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: The Center at Eden Hill

DATE SURVEY COMPLETED: May 20, 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. An unannounced Annual and Complaint survey was conducted at this facility from May 12, 2025, through May 20, 2025. The deficiencies contained in this report are based on interviews, record review and a review of other facility documentation as indicated. The facility census on the first day of the survey was seventy-two (72). The survey sample totaled twenty-nine (29) residents.		
3201	**Regulations for Skilled and Intermediate Care 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 was not met as evidenced by:** Cross refer to the CMS-2567-L survey completed May 20, 2025: F550, F551, F578, F609, F656, F657, F658, F684, F690, F757, F773 and F880.		

Provider's Signature _____ Title Executive Director Date 6/10/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 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 May 12, 2025 through May 20, 2025. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility from May 12, 2025, through May 20, 2025. The deficiencies contained in this report are based on interviews, record review and a review of other facility documentation as indicated. The facility census on the first day of the survey was seventy-two (72). The survey sample totaled twenty-nine (29) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; ED- Executive Director; EMR- electronic medical record; MDS - Minimal Data Set; NHA- Nursing Home Administrator; RN- Registered Nurse; BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best; Central line (Central venous catheter) - a form of	F 000		

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

Electronically Signed | 06/16/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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	Continued From page 1 intravenous access into the arm which goes all the way up to a vein near the heart or just inside the heart. Can be used for a prolonged time; DMOST - (Delaware Medical Orders for Scope of Treatment) - A medical document that outlines a patient's preferences regarding end-of-life care, including decisions about cardiopulmonary resuscitation (CPR) and other life-sustaining treatments; Enhanced Barrier Precautions (EBP) - refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities; MDRO (multi drug resistant organim) - these are microorganims (tiny cells only seen with a microscope, such as bacteria that have become resistant to multiple classes of antibiotics; Negligence - a form of resident abuse by failing to act as a reasonable person would in a similar situation; POA- Power of Attorney- someone appointed to make decisions on your behalf; Psychotropic (medication)- any medication capable of affecting the mind, emotions and behavior; UA - urinalysis, is an array of tests performed on urine, and one of the most common methods of medical diagnosis.	F 000		
F 550 SS=E	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	F 550		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 550	Continued From page 2 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 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 and interview, it was determined that for three (R16, R38, and R234) out of twenty-four (24) residents in the	F 550	A. R16, R38 and R234 no longer reside in the facility. Facility staff will knock on door and verbally request permission to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 550	Continued From page 3 investigative sample, the facility failed to ensure residents were treated with respect and dignity. Findings include: 1. Review of R16's clinical record revealed: 4/24/25 - R16 was admitted to the facility. 5/12/25 10:42 AM - During an observation, E14 (PTA) knocked on R16's room door and entered the room without waiting for R16's response/permission to enter the room. 5/12/25 10:43 AM - During an interview, E14 (PTA) confirmed that the expectation is to knock and wait for a response to enter a resident's room. E14 confirmed that she did not wait for a response before entering R16's room. 5/12/25 11:00 AM - During an observation, E15 (RN) knocked on R16's room door and entered the room without waiting for R16's response/permission to enter the room. 5/12/25 11:25 AM - During an interview, E15 (RN) confirmed that the expectation is to knock and wait for a response to enter a resident's room. E15 confirmed that she did not wait for a response before entering R16's room. 2. Review of R38's clinical record revealed: 4/30/25 - R38 was admitted to the facility. 5/12/25 10:36 AM - During an observation, E14 (PTA) knocked on R38's room door and entered the room without waiting for R38's response/permission to enter the room.	