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

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

STATE SURVEY REPORT

NAME OF FACILITY: Excelcare at Wilmington LLC

DATE SURVEY COMPLETED: March 13, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint Investigation survey was conducted by Healthcare Management Solutions, LLC on behalf of the Delaware Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/10/25 to 03/13/25 Survey Census: 130 Sample Size: 28 Supplemental Residents: 7	Cross Reference 2567 POC: F600	04/28/2025
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed March 13, 2025: F600.		

Provider's Signature _____ Title LNHA Date 4/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085002	A. BUILDING _____ B. WING _____	C 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCELCARE AT WILMINGTON LLC	2801 W. 6TH STREET WILMINGTON, DE 19805

(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
E 000	Initial Comments An Annual Recertification, Complaint Investigation, and Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC, on behalf of Delaware Health and Social Services, Division of Health Care Quality from 03/10/25 to 03/13/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint Investigation survey was conducted by Healthcare Management Solutions, LLC on behalf of the Delaware Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/10/25 to 03/13/25 Survey Census: 130 Sample Size: 28 Supplemental Residents: 7	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F 600		4/28/25

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

Electronically Signed | 04/03/2025

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.

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F 600	Continued From page 1 §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 observations, interviews, record review, policy review, and review of the facility's investigations, the facility failed to ensure four of five residents reviewed for abuse prevention (Resident (R) 8, R183, R184, and R286) out of 28 sampled residents were free from abuse from other residents. R184 verbally abused R183 when attempting to take R183's walker believing it was his. R8 slapped R286 when attempting to take a magazine away from R286. The verbal and physical abuse from R183 and R286 created the potential for fear, pain, and injury to R184 and R8. Findings include: Review of the facility's policy titled "Abuse/Neglect - Exploitation Mistreatment and Misappropriation of Property Prevention," dated 06/15/24, read, in part, "Residents of this facility shall be protected from occurrences of abuse, exploitation, misappropriation of property, mistreatment or neglect." 1. Review of the "Admission Record" located under the "Profile" tab in the electronic medical record (EMR) revealed R183 was admitted on 08/23/24 with diagnoses that included dementia with behavioral disturbances, major depressive disorder, anxiety disorder, and schizoaffective disorder.	F 600	600 Freedom from Abuse, and Neglect A. 1. All residents were immediately secured, and R286 was assessed for injury. R8 was immediately placed on additional monitoring without further incident. 2. All residents were immediately secured, R183 was assessed for injury, and R184 was placed on every 15-minute checks and was referred to the Behavioral Health Hospital. B. 1. All residents have the potential to be affected. C. 1. The Root Cause Analysis determined that staff could have better identified behaviors and risk factors that increase the likelihood of resident-to-resident behavior escalation. 2. The Staff Developer will educate staff across all departments on identifying behaviors and risk factors that increase the likelihood of resident-to-resident behavior escalation, such as verbal escalation, hoarding, delusions, and	

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F 600	Continued From page 2 Review of the readmission "Minimum Data Set (MDS)" located under the "MDS" tab of the EMR, with an assessment reference date (ARD) of 12/05/24, revealed a "Brief Interview for Mental Status (BIMS)" score of three out of 15 which indicated R183 was severely cognitively impaired. Behaviors during the assessment period noted "verbal behavioral symptoms occurred 1-3 days" and "other behavioral symptoms not directed at others occurred 1-3 days." Review of R183's "Care Plan," located under the "Care Plan" tab in the EMR, initiated 09/16/24, identified "The resident has a potential to be verbally aggressive as evidenced by screaming, yelling or cursing at others." Review of the "Admission Record" located under the "Profile" tab in the "EMR" revealed R184 was admitted on 02/14/25 with diagnoses that included displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing. R184 discharged home on 02/28/25 as planned following rehabilitation. Review of the admission "MDS" with an ARD of 02/21/25 revealed a BIMS score of 14 out of 15 which indicated R184 was cognitively intact. Review of the facility's investigation, dated 03/03/25, provided by the Administrator, revealed "On 2124/25 [02/24/25] at approximatety [approximately] 12:40PM [R183] was ambutating [ambulating] down the hattway [hallway] when he attempted to take the rotting [rolling] watker [walker] that was sitting in the doorway of [R184's room] in front of [R184] who was sitting in her	F 600	wandering, and on developing proactive interventions to prevent escalation. 3. The DON/designee will conduct daily audits on all resident-to-resident incidents to determine if behaviors and risk factors were identified prior to the escalation and if proactive measures were taken. D. 1. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. 2. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. 3. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. 4. Finally, the facility will conduct a monthly audit until 100% compliance is maintained.	

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room in her wheetchair. [wheelchair]. [R183] had one end of the rotting [rolling] watker [walker] and [R184] grabbed the other end of the watker [walker] and totd [told] [R183] that the walker belonged to her. [R183] then cursed at [R184] and totd [told] her that it betonged [belonged] to him. The Nurse [Licensed Practical Nurse, LPN4] and [Certified Nursing Assistant. CNA1] noted the exchange occurring with [R183] and were heading towards the residents and immediatety [immediately] separated the residents and redirected [R183] back to his room. No physical contact bewveen [between] the residents occurred. The safety of att [all] other residents was ensured. [R183] was ptaced [placed] on 30-minute safety checks post incident. [R183] was referred to [Behavioral Health Hospital] on 02/24/25 for further evatuation [evaluation]. [R184] was moved from room [current room] to [room further away from R183]. Changes made to the CP [care plan]: [R183] ptaced [placed] on 30-minute safety checks and transfered [transferred] to [Behavioral Health Hospital] on 2/25/25 lot [for] turlher [further] evaluation. PsychandSW [Psychiatrist and Social Worker] to continue to fotlow [follow]."

