated the expectation that the nurse who receives the verbal order would place it in the EMR. E24 also stated she is usually the person who calls the on-call provider due to being familiar how to operate the telehealth system. The facility failed to transcribe, input and follow a physician's order for R3. 7/29/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0684		09/14/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.	F0695	PLAN OF CORRECTION — F-695 ===== Immediate Action Taken:	09/14/2026

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F0684 SS = D	Continued from page 32 5/7/26 - A physician's order was written for R182 to receive an antibiotic three times a day for seven days for infection of foot wound. Three days after the original prescription for an antibiotic to treat infection of R182's wound to the foot was provided by the walk-in clinic on 5/4/26 and two days after the verbal order provided on 5/5/26. May 2026 - Review of R182's MAR documented the resident was given the ordered antibiotic starting 5/7/26. 7/28/26 1:24 PM - During an interview, RP2 stated, "I had to take my mom to a walk-in clinic because her foot was infected and they were ignoring it. Even after that I went and got the prescription filled and bought the antibiotic to the facility and they still didn't give it to her." 7/29/26 12:46 PM - During an interview E14 (LPN) confirmed that R182 received a prescription from the walk-in medical center for an antibiotic for infection of her foot wound. E14 stated that R182, "Complained of discomfort. Her daughter took her to the ER or walk-in clinic. They prescribed her an antibiotic." 7/30/26 10:47 AM - During an interview E30 (RNICP) confirmed that the physicians order for an antibiotic to treat R182 was not completed upon receiving the verbal order. E30 stated, "I spoke with the nurse, who's on vacation and she said the physician didn't give her all the information for the verbal order so it wasn't put in." 2. Review of R3's clinical record revealed: 9/7/21 - R3 was admitted to the facility. 5/10/26 5:22 PM - A provider's progress note documented R3 was seen by telehealth services with E24 (LPN) present during exam. The progress note documented that R3 had a purulent filled pustule noted to right upper arm with swelling, redness and warm to touch. The provider documented the following orders: warm compresses three times a day, wound culture of right upper extremity, labs in AM and Augmentin 875/125 mg one tablet by mouth for 10 days after obtaining wound culture. 5/10/26 5:39 PM - An Omnicell (emergency	F0684				09/14/2026	

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F0684 SS = D	Continued from page 31 residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for two (R3 and R182) out of eight residents reviewed for infection control the facility to follow physicians' orders related to antibiotics. Findings include: 1. Review of R182's clinical record revealed: 5/4/26 3:00 PM - An after care summary from a walk-in care clinic documented that R182, "You are being treated for cellulitis of the right foot due to injury. Oral antibiotic prescribed take as directed." The antibiotic was called in to a local pharmacy near the facility. 5/4/26 10:43 PM - A nurses note in R182's clinical record documented, "Resident approached this writer and reported that she had gone to urgent care for her right foot, where she was told she had an "infection." Resident stated she was prescribed an antibiotic and provided the medication bottle to this writer. Per MD instructions, the antibiotic is to be held, and resident will be evaluated in the morning." 5/5/26 - E45 (NP) documented in a progress note in R182's clinical record, "Verbal order given to nurse to start antibiotic [for foot]". 5/7/26 3:21 PM - A progress note in R182's clinical record documented, "Chief Complaint: Seen in follow-up for ongoing right foot pain. History of Presenting Illness: As above seen in follow-up. Patient was on LOA with family a couple of days ago when she went to urgent care, they diagnosed her with an infection in her foot and prescribed [antibiotic]. She returned here and the next day was seen by nurse practitioner who did not feel she had an infection. He gave verbal order to start antibiotic after he could not convince her she was not infected (in order to prevent ER visit). The order was not put in."			F0684	Continued from page 31 deficiency. R#182 Resident completed antibiotic. The facility cannot retroactively correct the deficiency. R#3 Resident completed antibiotic per physician order. Scope and Impact Assessment: Director of Nursing/Infection Control Nurse will review residents receiving antibiotics within the last 7 days. The audit involved a thorough review of clinical records and medication administration records to ensure compliance with physician orders. Education and Prevention Measures: The Staff Development Coordinator/Unit Managers/Nursing Supervisors will in-service licensed nursing staff & new hire licensed staff, on the importance of timely transcription and following physician orders for antibiotics. System Change: Nursing Supervisors will review orders pending confirmation, to ensure the orders are transcribed timely during daily clinical meetings. Root cause, determined that there was a miscommunication with the provider and nursing staff in transcribing timely per physician order. Ongoing Monitoring Plan: The Director of Nursing/Infection Preventionist, will conduct audits of medication administration records for antibiotics focusing on compliance with timely transcription of physician orders; Daily for 5 Days until 100% compliance is achieved, Audits will then be completed weekly for 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X 3 months.		09/14/2026

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F0677 SS = D	Continued from page 30 4/16/26 – A review of a quarterly MDS assessment revealed R137 required substantial to maximum assistance by staff with showers, bathing, and personal hygiene. 7/16/26 – A review of the annual MDS assessment revealed R137 was dependent on staff for personal hygiene. 7/21/26 2:05 PM – During a telephone interview, FM1 (Family) reported "I left plenty of shaving cream and razors for [R137] to be shaved. They told me [R137] won't allow them to do it." "But I know [R137] likes a clean-shaven face." 7/21/26 2:21 PM – R137 was observed with visible facial hair growth on the chin, lip, cheeks and sideburns. 7/22/26 9:25 AM – During a second - day observation, R137 was sitting up in the wheelchair at the nurse's station with visible facial hair growth on the chin, lip, cheeks and sideburns. 7/23/26 9:00 AM – During a third-day observation, R137 was in bed and dressed. R137 was rubbing his facial hair and stated, "I would like to be shaved." R137 then stated, "It's too long." 7/23/26 9:05 AM – During an interview E11 (CNA) reported "[R137/] refuses to allow us and tells us not to shave him." The surveyor asked E11 was the resident's refusal to be shaved reported to anyone. E11 further stated, "I report it to E12 (RN) or E14 (UM)." 7/23/26 9:15 AM – During an interview, E12 (RN) reported, "[R137] usually refuses to be shaved." [E12] further stated, "We can attempt to shave [R137] today." 7/23/26 9:50 AM – An observation revealed R137 was being shaved by E11. 7/30/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0677		09/14/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility	F0684	PLAN OF CORRECTION — F-684 =====	09/14/2026
			Immediate Action Taken: The facility cannot retroactively correct the	

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F0677 SS = D	Continued from page 29 provide and serve diet as ordered. 7/15/26 - A significant change nutrition assessment recommended pleasure feeds of food as tolerated. 7/15/26 11:59 PM - A functional abilities and goals evaluation documented, " Significant Correction. Self-Care: Eating: Resident is dependent on staff assistance." 7/20/26 8:01 AM - 8:08 AM - During a dining observation R76's tray remained in the holding cabinet while other residents were served breakfast. When the surveyor inquired if anyone would be assisting R76 with breakfast E42 (CNA) and E43 (CNA) both stated that R76 would not be served breakfast because "he's on hospice, comfort measures." 7/20/26 8:15 AM - During an interview E44 (RN) R76's assigned nurse reviewed R76's physicians orders with the surveyor. R76 confirmed that R76's did not have an order for food to be held. 7/20/26 12:20 PM - During an interview R76 responded verbally to the surveyor when called by name. 7/20/26 1:06 -1:20 PM- During a dining observation R76's tray remained in the holding cabinet while other residents were served lunch. R76's meal ticket was torn in half. E42 (CNA) confirmed that a torn ticket meant not to serve that resident's meal. 7/20/26 1:28 PM - During an interview E44 (RN) confirmed that R76 was alert and able to take medication by mouth that day without difficulty. E33 (LPN) unit manager confirmed that staff should have offered R76 both meals. E33 then checked R76's tray for warmth and instructed staff to attempt to feed R76 and verbally educated staff that hospice residents must still be offered their meal and assistance attempted. Cross Refer F657 3. R137's clinical record revealed: 7/12/25 – R137 was admitted to the facility.	F0677	Continued from page 29 assistance provided to residents ensuring that all residents receive the necessary support. Daily for 5 Days until 100% compliance is achieved, Audits will then be completed weekly for 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. Audits will be focusing on the completeness of informed consent discussions and associated documentation. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X3 months.	09/14/2026			