F 550	enter resident's rooms moving forward. B. All patients have the potential to be affected by this deficient practice. C. A root cause analysis, completed on 6/12/25, determined that facility staff were not aware that they must wait to be granted access before entering a patient's room. Executive Director or designee will educate all facility staff on dignity and resident rights, to include knocking on patient's doors and requesting permission to enter. This education will be completed by 7/3/25. D. Director of Nursing or designee will complete daily audit on a sample of 2 hallways to ensure staff are following the updated process. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 2 hallways sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 2 hallways sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 550	Continued From page 4 5/12/25 10:43 AM - During an interview, E14 (PTA) confirmed that the expectation is to knock and wait for a response to enter a resident's room. E14 confirmed that she did not wait for a response before entering R38's room. 3. Review of R234's clinical record revealed: 5/13/25 9:57 AM - During an observation, E16 (Dietary) knocked on R234's room door and entered the room without waiting for R234's response/permission to enter the room. 5/13/25 9:58 AM - During an interview E16 (Dietary) confirmed that the expectation is to knock and wait for a response to enter a resident's room. E16 confirmed that she did not wait for a response before entering R234's room. 5/13/25 10:19 AM - During an observation, E17 (Housekeeping) knocked on R234's room door and entered the room without waiting for R234's response/permission to enter the room. 5/13/25 10:25 AM - During an interview, E17 (Housekeeping) confirmed that the expectation is to knock and wait for a response to enter a resident's room. E17 confirmed that she did not wait for a response before entering R234's room. 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).	F 550		
F 551 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	F 551		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 551	Continued From page 5	F 551		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 551	Continued From page 6 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 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 one (R336) out of four residents reviewed for Advanced Directives, the facility failed to ensure that a responsible party of a cognitively impaired resident was involved in code status decisions. Findings include: Review of R336's clinical record revealed: 3/1/25 - R336 was admitted to the facility with diagnoses including but not limited to prostate cancer with secondary bone cancer and unsteady gait. 3/3/25 6:20 PM - FM1 signed the Delaware Medical Orders for Scope of Treatment (DMOST) form indicating FM1 as R336's responsible party (RP). 3/5/25 - E12 (MD) signed DMOST form.	F 551	A. R336 no longer resides in the facility. The deficient practice did not negatively impact R336 while he was a resident in our care. B. Director of Nursing or designee will complete a facility wide audit by on resident code status and DMOST forms to ensure that any legally declared incompetent residents had input from their responsible party when determining code status. Audit will be completed by 6/24/25. C. A root cause analysis, completed on 6/12/25, determined that not all staff are properly educated on how to determine resident competency and when to contact the responsible party. Moving forward, any resident deemed legally incompetent with documentation in place, will require the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 551	Continued From page 7 5/8/25 - R336 was re-admitted to facility with diagnoses including but not limited to, cerebral infarction (stroke). 5/8/25 - R336 signed DMOST form. 5/9/25 - E5 (NP) signed DMOST form. 5/9/25 - A Brief Interview for Mental Status (BIMS) assessment documented R336's BIMS score as 5, indicating severe cognitive impairment. 5/20/25 9:55 AM - During an interview, E5 (NP) stated that the facility utilizes the BIMS score when assessing a resident's cognitive capacity. E5 (NP) further explained that she would expect a resident to have a BIMS score between 14 and 15 to be considered cognitively intact and capable of signing medical documents independently and for residents with lower BIMS scores indicating severe cognitive impairment, the provider is expected to obtain input from the resident's responsible party (RP) with another staff member present as a witness, in conjunction with the provider. E5 (NP) confirmed R336 documented BIMS score was 5 and R336's RP was not contacted for their input at the time R336 signed the DMOST form. The facility failed to involve R336's RP in the decision-making process and ensure another staff member was present to witness the discussion and signing. 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).	F 551	input of the responsible party when completing the DMOST form. Executive Director or designee will educate all providers and nursing staff on this process by 7/3/25. Director of Nursing or designee will also provide education to all new providers and nursing staff as part of the orientation and onboarding process. D. Director of Nursing or designee will complete daily audits on a 5 patient sample to ensure compliance. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 578	Continued From page 8	F 578		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he	F 578		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 578	Continued From page 9 or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for three (R38, R76, and R234) out of four residents reviewed for Advance Directives, the facility failed to offer an opportunity to formulate an advance directive. Findings include: 1. Review of R38's clinical record revealed: 4/30/25 - R38 was admitted to the facility. 5/1/25 - A BIM's assessment was completed for R38 with a score of 15 indicating R38 was cognitively intact. 5/1/25 11:05 AM - A social history assessment was completed for R38 and documented that R38 was a full code and had a general POA. The assessment did not determine if R38 had an advanced directive or wanted to formulate one. 5/14/25 10:38 AM - During an interview, E18 (Clinical Liaison) confirmed that the admitting nurse is responsible to review admission documents with the residents upon admission. 5/14/25 10:42 AM - During an interview, E13 (LPN) confirmed that the admitting nurse is responsible to complete the resident assessments. 5/14/25 12:17 PM - During an interview, E1 (NHA) and E2 (DON) stated that the physician will	F 578	A. On 5/15/25, R38, R76, and R234 were offered the opportunity to formulate an advance directive. B. On 5/18/25, Director of Nursing and designees completed a facility wide audit to identify others who may be impacted by the deficient practice. Following the audit, all residents were offered the opportunity to formulate an advance directive. C. A root cause analysis, completed on 5/17/25, determined that the established facility process of offering information on Advance Directives to our residents did not meet the regulatory requirement. On 5/18/25, the Director of Nursing established a "Decision Maker/Healthcare Advanced Directives" form, which was provided to each resident residing in the facility. The form will also be included in the clinical admission packet for each new admission starting on 5/18/25. Executive Director or designee will educate all staff on the new Advanced Directive process by 7/3/25. Director of Nursing or designee will also provide education to all newly hired nursing staff as part of the orientation and onboarding process. D. Director of Nursing or designee will complete daily audits on a 5 patient sample to ensure each patient has been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 578	Continued From page 10 discuss advanced care options with the residents during an exam. 2. Review of R76's clinical record revealed: 4/23/25 - R76 was admitted to the facility. 4/24/25 - A BIM's assessment was completed for R76 with a score of 15 indicating R76 was cognitively intact. 4/24/25 4:02 PM - A social history assessment was completed for R76 and documented that R76 was a full code. The assessment did not determine if R76 had an advanced directive or wanted to formulate one. 5/14/25 10:38 AM - During an interview, E18 (Clinical Liaison) confirmed that the admitting nurse is responsible to review admission documents with the residents upon admission. 5/14/25 10:42 AM - During an interview, E13 (LPN) confirmed that the admitting nurse is responsible to complete the resident assessments. 5/14/25 12:17 PM - During an interview, E1 (NHA) and E2 (DON) stated that the physician will discuss advanced care options with the residents during an exam. 3. Review of R234's clinical record revealed: 5/9/25 - R234 was admitted to the facility. 5/10/25 12:02 PM - A BIM's assessment was completed for R234 with a score of 15 indicating R234 was cognitively intact.	F 578	provided the opportunity to complete an advance directive form. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 578	Continued From page 11 5/11/25 6:30 AM - A social history assessment was completed for R234 and documented that R234 was a full code. The assessment did not determine if R234 had an advanced directive or wanted to formulate one. 5/14/25 10:38 AM - During an interview, E18 (Clinical Liaison) confirmed that the admitting nurse is responsible to review admission documents with the residents upon admission. 5/14/25 10:42 AM - During an interview, E13 (LPN) confirmed that the admitting nurse is responsible to complete the resident assessments. 5/14/25 12:17 PM - During an interview, E1 (NHA) and E2 (DON) stated that the physician will discuss advanced care options with the residents during an exam. The facility lacked evidence of offering an opportunity to formulate an advance directive for R38, R76 and R234. 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).	F 578		