During an interview on 03/11/25 at 11:16 AM, the Director of Nurses (DON) and Administrator confirmed the verbal abuse by R183 to R184. The DON stated, "R184 was not afraid. No physical contact occurred. R183 thought the walker was his and started to take it from R184's doorway. R184 pulled it back, let go, and laughed at R183. R183 cursed at R184 claiming the walker was his. R183 was sent to a behavioral health hospital because his agitation had been increasing, he was trying to hoard wheelchairs, walkers, and the weight chair. His meds will be

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F 600	Continued From page 4 evaluated. He will return." Review of the R183's "Progress Notes" located under the "Clinical" tab in the EMR revealed a Behavior Note dated 02/04/25 which read, "Patient observed agitated and aggressive this morning. He was Collecting all the wheelchair claiming that they are his and nobody can use them without buying them from Him. He was also observed confronting staff when they attempted to use the Hoyer lift. Patient was also attempting to get into other patient rooms to retrieve their jerry chair claiming it belongs to him. when redirected by staff he attempted to use his cane to hit staff. Patient was redirected to a calm environment, and was also offered a snack but was not effective. MD was notified. Order was obtained for Ativan gel I mg [milligram] PRN [as needed] Q [every] 8 hours." During an interview on 03/13/25 at 11:30 AM, the Social Services Director (SSD) stated, "We're able to utilize the services of the behavioral health hospital to help with medication management when R183 starts escalating. In his dementia, he will think everything around him is his and he starts hoarding. He will resist cares, medication, food at those times. The behavioral health hospital works with his dementia and schizophrenia and medications. The resident's responsible person is involved and was in agreement to the transfer. Resident is not physically aggressive. He is expected to return, staff will continue with close supervision. The psychiatrist will following him in the facility as well." 2. R8 was originally admitted to the facility on 11/26/24 following a hospitalization to treat	F 600		

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metabolic encephalopathy. R8's other diagnoses include anxiety, dementia, depression, and atrial fibrillation.

Review of R8's EMR revealed R8 quarterly MDS with ARD of 03/04/25 indicated a BIMS of five out of 15 which indicated serve cognitive impairment.

Review of the facility provided "Incident/Accident" log, revealed a resident-to-resident incident involving R8 and R286.

Review of R8's "Progress Note," dated 03/05/25 at 1:29PM read, "Resident to resident abuse. While in Dining Room this resident (the aggressor) approached fellow resident in attempt to take her magazine from her, they began to yell and this resident slapped fellow resident's left side of face with open hand."

Review of the facility's investigation of the resident-to-resident incident revealed an interview with R286 dated 03/05/25 at 1:52PM.indicated, R286 stated she was "sitting in at the dining room table by myself when the lady (R8) walked up to me and grabbed my magazine. I said you can't come up taking other people's stuff, then she hit me."

An interview was attempted with R286 on 03/13/25 at 11:37AM but the resident was not able to offer any information regarding the incident between her and R8.

During an interview with R8's resident representative (RR1) on 03/10/25 at 12:43PM, she confirmed that she was notified of the incident that occurred on 03/05/25. She added that she has been surprised at R8's behavior, but

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did advise that there has been a cognitive decline due to the dementia diagnosis.

During an interview on 03/11/25 at 9:03AM LPN1 she stated that outside of the incident on 03/05/25, R8 had not shown aggression towards other residents but could be combative during care.

During an interview with Certified Nursing Assistant (CNA)3 on 03/13/25 at 11:40AM, she confirmed that she was present in the dining room at the time of the incident and stated, "R8 had just been redirected by another aide, because she was trying to get at the hole punch on the nurses' station. R8 then approached R286, who was reading a magazine, and R8 attempted to take it from her. They began to speak to incoherently yell at each other and before staff could separate the two, R8 reached back and slapped R286." CNA3 continued, advising the residents were separated and assessed. CNA3 also confirmed that neither resident was injured and notification to resident representative and physician was made. CNA3 was asked if R8 had showed any signs of aggression towards other residents prior to this incident and she stated that she had not and she was very surprised by the incident.

Interview with the DON was interviewed on 03/13/25 at 9:18AM, and she confirmed that the incident was investigated and reported to the State Agency (SA) per the facility's abuse reporting policy. She added that local law enforcement was also contacted. The DON also advised that the investigation concluded that the incident did occur, and the facility responded by adding additional monitoring for R8. The DON

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F 600	Continued From page 7 was asked how she was ensuring the ongoing safety of the facility's residents and the DON stated that R8 had shown no physical aggression towards others since her admission to the facility in November and since the incident on 03/05/25. She added that R8 is monitored and followed by their psych services, and they are monitoring R8 closely.	F 600		