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F0677 SS = D	Continued from page 28 dementia. 6/30/26 - An annual MDS documented that R13 was severely cognitively impaired and was dependent on staff for bathing and hygiene. 7/2026 - The CNA's task list documented that R13's shower days were Tuesday and Thursday. 7/20/26 9:15 AM - The resident was observed with visible facial hair growth and an untrimmed beard. 7/21/26 10:00 AM - The resident was observed with visible facial hair growth and an untrimmed beard. 7/22/26 10:15 AM - The resident was observed with visible facial hair growth and an untrimmed beard. 7/24/26 9:30 AM - The resident was observed with visible facial hair growth and an untrimmed beard. 7/24/26 9:30 AM - During an interview, E5 (RN) confirmed that the resident had not been shaved and stated that the resident required an electric razor for shaving. 7/24/26 9:30 AM - During an interview, E7 (CNA) stated that when providing a complete bath, she cleans the resident's nails, washes the resident's hair, and shaves male residents. 7/24/26 9:45 AM - During an interview, E6 (CNA) stated that when providing a shower or bath, she washes residents from head to toe. She further stated that she washes residents' hair and shaves male residents as needed. 7/24/26 10:30 AM - During an interview, E2 (DON) confirmed that the resident had not been shaved and stated that he would ensure the resident was shaved. 2. Review of R76's clinical record revealed: 6/16/26 - A quarterly MDS assessment documented that R76 required staff to set up and assistance with eating meals. 7/9/26 - R76 was admitted to hospice care. 7/15/26 - A nutrition care plan was reviewed for R76. Interventions in the care plan included to	F0677	Continued from page 28 R#137 was immediately groomed. Scope and Impact Assessment: Director of Nursing/Unit Managers will review and identify residents requiring assistance with activities of daily living (ADLs) & assistance with meals and determined that residents in the facility who are dependent on staff for personal care & meal service have the potential to be affected. Nursing Staff will be re-educated on the importance of ensuring residents who need assistance are well groomed and assisted with meals. Education and Prevention Measures: Staff Development Coordinator/Unit Managers/Nursing Supervisors will conduct training for nursing staff on the importance of providing personal grooming and meal assistance to residents & residents on hospice This training will also cover the proper documentation of resident preferences and refusals. System Change: POC tasks will be updated by Unit Managers and Nurse Supervisors on residents who recently transitioned to hospice and determined to need assistance with meals. On Daily Unit Rounds, Unit Managers will conduct grooming checks on residents who need assistance with ADL's to ensure residents are well groomed and assisted with meals. Daily and on weekends and off hour/shifts, Nurse Supervisors during unit rounds will conduct grooming checks on residents who need assistance with daily ADL's to ensure residents are well groomed and assisted meals. Root cause staff failed to ensure resident grooming performed timely & to offer meal assistance as ordered Ongoing Monitoring Plan: The Director of Nursing/Asst Director of Nursing will conduct audits of personal grooming and meal	09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
NAME OF PROVIDER OR SUPPLIER OCEAN GROVE POST ACUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET , MILLSBORO, Delaware, 19966			
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F0657 SS = D	Continued from page 27 mechanical soft diet to help with this issue. R128 will continue to be monitored. 4/23/26 10:36 AM - A dietitian ordered R128 to have a no-added-salt diet, mechanically soft texture, and thin liquid consistency for meals. 5/12/26 - A revised care plan goal documented that R128 would tolerate the current diet and liquid consistency, with one intervention being to provide a diet as ordered of no added salt, low concentrated sweets, regular texture, and thin liquids. 7/20/26 8:10 AM - An observation of R128's breakfast tray revealed mechanically soft food, and the meal ticket documented the mechanically soft diet. 7/23/26 - A quarterly MDS documented that R128 was on a mechanically altered diet. 7/24/26 12:46 PM - An observation of R128's lunch tray revealed mechanically soft food, and the meal ticket documented the mechanically soft diet. 7/27/26 1:51 PM - During an interview, E16 stated that on 4/23/26 R128 was downgraded to a mechanically soft diet due to difficulty chewing food with a regular diet with teeth. E16 confirmed that the care plan was not updated from a regular diet to a mechanically soft diet and that this would be corrected immediately. 7/29/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0657				09/14/2026	
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, interview, and record review, it was determined that for three residents (R13, R76, and R137) out of eight residents reviewed for ADL's, the facility failed to provide care and services reviewed for dependent residents. Findings include: 1. Review of R13's clinical record revealed: 6/24/26 - R13 was admitted to the facility with	F0677	PLAN OF CORRECTION — F-677 ===== Immediate Action Taken: On 7/24/26, the nursing staff implemented immediate grooming for Resident #13, ensuring the resident was shaved using an electric razor. Additionally, staff provided assistance with meals for Resident #76 on 7/20/26, ensuring that the residents were offered breakfast and lunch. For Resident #137, staff initiated a shaving attempt on 7/23/26 after confirming the resident's desire for grooming. R#13 was immediately groomed. R#76 was served & assisted with meals as ordered.			09/14/2026	

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F0657 SS = D	Continued from page 26 (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review and review of other facility records, it was determined that for two (R137 and R128) out of fifty-seven (57) residents reviewed for care plans, the facility failed to revise care plans for identified changes in care. Findings include: Cross Refer F677 1. R137's clinical record revealed: 7/12/25 – E137 was admitted to the facility. 7/16/26 – A review of an annual MDS assessment revealed R137 was dependent for personal hygiene. 7/21/26, 7/22/26 and 7/23/26 – Observations revealed R137 had visible facial hair growth to the upper lip, chin, cheeks and sideburns. 7/21/26 2:10 PM – R137's care plans were reviewed. The care plans lacked evidence that R137 refuses personal grooming services for facial hair. 7/23/26 9:05 AM – During an interview E11 (CNA) reported [R137] refuses personal grooming services for facial hair. 7/23/26 9:15 AM – During an interview and observation of R137's care plan with E12 (RN), it was revealed that R137's care plan lacked evidence documenting the resident's refusal to be shaved. E12 confirmed this during the review of the care plan and stated, "I don't know if [R137] is care planned to refuse to be shaved." E12 further stated, "No I don't see it in the care plan, but we can add it to the care plan." 2. Review of R128's clinical record revealed: 5/23/23 - R128 was admitted to the facility. 4/23/26 - A quarterly MDS documented that R128 was not on a mechanically altered diet. 4/23/26 10:28 AM - A progress note by E16 (Dietitian) documented that R128 was experiencing difficulty chewing certain foods, which is common in advanced age. They agreed to switch R128 to a			F0657	Continued from page 26 Staff Development Coordinator/Asst Director of Nursing, will provide training to nursing staff and dietary staff on the importance of timely updates to care plans following changes in resident care needs. The training will cover documentation practices and the process for revising care plans to ensure compliance with regulatory standards. System Change: Daily, morning meeting, IDT will discuss residents with new refusals from medical record review and plan of care will be revised by Unit Managers. Dietician will review new orders for modified diet and plan of care revised as applicable. Root cause the staff failed to update care plans timely regarding refusal of care & dietary changes. Ongoing Monitoring Plan: The Director of Nursing/Unit Managers/Nurse Supervisors will conduct audits of care plan documentation focusing on updates related to personal grooming services and dietary modifications. Daily for 5 Days until 100% compliance is achieved, Audits will then be completed weekly for 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X3 monthly.		09/14/2026

