



**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: Delaware Hospital for the Chronically III

DATE SURVEY COMPLETED: March 24, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced Follow-Up to a Complaint Survey ending February 24, 2025, was conducted at this facility on March 24, 2025. The survey process included observations, interviews, review of residents' clinical records and other documentation. The facility census was 70 (seventy). The survey sample size totaled three (3) residents.</p>		
3201	Regulations for Skilled and Intermediate Care Facilities		
3201.1.0	Scope		
3201.1.2	<p>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.</p> <p>The facility was in found to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities as of March 24, 2025.</p> <p>No deficiencies were identified at the time of the survey.</p>		

Provider's Signature

Gwendolyn Stewart, BON, RN
LNHA

Title

Acting Facility Dr.

Date

3/26/2025

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

PRINTED: 04/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 03/24/2025
NAME OF PROVIDER OR SUPPLIER DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNNYSIDE ROAD SMYRNA, DE 19977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{F 000}	INITIAL COMMENTS An unannounced Follow-Up to a Complaint Survey ending February 24, 2025, was conducted at this facility on March 24, 2025. The survey process included observations, interviews, review of residents' clinical records and other documentation. The facility census was 70 (seventy) The survey sample size totaled three (3) residents. The facility was in found to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities as of March 24, 2025.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/26/2025

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 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.