F 609 SS=D	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	F 609		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 609	Continued From page 12 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 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 one (R24) out of two residents reviewed for abuse, the facility failed to report the allegations of abuse to the State Agency within two hours. Findings include: A facility policy titled, Abuse and Neglect Prohibition last revised October 12, 2022, documented: 1. State Reporting Obligations: The facility will report all allegations and substantiated occurrences of abuse, neglect ... to the administrator, State Survey Agency ... in accordance with Federal and State law through established procedures. ... a. If the events that caused the allegation involve abuse ...a report is	F 609	A. R24 no longer resides at the facility. Allegation of abuse was reported on 5/12/25 B. There is potential for all residents to be affected by the deficient practice, although no residents have been adversely affected at this time. C. A root cause analysis, completed on 6/12/25, identified a possible education gap among facility staff in abuse identification and timeliness of reporting. Executive Director or designee will provide education to all facility staff in regards to identifying and timely reporting	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 609	Continued From page 13 made not later than 2 hours after the management staff becomes aware of the allegation .... 1. Review of R24's clinical record revealed: 4/15/25 - R24 was admitted to the facility. 4/16/25 - A BIMS assessment documented that R24 was cognitively intact with a score of 15. 5/10/25 - R24 stated that nursing staff touched her inappropriately while taking vital signs. 5/12/25 3:01 PM - E1 (ED) reported the allegation of abuse incident to the State Agency. 5/19/25 9:22 AM - During an interview, E10 (RN) stated that on 5/10/25, E11 (LPN) notified her about an allegation of abuse from R24. E10 stated that she went to interview R24, and R24 stated that a nurse on the overnight shift had touched the side of her breast while taking her vital signs. E10 then stated she let E2 (DON) know that same day. E10 then continued to do interviews for the investigation. 5/19/25 1:35 PM - During an interview, E2 stated that E10 did tell her about the incident from R24 on 5/10/24 and asked E10 to do the investigation. E2 further confirmed this was an allegation of abuse and explained that was why the investigation was started that day. The report of the alleged abuse was submitted two days after the alleged incident occurred. 5/20/25 2:15 PM - Findings were reviewed with E1 and E2.	F 609	of abuse by 7/3/25. Human Resources Director or designee will also provide education to all newly hired staff as part of the orientation process. D. Director of Nursing or designee will complete daily audits on a 5 patient sample to ensure compliance. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 656	Continued From page 15 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R76) out of twenty-four residents in the investigative sample, the facility failed to develop a comprehensive resident centered care plan for an identified care area. Findings include: Review of R76's clinical record revealed: 4/23/25 - R76 was admitted to the facility. 4/23/25 - A physician's order was written for enoxaparin sodium (anti-coagulant) inject 40 mg subcutaneously one time a day for DVT (deep vein thrombosis) prophylaxis. Additionally, a physician's order was written to monitor side effects of anticoagulant medication for signs and symptoms of bleeding and report any complications to the physician. 4/24/25 - A care plan was initiated for R76 and lacked evidence of a care plan related to anti-coagulant use. 5/16/25 1:24 PM - During an interview, E19 (MDS Coordinator) stated the process was the admission nurse will initiate the baseline care plan and after the MDS was completed the MDS coordinator will add any additional care plans identified during completion of the MDS. E19	F 656	A. An anti-coagulation care plan was added for R76 on 5/16/25. B. MDS Coordinator or designee will complete a facility wide audit for all patients on anti-coagulants by 6/24/25. MDS Coordinator or designee will ensure that any patients on anti-coagulants have a corresponding care plan C. A root cause analysis, completed on 6/12/25, determined a gap in staff knowledge while developing a baseline care plan. Executive Director or designee will provide education to all nursing staff regarding anti-coagulation care plans by 7/3/25. Director of Nursing or designee will also provide education to all newly hired nursing staff as part of the orientation and onboarding process. D. Director of Nursing or designee will complete daily audits in morning clinical meeting to review all new admission with anti-coagulants ensuring they have a corresponding anti-coagulant care plan. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed until 100% compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 656	Continued From page 16 confirmed that a care plan for anticoagulant use was not initiated for R76. 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).	F 656	is achieved for 3 consecutive audits. Finally, a weekly audit will be completed until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	