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F0641 SS = D	Continued from page 25 3. Review of R182's clinical record revealed: 4/7/26 - A quarterly MDS assessment section documented the resident had a BIMS score of "00". 4/8/26 - A social work assessment documented, "Resident refused to answer assessment questions for BIMS." 7/29/26 11:10 AM - During an interview E19 (RNAC) confirmed that R184's 4/7/26 quarterly MDS assessment was incorrect and that a score of "99" should have been documented for refusal. 7/30/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0641		09/14/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F0657	PLAN OF CORRECTION — F-657 =====	09/14/2026
			Immediate Action Taken: The nursing staff reviewed the care plans for Resident #137 and Resident #128 to ensure that all identified changes in care were documented. The Director of Nursing (DON) confirmed that the necessary updates were made to reflect R137's refusal of personal grooming services for facial hair and R128's transition to a mechanically soft diet. R#137 Careplan updated to reflect current shaving needs/wishes. R#128 Careplan updated to reflect current physician ordered diet. Scope and Impact Assessment: Unit Managers/Asst Director of Nursing will review residents who refuse ADLs or with known refusals to ensure care plan reflects refusals/wishes. Dietician/Food Service Manager will audit resident's care plan with modified diet to ensure it reflects current physician ordered diet. Education and Prevention Measures:	

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F0641 SS = D	Continued from page 24 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for three (R158, R180 and R182) out of fifty-seven (57) residents reviewed the facility failed to ensure accuracy of the MDS assessment. Findings include: 1. Review of R158's clinical record revealed: 6/8/26 - A quarterly MDS assessment documented that R158's cognitive status was not assessed and contained no BIM's score. 6/17/26 - A social services assessment was completed for R158, and the resident was documented with a BIM's score of 15 indicating cognitively intact. 7/23/26 12:02 PM - During an interview, E19 (RNAC) confirmed that R158's quarterly MDS assessment was inaccurate as evidenced by an omitted BIMS score. E19 stated "The social worker did not complete it on time." 2. Review of R180's clinical record revealed: 8/20/25 4:13 PM - A progress note in R180's clinical record documented, "Staff report resident witnessed cursing at and threatening female resident..." 8/24/25 - A quarterly MDS assessment was completed for R180 who was assessed as having no behaviors. 7/29/26 11:10 AM - During an interview E19 (RNAC) confirmed that R180's 8/24/25 quarterly MDS was incorrect and that threatening should have been coded on the behavior segment of the assessment.			F0641	Continued from page 24 coding. An initial audit of MDS assessments will be conducted by Regional RNAC following the training to reinforce learning. System Change: The IDT team will review residents with recent MDS assessments, weekly during utilization review meetings to ensure BIMS reflects resident cognitive status. Root cause MDS staff failed to complete required assessments timely and ensure accuracy. Ongoing Monitoring Plan: The MDS Coordinator/Asst Director of Nursing will conduct audits of 10 MDS assessments due weekly, to ensure ongoing compliance with BIMS accuracy & Behavior Coding accuracy. Daily for 5 Days until 100% compliance is achieved, Audits will then be completed weekly for 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X3 months.		09/14/2026

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F0605 SS = D	Continued from page 23 notification of the increased side effects documented from R17's AIMS assessments. 7/28/26 2:52 PM - During an interview E2 (DON) confirmed the facility did notify R17's provider of the increased side effects of antipsychotic medication use. 7/30/26 8:57 AM - During an interview, E34 (PMHNP) confirmed that the facility did not relay that R17 was having an increase in side effects related to antipsychotic medication use. E34 stated, "I believe that the person who completed it should have notified me." 7/30/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0605		09/14/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or	F0641	PLAN OF CORRECTION — F-641 =====	09/14/2026
			Immediate Action Taken: The facility cannot retroactively correct the deficiency. R#158 resident is discharged from facility. The facility cannot retroactively correct the deficiency. R#180 residents are deceased. The facility cannot retroactively correct the deficiency. R#182 resident is discharged from facility. Scope and Impact Assessment: MDS Coordinator/Designee will review completed MDS assessments within the last 7 days for accuracy of BIMS and behaviors coding. MDS will be clarified as applicable. Audits will reflect last quarter. Education and Prevention Measures: MDS Coordinator/DON/ADON will provide training for all MDS coordinators and social services staff on accurate MDS assessment completion and the importance of timely documentation. This training will cover the BIMS scoring process and behavior	

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F0605 SS = D	Continued from page 22 12/10/25 - An AIM's assessment documented R17 as a 3.0 score indicating the presence side effects from use of antipsychotic medications. 12/25/25 - An annual MDS assessment documented that R17 experienced hallucinations, and delusions and received antipsychotic medications. 1/9/26 - A psychiatric evaluation and consultation was completed for R17. The evaluation lacked documentation of R17's AIM's score, the AIM's section was blank and recommended continued use of antipsychotic medication. 4/27/26 - An AIM's assessment documented R17 as a 27.0 score indicating the presence side effects from use of antipsychotic medications. 6/22/26 - R17s care plan for use of antipsychotic medications was reviewed. Interventions in the care plan included monitor for side effects. Monitor /document/report and adverse reactions of psychotropic medications. 7/6/26 - An quarterly MDS assessment documented R17 experienced hallucinations, and delusions and was given antipsychotics and antidepressant 9/26/25 9:32 AM - A progress note in R17's clinical record written by E4 (RN) documented, "Resident seen by psych NP for auditory hallucinations, paranoia, recently starting Clozapine, lethargic, isolation and confusion. Resident stated he is constipated and has rash. Requests 1 chocolate milk with meals. Tremors noted. Resident reports auditory hallucination but cannot determine if they are worsening or getting better. Denies visual hallucination. Scored poorly on AIMS. Major fall risks, resident on precautions already." The note lacked evidence that the psych NP or R17's primary care provider were made aware of the AIMS assessments. 7/28/26 1:03 PM - During an interview, E4 (RN) confirmed completing R17's AIMS assessment. E4 stated, "I usually would notify [E2 (DON)] and [E34 (PMHNP)] but [R17] waxed and waned sometimes more symptoms than others." E4 could not confirm	F0605				09/14/2026	

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F0605 SS = D	Continued from page 21 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R17) out of two residents reviewed for behavioral/emotional condition the facility failed to ensure adequate monitoring of antipsychotic medication use. Findings include: Review of R17's clinical record revealed: 12/22/23 - R17 was admitted to the facility with multiple diagnoses including anxiety, schizophrenia, and depression. 6/25/25 - An AIM's assessment documented R17 as a 0.0 score indicating no side effects from use of antipsychotic medications. 9/17/25 - An AIM's assessment documented R17 as a 4.0 score indicating the presence side effects from use of antipsychotic medications. 11/19/25 - A psychiatric evaluation and consultation was completed for R17. The evaluation lacked documentation of R17's increased AIM's score, the AIM's section was blank and recommended continued use of antipsychotic medication.	F0605				09/14/2026	

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F0605 SS = D	Continued from page 20 §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;		F0605	Continued from page 20 change in side effects is notified to the provider. Audits will be done daily for 5 days, then be completed weekly for 4 weeks, then monthly for 3 months or until 100% compliance is achieved. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X3 months.		09/14/2026	

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F0551 SS = D	Continued from page 19 beforehand. I found out when I got a letter in the mail. Me and my daughter had told them after we found out to change it back!" 7/28/26 9:57 AM - During an interview E18 (BOM) confirmed that a disenrollment form was completed to change R184's insurance coverage without involvement of R184's responsible party, RP1. 7/30/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0551		09/14/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any ... chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- ... §483.12(a)(2) Ensure that the resident is free from ... chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms.	F0605	PLAN OF CORRECTION — F-605 =====	09/14/2026
			Immediate Action Taken: R17 AIMS assessment was completed and provider was notified related to any change in side effects related to antipsychotic medication use. Scope and Impact Assessment: The Asst Director of Nursing/Unit Managers will review AIMS assessments completed in the last 30 days and residents receiving antipsychotic medications to ensure that any side effects identified were addressed with provider. Education and Prevention Measures: The Staff Development Coordinator will conduct in-service training for nursing staff on the importance of timely documentation and communication regarding AIMS assessments and antipsychotic medication side effects to provider. System Change: Weekly, during high-risk meetings, Unit Managers will identify residents with AIMS Assessments completed, and residents with potential side effects will be reviewed. Root cause staff failed to timely notify the provider when there is a significant change in the resident AIMS assessment. Ongoing Monitoring Plan: The Director of Nursing/Unit Managers/Asst Director of Nursing will conduct audits of AIMS assessments completed within the week of residents on anti-psychotic medications to ensure that any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
NAME OF PROVIDER OR SUPPLIER OCEAN GROVE POST ACUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET , MILLSBORO, Delaware, 19966			
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F0551 SS = D	Continued from page 18 jurisdiction, in accordance with State law, (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review it was determined that for one (R184) out of seventeen residents reviewed for abuse the facility failed to ensure that the rights of resident representative were exercised. Findings include: Review of R184's clinical record revealed: 1/26/26 - R184 was admitted to the facility with diagnoses that included dementia and cognitive communication deficit. The admission agreement was signed by RP1, who had served as R184's durable power of attorney since June 2010. 1/26/26 6:54 PM - A progress note in R184's clinical record documented, "Code status confirmed with spouse [RP1]," demonstrating the facility recognized RP1 as the resident's decision-maker. 2/1/26 - An admission MDS assessment documented that R184 had severe cognitive impairment. 2/26/26 - A disenrollment form changing the resident's insurance coverage was completed by E18 (BOM) and signed by R184 rather than RP1. 3/16/26 1:10 PM - A social services note in R184's clinical record documented, "Family expressed concerns regarding insurance being converted and are upset about the change." 7/27/26 1:24 PM - During an interview, RP 1 confirmed that R184's insurance coverage had been changed without RP1's knowledge or permission. RP1 stated. When asked did the facility discuss the change prior to completing the disenrollment RP1 stated, "No. They didn't say anything about it			F0551	Continued from page 18 necessary forms requiring signatures before they are signed. Root cause was staff failed to ensure residents' cognitive abilities were intact to make an informed decision prior to holding a conversation regarding financial decisions. Ongoing Monitoring Plan: The NHA/Social Services will conduct audits of residents with insurance disenrollment to ensure resident/responsible party consented to the change, Daily for 5 Days until 100% compliance is achieved, Audits will then be completed weekly for 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. Audits will be focusing on the completeness of informed consent discussions and associated documentation. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X3 months.		09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026
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F0550 SS = D	Continued from page 17 and E2 (DON) during the exit conference.	F0550		09/14/2026
F0551 SS = D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent	F0551	PLAN OF CORRECTION — F-551 ===== Immediate Action Taken: On 4/02/26, the Business Office Manager met with RP1 to discuss the concerns/confirm regarding R184's insurance coverage. At the time RP1 provided facility with POA documentation. The BOM ensured that the disenrollment form was voided and that R184's insurance coverage was reinstated as per RP1's request. This action was completed to ensure that the rights of the resident representative were upheld. Scope and Impact Assessment: On 7/29/26, the Social Services/NHA will complete an audit of all residents who recently had insurance disenrollment forms completed within the last 30 days to ensure Resident/RP consented. The review confirmed that all residents with a designated representative have the potential to be affected by similar issues regarding decision-making and consent. Education and Prevention Measures: The Staff Development Coordinator conducted training for nursing and administrative staff on the importance of involving resident representatives in decision-making processes. Staff were educated on the legal rights of residents and their representatives, emphasizing the need for clear communication regarding changes in care and services. The Nursing Home Administrator will provide education to the BOM and newly hired BOM about communicating impending insurance disenrollment information to the IDT team. System Change : The business office manager will notify the IDT Team when there is an insurance disenrollment to determine if resident or RP/POA consented & the	09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER OCEAN GROVE POST ACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET , MILLSBORO, Delaware, 19966	
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F0550 SS = D	Continued from page 16 7/20/26 1:00 PM - During an interview, R158, a resident on unit one, reported "meals served at inconsistent times." Observed lunch cart deliver times on unit one: 7/20/26 1:06 PM - 1:16 PM 7/21/26 12:53 PM - 1:04 PM 7/22/26 12:57 PM - 1:00 PM 7/24/26 12:09 PM - Observations on unit one, unit two, unit three and unit four and the facility main dining room lacked evidence of posted mealtimes notifying residents of current mealtimes. 7/24/26 12:30 PM - During an interview, R168 (acting RCP) stated that a change of mealtimes was communicated at the Food Committee Meeting but not posted. 7/24/26 1:58 PM - During an interview E13 (Dietary Director) provided a second copy of the facility mealtimes. Review of the mealtimes indicated that lunch would be served on unit one at 12:45 PM - 12:50 PM with the Main Dining room continued to open at noon. E13 stated the meal schedule had been changed in 2026 and that R168 (acting RCP) was informed. E1 (NHA), who was present during the interview, confirmed the revised meal schedule had not been posted for residents. 2. Review of R155's clinical record revealed: 11/15/23 - R155 was admitted to the facility. 5/7/26 - A quarterly MDS assessment documented that R155 had a BIm of 12 indicating moderate cognitive impairment. The MDS also documented that R155 required supervision or touching supervision for ADL's and lower body dressing. 7/20/26 6:35 AM - A direct observation of E10 (CNA) providing ADL care to R155 in the corner of the room with the door open and curtain open. R155 was not clothed and E10 was washing, drying and assisting R155 into a clean brief. 7/20/26 6:43 AM - During an interview, E10 confirmed that R155 received ADL care with the door and curtain open. E10 stated that the door and curtain should have been closed to maintain dignity. 7/29/26 2:00 PM - Findings reviewed with E1 (NHA)	F0550	Continued from page 16 Week audit by Unit Managers of 2 staff members when providing care will be added to their weekly task to ensure staff are maintaining privacy for residents during care. Ongoing Monitoring Plan: 1.) The Director of Dietary Services/NHA will conduct audits of mealtime notifications weekly x 4 weeks or until a 100% compliance is achieved followed by monthly x 3 months. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X3 months. 2.) The Director of Nursing/Unit Managers/Nurse Supervisors will conduct daily audits of 5 staff while providing care to ensure privacy practices is maintained during personal care Daily for 5 Days until 100% compliance is achieved, then weekly for 4 weeks or until 100% compliance is achieved. Audits will then be completed X 1 monthly for 3 months or until 100% compliance is achieved. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly for 3 months.	09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026
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F0550 SS = D	Continued from page 15 facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure protection of resident rights to promote dignity and respect when residents were not notified of mealtimes. Additionally, for one (R155) out of seventy-four residents sampled the facility failed to promote care in a manner that maintained or enhanced dignity and respect. Findings include: 1. 7/20/26 – During entrance conference, the facility provided a copy of its meal schedule indicating lunch on Unit One was scheduled from 12:00 PM to 12:08 PM and in the Main Dining Room at 12:00 PM. 7/20/26 10:19 AM - During an interview, R161, a resident on unit one reported "the meals are never on time." 7/20/26 12:17 PM - During an interview, R80, a resident on unit one reported "lunch is never on time."	F0550	Continued from page 15 E10/CNA who was providing care for R#155 and was educated to ensure the door is closed when providing care to ensure resident privacy. Scope and Impact Assessment: Director of Nursing/Unit Managers/Licensed Nurses conducted a 100% audit of resident records and interviews with residents on all units. The assessment determined that all residents receiving meals in the facility and providing privacy have the potential to be affected by the lack of notification regarding mealtimes and the observed practices impacting dignity. Mealtimes were posted for each resident to view on each unit. Nursing Staff will be educated to ensure privacy is maintained when providing care. Education and Prevention Measures: 1.) Nursing Home Administrator/Food Service Manager will re-educate Dietary staff on the importance of notifying residents of mealtimes. The root cause of this issue was lack of communication between dining services and residents when the mealtimes were changed. 2.) The Staff Development Coordinator/UM-RN Supervisors nursing staff will be educated to ensure privacy is maintained while providing care. Staff were educated on the facility's policies regarding resident rights and dignity, with a focus on ensuring that mealtimes are communicated effectively, and personal care is conducted privately. The root cause was determined to be due to the staff's lack of thorough understanding of the importance of ensuring privacy is maintained during care. System Change: Posting of menu will be verified by NHA/Food Service Manager at the beginning of each month.	09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026
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F0921 SS = E	Continued from page 14 hazard to anyone walking into that area to use the warewashing sink or warewashing machine.	F0921	Continued from page 14 Education and Prevention Measures: Food Service Manager/Asst Food Service Manager conducted training for kitchen staff on maintaining a safe and sanitary environment, emphasizing the importance of reporting any standing water or hazards immediately. Staff were also educated on proper cleaning protocols to prevent recurrence. System Change: Food Service Director will observe floors/equipment during daily kitchen rounds utilizing checklist and report to Maintenance Department for repair. The checklist includes, are the floors clean? Wet signs for spills? Electrical Appliances in good repair? Freezer/Refrigerator door operable from inside? Root cause dietary staff failed to promptly identify standing water and correct the issue. Ongoing Monitoring Plan: The Environmental Services Manager will conduct audits of the kitchen area for safety and sanitation, ensuring that all floor drains are clear and free of standing water. Daily for 5 Days until 100% compliance is achieved, Audits will then be completed weekly for 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X3 months.	09/14/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The	F0550	PLAN OF CORRECTION — F-550 Immediate Action Taken: On 7/24/26, the Food Service Manager/NHA implemented immediate communication of the revised meal schedule to staff on Unit One and ensured that mealtimes were posted in common areas for residents. Dining times were also displayed on the in-house resident TV Channel. Additionally, staff were instructed to ensure that residents are informed of mealtime changes promptly. This action was taken to enhance resident awareness and promote dignity during meal service.	09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER OCEAN GROVE POST ACUTE			STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET , MILLSBORO, Delaware, 19966	
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F0908 SS = E		F0908	Continued from page 13 Maintenance Director/Food Service director/ provided training to the kitchen and maintenance staff on the importance of regular equipment maintenance and safety protocols. Staff were educated to identify signs of wear and damage in kitchen equipment and the procedures for reporting issues promptly to ensure timely repairs. System Change: Food Service Director will observe floors/equipment during daily kitchen rounds utilizing checklist and report to Maintenance Department for repair. The checklist includes, are the floors clean? Wet signs for spills? Electrical Appliances in good repair? Freezer/Refrigerator door operable from inside? Root cause staff failed to identify & repair refrigerator door & damaged flooring. Ongoing Monitoring Plan: The Maintenance Supervisor will audit all kitchen equipment to ensure ongoing compliance with safety standards. Daily for 5 Days until 100% compliance is achieved, Audits will then be completed weekly for 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months or until 100% compliance is achieved. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X 3 months	09/14/2026
F0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain a safe and sanitary environment for staff. Findings include: 7/23/26 12:22 PM - During a tour of the kitchen, an approximately six (6) inch by eight (8) inch sized area of standing water was observed around the floor drain located near the warewashing machine and sink. The standing water presents a safety	F0921	PLAN OF CORRECTION — F-921 =====	09/14/2026
			Immediate Action Taken: On 7/23/26, the Maintenance Supervisor promptly addressed the standing water issue by cleaning the area around the floor drain near the warewashing machine and sink. The area was dried thoroughly to eliminate any safety hazards for staff accessing the kitchen. Scope and Impact Assessment: On 7/23/26, the Food Service Manager completed a 100% audit of the kitchen and identified that staff working in the kitchen area have the potential to be affected by similar safety hazards. The review included an inspection of all floor drains and surrounding areas.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026
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F0609 SS = E	Continued from page 12 wanted the full-time position given to [E46]. E2 confirmed that the facility did not recognize the allegation as neglect and as a result did not report the allegation to the State Agency. 3. Review of R1's clinical record revealed: 5/2/25 - R1 was admitted to the facility. 3/4/26 6:45 PM - An incident alleging that a staff member pushed R1 when attempting to get up from the floor post fall. 3/5/26 11:27 AM - A facility reported incident was submitted to the State Agency. 7/28/26 12:01 PM - During an interview, E2 (DON) stated the staff member failed to recognize the incident as an allegation of abuse. E2 confirmed that the report was not submitted to the agency within the appropriate timeframe. E1 (NHA) and E2 stated facility wide education was completed regarding recognizing abuse and reporting requirements. 7/29/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0609		09/14/2026
F0908 SS = E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that essential kitchen equipment is maintained in safe operating condition. Findings include: 7/23/26 12:16 - PM A tour of the Walk-in refrigerator revealed the back of the door was heavily rusted and had several areas of peeling and degraded paint. The refrigerator door was unable to be closed completely, however the correct temperature was being maintained at that time. The refrigerator floor was damaged in numerous areas where there were broken and missing tiles. The walls and ceiling of the walk-in refrigerator were observed to have numerous areas of condensation droplets and what appeared to be damage from moisture.	F0908	PLAN OF CORRECTION — F-908 =====	09/14/2026
			Immediate Action Taken: On 7/23/26 the Maintenance Supervisor conducted an immediate inspection of the Walk-in refrigerator and identified the areas of concern, including the rusted door and damaged flooring. Temporary repairs were initiated to ensure the door could close securely, and the refrigerator was monitored to maintain the correct temperature. These actions were completed by the Maintenance Supervisor by the end of the day. Scope and Impact Assessment: On 7/24/26, the Maintenance Supervisor completed a 100% audit of all kitchen equipment. The review included an inspection of all refrigeration units, cooking appliances, and food storage areas to ensure they are in safe operating condition. Education and Prevention Measures:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
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F0609 SS = E	Continued from page 11 consulted prior to the disenrollment E18 confirmed that [RP1] was not consulted prior to the disenrollment to change R184's insurance provider. E18 (BOM) confirmed documenting the date next to the signature on R184's insurance disenrollment form and that now a resident's mental status is reviewed prior to obtaining signatures. 7/28/26 10:07 AM - During an interview, E1 (NHA) confirmed that the facility was aware that RP1 did not sign consents to change insurance providers for R184 and that E18 (BOM) assisted with R184, a cognitively impaired resident with signing the insurance disenrollment form. E1 did not recognize this as suspicion of the crime of forgery and subsequently did not report the incident to the State Agency. 7/30/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference. 2. Review of R32's clinical record revealed: 9/5/24 - A physician's order was written for R32 to have their blood sugar checked at 2:00 AM for diabetes. 3/16/26 - R32's MAR documented that at 2:00 AM a blood sugar level was obtained with a result of 225. 2. Review of R188's clinical record revealed: 2/25/26 - A physician's order was written for R188 to have their blood sugar checked at 6:00 AM for diabetes. 3/16/26 - R188's MAR documented that at 6:00 AM a blood sugar level was obtained with a result of 235. 7/27/26 10:36 AM - The surveyor requested a copy of any investigations involving allegations that included R32 and R188 from E2 (DON). 7/27/26 11:00 AM - A statement written by E2 (DON) on 3/20/26 documented "Two LPN's came to the DON office expressing concerns about blood sugars for residents...They believed the results were inaccurate and possibly made up". 7/27/26 11:43 AM - During an interview E2 (DON) stated, "On March 16th two nurses came and said we don't believe [E46 (LPN)] is doing the blood sugars correctly on [R32] and [R188]. There were a lot of suspicions, but I believe it was the nurse	F0609	Continued from page 11 be completed weekly for 4 weeks, then be monthly for 3 months or until 100% compliance is achieved. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X3 months.	09/14/2026			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026
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F0609 SS = E	Continued from page 10 to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for four (R1, R32, R184 and R188) out of twenty-six residents reviewed for abuse and neglect, the facility failed to identify and report the allegations of abuse, neglect or suspicion of a crime to the State Agency within appropriate timeframe. Findings include: The facility policy on abuse last updated May 2026, indicated, "The facility will have written procedures that include: 1. Reporting of all violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified time frames." 1. Review of R184's clinical record revealed: 1/26/26 - R184 was admitted to the facility with multiple diagnoses including dementia and cognitive communication deficit. R184 was admitted with Medicare Advantage insurance coverage and an admission agreement that was signed by RP1, R184's POA since of June 2010. 2/1/26 - An admission MDS assessment documented that R184 has severe cognitive impairment and upper extremity impairments of range of motion on both sides. 2/26/26 - A disenrollment form was completed and dated by E18 (BOM) and signed by R184. 3/16/26 1:10 PM - A social services note in R184's clinical record documented, "Family expressed concerns regarding insurance being converted and are upset about the change." 7/27/26 1:24 PM - During an interview, RP 1 confirmed that R184's insurance coverage was disenrolled to change to another insurance provider without permission. 7/28/26 9:57 AM - During an interview, E18 (BOM) stated, "[R184] was able to sign. A lot of times residents won't do the date, so I plug that in for them. " When asked if R184's responsible party was	F0609	Continued from page 10 NHA /Business Office Manager will complete an audit of residents who recently had insurance disenrollment forms completed to assure resident/RP consented. NHA will review any concerns/grievances related to allegations of abuse, neglect or suspicion of a crime to assure that it is reported to the State Agency within appropriate timeframe System Change: IDT team will review resident BIMS scores/POA designations weekly during the Utilization Review Meeting to ensure POA designations are in place as appropriate. Root cause, interdisciplinary team's lack of understanding of abuse, neglect or suspicion of crime policies and procedures and reporting guidelines. Education and Prevention Measures: The Senior Administrator/Regional Clinical Consultant will educate NHA/DON on Abuse/Neglect, financial exploitation, suspicion of crime and reporting guidelines. The NHA/designee will educate BOM on the policies and procedures related to abuse, neglect, financial exploitation & suspicion of crime. The Staff Development Coordinator/Unit Managers/Nurse Supervisors will conduct education to interdisciplinary team on recognizing and reporting allegations of abuse and neglect. This training will include a review of the facility's policies and procedures regarding abuse reporting. Yearly training for recognizing and reporting allegations of abuse and neglect will be provided to all staff. Ongoing Monitoring Plan: The NHA /Business Office Manager will conduct audits of insurance disenrollment forms and grievances /concerns for last 30 days to ensure that any concerns related to abuse, neglect or suspicion of a crime policies and procedures and reporting guidelines were followed. In addition, audits will be conducted to ensure present & future concerns related to abuse, neglect or suspicion of a crime, policies and procedures and reporting guidelines are followed. Audits will be done daily for 5 days, then	09/14/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026
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F0603 SS = E	Continued from page 9 unit transfer." 4/6/26 9:21 AM - A psychological progress note in R182's clinical record written by E35 (LCSW) documented, "[R182] alert and oriented throughout the session...verbalized significant dissatisfaction with her placement on the dementia unit stating that she does not feel she belongs there and believes she still has all her mental faculties." 4/6/26 10:26 AM - A progress note in R182's clinical record written by E4 (RN) documented "Resident evaluated by psych NP. Resident is Alert and oriented to [person, place, time, situation] with anxiety, tearfulness, and mood lability related to recent transfer to the dementia unit, exhibiting perseveration, social isolation, and intermittent emotional outbursts without psychosis...". 4/7/26 - A quarterly MDS assessment documented that R182 exhibited verbal behaviors one to three days during the assessment period. The assessment did not document dementia as a diagnosis, physical behaviors or elopement risk. 7/30/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0603		09/14/2026
F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations	F0609	PLAN OF CORRECTION — F-609 =====	09/14/2026
			Immediate Action Taken: Residents #1, #32, #184, and #188. The facility cannot retroactively correct the deficiency. Residents #184 & #188 are no longer at the facility. (Discharged) The facility cannot retroactively correct the deficiency for Resident #32. Management team will be educated on allegations of neglect reporting guideline. The facility cannot retroactively correct the deficiency. Resident #1 was reported, Staff educated on reporting timeframe for allegation of abuse. Scope and Impact Assessment:	