F 657 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. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.	F 657		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 657	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one residents (R68) out of twenty-four residents reviewed the facility failed to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings. Findings include: Review of R68's clinical record revealed: 4/8/25 - R68 admitted to facility. 4/14/25 - An admission MDS was completed for R68. 5/12/25 - Review of R68's clinical record lacked evidence that a care plan meeting occurred with the case manager and R68. 5/12/25 2:05 PM - During an interview, R68 stated that each week the facility's case manager meets with her and her husband to discuss the care she is receiving and the plans for discharge, which are reviewed during the facility's weekly Interdisciplinary Team (IDT) meetings. R68 explained that she is not present during the IDT meetings, but the case manager provides a summary of the discussions held by the staff present regarding her care. 5/16/25 9:38 AM - During an interview, E1 (ED) stated that Interdisciplinary Team (IDT) meetings occur weekly and include all staff members. Additionally, the Case Manager/Social Worker (SW) meets with the resident and the resident's representative on a biweekly basis. These biweekly meetings are considered the formal care plan meetings.	F 657	A. A care plan meeting, including the entire required interdisciplinary team (IDT), was held with R68 on 6/16/25. B. There is potential for all residents to be affected by the deficient practice, although no residents have been adversely affected at this time. C. A root cause analysis, completed on 6/12/25, determined that the facility did not have a standardized process to ensure that all IDT members are involved in the initial care plan meeting process. Moving forward, all initial care plan meetings will include input from the attending physician or designee, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident and a member of food and nutrition services staff – in addition to any other appropriate staff as determined by the resident's needs or preferences. Executive Director or designee will educate all staff on this new process by 7/3/25. Director of Nursing or designee will educate all new staff members going forward as part of the orientation process. D. Director of Nursing or designee will complete daily audits of a 5 resident sample to ensure they have documented input from all necessary parties for their initial care plan meeting. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 657	Continued From page 18 5/19/25 10:51 AM - During an interview, E2 (DON) confirmed that the IDT meeting notes do not reflect that all the members are present or input is provided. 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).	F 657	for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R15 and R76) out of twenty-four residents in the investigative sample, the facility failed to provide services that meet professional standards of quality by having Licensed Practical Nurses (LPN) complete admission assessments. Findings include: Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024 ... Admission Assessments * - RN ...* = Once a care plan is established, the LPN may do assessments ...". 1. Review of R15's clinical record revealed: 3/28/25 - R15 was admitted to the facility. 3/28/25 3:54 PM - A "Nursing Comprehensive	F 658	A. Neither affected resident remains in the facility. R15 discharged on 5/23/25 and R76 discharged on 5/30/25. B. There is potential for all residents to be affected by the deficient practice, although no residents have been adversely affected at this time. C. A root cause analysis, completed on 6/12/25, determined that the established facility process to ensure that a registered nurse was involved in all admission assessments and evaluations did not meet the regulatory requirements. Moving forward, all assessments, including the "Comprehensive Admission Data Collection and Baseline Care plan" will be	7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 658	Continued From page 19 Admission Data Collection" assessment was completed by E23 (LPN). The nursing Comprehensive Admission Assessment reviewed R15's demographics, drug regimen review, self care and mobility activities, skin, sensory perception, oral/nutritional, neurological, respiratory, cardiovascular, gastrointestinal, dehydration risk screener, bladder/bowel, sleep, pain, and fall risk. 3/29/25 3:14 PM - A "Functional Abilities and Goals Admission" assessment was completed by E8 (RN). The Functional Assessment reviewed R15's prior functioning, prior device use, self care, and mobility. 5/20/25 10:57 AM - During an interview, E15 (RN) stated the expectation was if the LPN was assigned to the pending admission then the LPN would complete the "Nursing Comprehensive Admission Data Collection" and the RN would complete the Functional Assessment and any other Assessments. E15 confirmed that the comprehensive admission data collection was completed by E23 (LPN). 2. Review of R76's clinical record revealed: 4/23/25 - R76 was admitted to the facility. 