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F0603 SS = E	Continued from page 8 multiple diagnoses including anxiety and depression. 10/7/24 - An admission MDS assessment documented R182 as cognitively intact with a BIMS score of 15. There were no behaviors and no diagnosis of dementia documented. 3/24/26 - R182 was transferred from a long-term care unit to the facilities locked dementia unit. 3/24/26 11:36 AM - A social services progress note in R182's clinical record documented, "SW spoke with [R182's] daughter via telephone. SW informed daughter that [resident] will be changing rooms to room (xxx). Daughter verbalized understanding and is agreeable to room change. SW spoke with [R182] regarding room change. Resident verbalized understanding and is agreeable to room change." 3/25/26 12:24 PM - A progress note in R182's clinical record documented "Resident evaluated by psyche; Resident continues to refuse any intervention for increased anxiety. Nursing will continue to monitor mood, behavior, and sleep in new environment. Resident transferred to another unit." 3/25/26 untimed - A psychiatric evaluation and consultation written by E34 (PMHNP) in R182's clinical record documented, "Seen for routine psychiatric follow-up. She expresses distress regarding her move to dementia unit. Per staff, resident has a history of difficulty getting along with roommates and is being transitioned to the dementia unit for better support and management. Adjustment difficulty related to environmental changes (unit transfer)." 3/30/36 1:49 pm - A psychological progress note in R182's clinical record written by E35 (LCSW) documented, "[R182] observed in new room on the dementia unit and reported that she is still adjusting to the new environment. She expressed discomfort with her current situation." 4/5/26 untimed - A psychiatric evaluation and consultation written by E34 (PMHNP) in R182's clinical record documented, "Resident reports difficulty coping with recent transfer to the dementia unit, stating 'I don't belong over here'...Per staff she is tearful, frequently isolating, and exhibits emotional outburst. She demonstrates anxiety symptoms and distress related to the unit transition. Resident is alert and oriented...though process is logical. No evidence of psychosis. Adjustment reaction with anxiety and mood lability related to		F0603	Continued from page 8 System Change: Daily in morning meeting, residents with room change will be referred to Social Services Director to visit residents to determine adjustments status. Root cause was determined to be due to staff's failure to recognize steps to follow when residents show emotional distress with room change to an alternative setting. Ongoing Monitoring Plan: Social Services Director will conduct audits by face-to-face visit with residents post room change to ensure residents adjust to new environment and are free from involuntary seclusion. Audits will be done daily for 5 days, then weekly for 4 weeks, then monthly for 3 months or until 100% compliance is achieved. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly x 3 months.		09/14/2026	

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F0584 SS = E	Continued from page 7 and appeared to have moisture related damage or deterioration. An observation behind the bed revealed piles of dust and missing flooring. The trim at the bottom of the bathroom vanity was peeling away, and the material on the side of the vanity was peeling. The bathroom floor was dirty and both the walls and ceilings required painting. 7/23/26 11:39 AM – During an interview, E9 (Housekeeper) reported, room 209 and bathroom are cleaned and mopped every day. E9 confirmed the floor was dirty and the bathroom needed to be cleaned. 7/23/26 1:40 PM – The Surveyor and E8 went to room 209. E8 reported "I was not aware of the issues in this room." E8 further stated, "We are going to start working on this room we'll take care of it." 7/29/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0584		09/14/2026
F0603 SS = E	Free from Involuntary Seclusion CFR(s): 483.12(a)(1) §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(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 and interview it was determined that for one (R182) out of sixteen residents reviewed for abuse the facility failed to ensure the resident was free from involuntary seclusion. Findings include: Review of R182's clinical record revealed: 10/2/24 - R182 was admitted to the facility with	F0603	PLAN OF CORRECTION — F-603 =====	09/14/2026
			Immediate Action Taken: Resident #182 discharged to an ALF of her choice to be closer to family on 6/2/2026. The Social Worker and nursing staff communicated with Resident #182 to address any concerns regarding her placement and ensure her comfort in the transition. This action was completed by Farrah Spain, SSD, to ensure the residents' needs were prioritized. Scope and Impact Assessment: Director of Nurses/Asst Director of Nurses/NHA completed an audit of psychiatric evaluation for residents with room changes in the last 14 days to the dementia unit to ensure that all residents are adjusting to new environment and free from involuntary seclusion. Education and Prevention Measures: Staff Development Coordinator/Asst Director of Nurses conducted training for social services, Psychiatric providers and interdisciplinary team on the importance of ensuring residents adjusts to new environment with room changes and are free from involuntary seclusion.	