4/23/25 10:35 PM - A "Functional Abilities and Goals Admission" assessment was completed by E24 (RN). The Functional Assessment reviewed R76's prior functioning, prior device use, self care, and mobility. 4/24/25 2:35 AM - A "Nursing Comprehensive Admission Data Collection" assessment was completed by E23 (LPN). The Nursing	F 658	reviewed by a registered nurse. All nursing staff will be educated on the new process by 7/3/25. Director of Nursing or designee will educate all newly hired nursing staff going forward as part of the orientation process. D. Director of Nursing or designee will complete daily audits on 10% of all new admissions to ensure each assessment is reviewed by a registered nurse. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 10% sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 10% sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 658	Continued From page 20 Comprehensive Admission Assessment reviewed R76's demographics, drug regimen review, self care and mobility activities, skin, sensory perception, oral/nutritional, neurological, respiratory, cardiovascular, gastrointestinal, dehydration risk screener, bladder/bowel, sleep, pain, and fall risk. 5/20/25 10:57 AM - During an interview, E15 (RN) stated the expectation was if the LPN was assigned to the pending admission then the LPN and the "Nursing Comprehensive Admission Data Collection" and the RN would complete the Functional Assessment and any other assessments. E15 confirmed that the Comprehensive Admission Data Collection was completed by E23 (LPN). 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).	F 658		
F 684 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 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 interview and record review it was determined that for one (R38) out of twenty-four residents reviewed in the investigative sample, the facility failed to follow a physician's order.	F 684	A. R38 no longer residents at the facility and was not adversely impacted by deficient practice.	7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 684	Continued From page 21 Findings include: 1. Review of R38's clinical record revealed: 4/30/25 - R38 was admitted to the facility. 4/30/25 - A physician's order was written for metoprolol tartrate 25 mg give one tablet by mouth two times a day for hypertension and hold for SBP (systolic blood pressure) less than 110 and heart rate less than 60. 5/2025 - The May MAR documented metorprolol tartrate 25 mg given on the following dates when the systolic blood pressure or heart fell outside of the parameters: -5/11/25 BP 124/59 HR 55. -5/13/25 BP 128/62 HR 58. -5/14/25 BP 145/60 HR 55. -5/15/25 BP 143/62 HR 55. 5/20/25 9:41 AM - During an interview, E5 (NP) stated the expectation with medications not meeting parameters to administer should be reported to the medical provider and the expectation was for the medication to be held. E5 confirmed that she was not aware of R38's medication being held for parameters and confirmed that medication was administered with no adverse effects noted. 5/20/25 10:40 AM - During an interview, E15 (RN) stated the expectation with medications not meeting parameters would be to hold the medication and explain to the resident why it is being held. E15 also stated that the medication being held should be reported to the provider. E15 confirmed that R38's medication was administered from the aforementioned dates.	F 684	B. Director of Nursing or designee will complete a facility wide audit of all residents with systolic blood pressure and heart rate parameters by 6/24/25. C. A root cause analysis, completed on 6/12/25, determined that nursing staff needed to be re-educated on parameters and following physician orders. Executive Director or designee will provide education to all facility nursing staff regarding blood pressure medication parameters and following physician orders by 7/3/25. Director of Nursing or designee will educate all newly hired nursing staff going forward as part of the orientation process. D. Director of Nursing or designee will complete a daily audit of 5 patient sample to ensure necessary parameters are present. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 684	Continued From page 22 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 690	Continued From page 23 restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for two (R15 and R78) out of four residents reviewed for bowel and bladder, the facility failed to provide services to maintain or restore bowel and bladder continence for R15. For (R78), the facility failed to initiate antibiotic therapy for a resident without a urinary catheter who met criteria. Findings include: 1. Review of R15's clinical record revealed: 3/28/25 - R15 was admitted to the facility. 3/28/25 3:54 PM - A Nursing Comprehensive Admission Data Collection Assessment documented that "R15 was incontinent of bladder for less than a week and was occurring one to two times a day. Additionally the assessment documented R15 was wet during the day and night time and amount of urine was a large amount resulting in puddles, clothes, bed, or floor." 