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F0584 SS = E	Continued from page 6 housekeeping trash bags were stored on the windowsill. 7/22/26 9:00 AM – Room 407A was observed with the used oxygen tubing still lying on the floor, the used enteral feeding pump and IV pole remaining in the room, and housekeeping trash bags stored on the windowsill. 7/24/26 9:00 AM – Room 407A was again observed with the used oxygen tubing lying on the floor, the used enteral feeding pump and IV pole remaining in the room, and housekeeping trash bags stored on the windowsill. 7/24/26 9:30 AM – During an interview, E5 (RN) confirmed that the previous resident had been discharged on 7/20/26 and that the used oxygen tubing, enteral feeding pump, and IV pole had not been removed from the room. E5 also confirmed that housekeeping trash bags were being stored on the windowsill. 7/24/26 9:45 AM – During an interview, E2 (DON) confirmed that the previous resident had been discharged on 7/20/26 and stated that the items would be removed. 7/24/26 10:00 AM – Housekeeping staff was observed cleaning the room and removing the used oxygen tubing, enteral feeding pump, IV pole, and housekeeping trash bags. 2. 7/23/26 1:00 PM – The Surveyor entered room 221 and observed scraped walls with dark markings as well as large areas where the paint was chipped. The baseboard trim around the room was dirty with dark markings. The metal trim had scraped paint, and the trim around the bathroom doorway is marked and chipped, in addition the ceiling had uneven areas and required painting. 7/23/26 1:20 PM – During an interview, E8 (DOM) reported, room 221 needed to be painted, and the baseboards needed to be repaired." E8 further stated, "Yes I know it doesn't look good and it not a homelike environment." 3. 7/23/26 11:00 AM – The Surveyor entered room 209 there was a sticky, dirty residue on the floor. As the Surveyor walked across the room the floor was dirty. Additional observations included dark stains and markings on the wall on the right side of the room. The base board trim near the air conditioner/heating unit was splintered, dirty, dusty			F0584	Continued from page 6 Ongoing Monitoring Plan: The Director of EVS/Maintenance Director will conduct audits of the cleanliness and maintenance of resident rooms on a daily for 5 days, or until 100% compliance is achieved, Audits will then be completed weekly for 4 weeks, or until 100% compliance is achieved, Audits will then be monthly for 3 months or until 100% compliance is achieved. The audits will be focusing on the Ocean Garden/Seaside Units. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly X 3 months.		09/14/2026

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F0584 SS = E	Continued from page 5 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, it was determined that for two out of four resident units reviewed for environmental concerns, the facility failed to ensure and provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and home like comfortable interior in the resident rooms. Findings include: 1. 7/21/26 9:00 AM – Room 407A on the Seaside Unit was observed with used oxygen tubing from the previous resident lying on the floor. A used enteral feeding pump and IV pole remained in the room, and	F0584	Continued from page 5 housekeeping trash bags that were stored on the windowsill. This action was completed by the housekeeping team to ensure the room was restored to a sanitary condition. On 7/24/2026 the housekeeping team cleaned 221, on the Ocean Gardens Unit, sweeping & mopping, cleaning bathroom & walls. Maintenance staff were observed repairing room, painting, of walls and ceiling. On 7/24/2026 the housekeeping team cleaned 209 on the Ocean Gardens Unit, sweeping & mopping, cleaning bathroom & walls. The maintenance team scheduled the room for renovation for the following week. Maintenance completed the painting, tile replacement, walls around HVAC unit, vanity siding, and repaired/painted baseboards on 7/29/2026. Scope and Impact Assessment: On 7/24/26, the EVS Director/Designee completed a 100% audit of all resident rooms in the Seaside/Ocean Grove Units and identified that all residents in the unit have the potential to be affected by similar environmental concerns. The review included an assessment of cleanliness and maintenance needs in each room. Education and Prevention Measures: The Housekeeping Director and Maintenance Director/Designee will conduct training for housekeeping and maintenance staff on the importance of maintaining a sanitary and home-like environment. This training will cover proper cleaning protocols, room inspections, and timely removal of equipment and waste. Initial audits will be conducted to ensure understanding and compliance with these procedures. System Change: The EVS Director will conduct daily inspections utilizing the EVS DEEP CLEAN Checklist of one room on each unit. The checklist includes dusting, high/low, bathrooms, window sills, under beds, walls, baseboards, corners/edges, etc. Housekeepers will be retrained on the checklist. Root cause staff failed to follow facility protocol for removing used equipment upon discharge. Maintenance staff failed to identify resident environmental issues in rooms and prioritize repairs.			09/14/2026	

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F0552 SS = E	Continued from page 4 risperidone 0.5 mg give one tablet by mouth at bedtime. 7/27/26 1:14 PM - During an interview, E3 (ADON) stated the provider usually discusses treatment options with the resident or responsible party including the risks versus benefits. E3 confirmed that the EMR lacked evidence that R118's responsible party was informed of the risk versus benefits of the medication prior to provider implementing. 4. Review of R119's clinical record revealed: 4/28/22 - R119 was admitted to the facility. 2/4/26 - A quarterly MDS assessment documented that R119 was a BIMs of 0, indicating severe cognitive impairment. 3/6/26 - A physician's order documented Seroquel (anti-psychotic) 25 mg give 12.5 mg by mouth at bedtime. 6/4/26 - A Psychotropic Medication Informed Consent form documented that R119 was receiving an anti-psychotic and anti-depressant medications and R119's responsible party gave verbal consent. 7/27/26 1:14 PM - During an interview, E3 (ADON) stated the provider usually discusses treatment options with the resident or responsible party including the risks versus benefits. E3 stated that the Unit Manager can also call have the discussion with responsible party, complete the consent form over the phone. E3 confirmed that the EMR lacked evidence that R119's responsible party was informed of the risk versus benefits of the medication prior to provider implementing. E3 also confirmed that the informed consent was verbally authorized after the initiation of the medication. 7/29/26 2:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0552		09/14/2026
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F0584	PLAN OF CORRECTION — F-584 ===== Immediate Action Taken: On 7/24/26, the housekeeping staff cleaned 407 A on the Seaside Unit and removing the used oxygen tubing, enteral feeding pump, IV pole, and	09/14/2026

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F0552 SS = E	Continued from page 3 options with the responsible party including the risks versus benefits. E3 stated that the Unit Manager can also call have the discussion with responsible party, and document in a progress note as well as complete the consent form over the phone. E3 confirmed that the EMR lacked evidence that R1's responsible party was informed of the risk versus benefits of the medication prior to provider implementing. 2. Review of R3's clinical record revealed: 9/17/21 - R3 was admitted to the facility. 3/2/26 - An annual MDS documented that R3 was a BIMs of 5, indicating severe cognitive impairment. 3/9/26 - A psychiatric provider consult note documented R3 was having increased behavioral symptoms especially at nighttime with a recommendation of donepezil, a medication to help slow cognitive decline. The consult note lacked evidence of discussing plan of care with responsible party, specifically risk versus benefit. 3/10/26 - A physician's order documented donepezil hydrochloride 5 mg give one tablet at bedtime for dementia with agitation. 7/27/26 1:14 PM - During an interview, E3 (ADON) stated the provider usually discusses treatment options with the resident or responsible party including the risks versus benefits. E3 stated that the Unit Manager can also call have the discussion with responsible party, and document in a progress note as well as complete the consent form over the phone. E3 confirmed that the EMR lacked evidence that R3's responsible party was informed of the risk versus benefits of the medication prior to provider implementing. 3. Review of R118's clinical record revealed: 9/17/25 - R118 was admitted to the facility. 12/29/25 - A quarterly MDS documented that R118 was a BIMs of 6 indicating severe cognitive impairment. 2/2/26 - A psychiatric provider consult note documented to discontinue olanzapine, a anti-psychotic and start risperidone, a anti-psychotic due to increased metabolic risk with long term use of olanzapine. 2/13/26 4:22 PM - A physician's order documented			F0552	Continued from page 3 The Director of Nursing/Assistant DON/Unit Managers will conduct audits of medical record to ensure there is documentation related to risks versus benefits of psychotropic medication of new admissions and new orders obtained. Audits will be done daily for 5 Days then weekly for 4 weeks then monthly for 3 months or until 100% compliance is achieved. Findings will be reviewed at the QAPI/Quality Assurance meeting monthly for 3 months.		09/14/2026

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F0552 SS = E	Continued from page 2 §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for four (R1, R3, R118, and R119) out of five residents sampled for medication review, the facility failed to discuss the risk and benefits of proposed care. Findings include: 1. Review of R1's clinical record revealed: 5/2/25 - R1 was admitted to the facility. 5/20/26 - An annual MDS assessment documented that R1 had a BIMs of 4, indicating severe cognitive impairment. 6/3/26 - A Psychotropic Medication Informed Consent form documented that R1 was receiving an anti-depressant, anti-psychotic, and anti-anxiety medication with verbal consent from R1's responsible party. 6/25/26 - A psychiatric provider consult note documented to discontinue Seroquel an anti-psychotic and to implement divalproex, a mood stabilizer for mood and behavior. The consult note lacked evidence that risk versus benefit was discussed with R1's responsible party. 6/30/26 1:47 PM - A physician's order documented divalproex sodium 125 mg give one tablet by mouth twice a day for unspecified dementia with agitation. 7/27/26 11:19 AM - During an interview, E17 (LPN) stated the expectation was to discuss any psychotropic medications with the resident/responsible party, risk versus benefit, adverse outcomes and alternative treatments prior to the provider implementing the medications. E17 stated if the aforementioned topics were discussed with the responsible party a progress note and form would be completed. 7/27/26 1:14 PM - During an interview, E3 (ADON) stated the provider usually discusses treatment	F0552	Continued from page 2 records. R#1 reviewed, RP notified of risks vs benefits/conversation & documented R#3 reviewed, RP notified of risks vs benefits/conversation & documented R# 118 reviewed, RP notified of risks vs benefits/conversation & documented R#119 reviewed, RP notified of risks vs benefits/conversation & documented Scope and Impact Assessment: Assistant Director of Nursing/Unit Managers will audit of residents receiving psychotropic medications to assure risks versus benefits were discussed with residents/RP and consents were obtained. Education and Prevention Measures: The Staff Development Coordinator/Unit Managers/Nurse Supervisors will conduct an in-service training for licensed nursing staff and providers on the importance of discussing the risks and benefits and obtaining consents of psychotropic medications with residents and their responsible parties. Staff were educated on proper documentation practices to ensure compliance with regulatory expectations. System Change: The Assist Director of Nursing/Unit Managers will review during daily clinical meetings, new admissions and new orders for psychotropics discussion of risk and benefit of psychotropic medication use and consents with resident/responsible parties is in place. Root cause determined licensed nursing staff and providers failed to notify responsible parties of residents who were cognitively impaired regarding the risks vs benefits for psychotropic medications and consents are obtained. Ongoing Monitoring Plan:			09/14/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085037		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/30/2026	
NAME OF PROVIDER OR SUPPLIER OCEAN GROVE POST ACUTE				STREET ADDRESS, CITY, STATE, ZIP CODE 231 SOUTH WASHINGTON STREET , MILLSBORO, Delaware, 19966			
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F0000	Continued from page 1 total possible BIMS Score ranges from 0 to 15. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Cognitively intact - alert and oriented enough to make one's own decisions; Electronic Medical Record - electronic documentation of a resident's medical record; Chronic Obstructive Pulmonary Disease – (COPD) a chronic inflammatory lung disease that causes obstructed airflow from the lungs. Symptoms include breathing difficulty, cough, sputum production and wheezing; Mechanical soft diet- smoother texture than regular foods; eliminates foods that are difficult to chew or swallow; Medication Administration Record (MAR) - documentation of medications given to a resident; Minimum Data Set (MDS) – standardized assessment forms used in nursing homes; Power of Attorney (POA) - a legal document that allows a designated person to be responsible for decision making for a resident; Respiratory failure- inability of the lungs to perform basic task of gas exchange;	F0000					
F0552 SS = E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.	F0552	PLAN OF CORRECTION — F-552 =====			09/14/2026	
			Immediate Action Taken: Nursing staff reviewed the clinical records of Residents #1, #3, #118, and #119 to ensure that all necessary discussions regarding the risks and benefits of psychotropic medications were conducted with their responsible parties. Documentation was updated to reflect these discussions where applicable, ensuring compliance with care expectations. Responsible parties are notified of psychotropic medications risk vs. benefits. Informed consents placed in medical				

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E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from July 20, 2026 through July 30, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.		E0000				
F0000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility from July 20, 2026, through July 30th, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 160. The investigative sample totaled 74 residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA – Nursing Home Administrator; RN - Registered Nurse; RP - Responsible Party; Abnormal Involuntary Movement Scale (AIMS) - test to measure body movements the resident cannot control as a result of side effects from use of antipsychotic medications; Activities of daily living (ADL's) - task needed for daily living such as bathing, shaving, dressing, hygiene, eating and toileting; Brief Interview for Mental Status (BIMS) – assessment of the resident's mental status. The		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
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