4/1/25 - A base line care plan was initiated for R15 documenting that R15 had bowel or bladder incontinence with interventions as follows: check frequently and assist with toileting as needed, keep call light within reach, provide loose fitting and easily removable clothing, and provide pericare after each incontinent episode and apply barrier cream as needed. 4/2/25 - An admission MDS documented that R15 required an assist of one person for toileting	F 690	A. R15 discharged from the facility on 5/23/25 and R78 was started on antibiotics on 5/13/25, neither were affected by the deficient practice. B. Infection Preventionist or designee will complete a facility wide audit of all urinalysis ordered to ensure that the results are reviewed timely and addressed appropriately by 6/20/25. DON or designee will also complete a facility wide audit by 6/20/25 to ensure that each resident has been properly assessed for incontinence. C. A root cause analysis (RCA), completed on 6/12/25, determined that the facility did not have a process to ensure all residents had an individualized bowel and bladder program. The RCA also showed that additional education is needed for both facility staff and providers on our antibiotic stewardship guidelines. Executive Director or designee will provide education on facility antibiotic stewardship protocol and timely reviewing of lab results to all nursing staff and providers by 7/3/25. Executive Director or designee will also provide education to all nursing staff by 7/3/25 regarding assessing all new residents for incontinence and developing an individualized toileting program. Director of Nursing or designee will provide education on antibiotic stewardship and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 690	Continued From page 24 transfer, toileting hygiene, and lower body dressing. Additionally, the MDS documented that R15 was frequently incontinent of urine and no toileting program in place to manage urinary incontinence. A BIMS score of 6 was noted on admission MDS indicating moderate cognitive decline. 4/2025 - The April CNA documentation record revealed that R15 was continent of urine 10 out of 90 opportunities. 5/2025 - The May CNA documentation record revealed that R15 was continent of urine 3 out of 54 opportunities. 5/12/25 - During an interview, R15 stated he was continent of urine when staff assists him to the toilet. 5/19/25 2:22 PM - During an interview, E21 (CNA) stated that R15 requires an assist of one and uses the toilet with staff assistance. E21 stated the standard is toileting every two hours and confirmed that R15 was not on a toileting program or voiding diary. 5/20/25 10:57 AM - During an interview, E15 (RN) stated that a toileting program is a standard every two hours and as needed for all residents. E15 stated that toileting programs and voiding diaries are not personalized and occur every two hours. E15 confirmed that R15 was not on an individualized toileting program to address his incontinence needs. 2. Review of R78's clinical record revealed: An undated protocol titled "Urine dip protocol"	F 690	individualized toileting programs to all new hires and newly credentialed providers going forward. D. Director of Nursing or designee will complete daily audits on a 5 resident sample to ensure that all lab results have been timely reviewed and that each resident has been properly assessed for incontinence. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 690	Continued From page 25 was provided by E9 and documented ... 1. "Only order a urine dip if a resident is symptomatic: fever, new onset dysuria (burning or pain with urination), or changes in urinary frequency or urgency ... 2. If positive, notify MD (physician), document [results] in a progress note, order urine culture to be sent out, and enter an order in PointClickCare (the facility's charting system) to result to MD once completed". 4/27/25 - R78 admitted to facility for rehab with diagnoses including but not limited to right and left broken arm. 5/10/25 7:45 PM - The facility Urine Dip Protocol revealed positive nitrates (presence of bacteria) and small leukocytes (white blood cells). 5/10/25 8:13 PM - A nursing note written by E3 (RN) documented " ...Informed by day shift nurse pt [patient] c/o [complained of] burning [dysuria] on urination. Urine collected and dipstick completed. + [positive] for nitrates and small amount of leukocytes. Call placed to Team Health on call and spoke with E4 (on call provider) who gave order for Urinalysis (UA), Culture and Sensitivity (C&S). Order noted ..." 5/11/25 6:04 AM - A lab report in the electronic medical record (EMR) revealed the urine sample for UA and C&S was obtained. 5/12/25 5:00 AM - A lab report in the EMR revealed the lab received the urine sample for UA and C&S from the facility. 5/12/25 6:41 PM - A lab report in the EMR revealed abnormal UA results with moderate blood, positive nitrates, and 10-20 white blood	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 690	Continued From page 26 cells was reported to facility with C&S pending. 5/13/25 9:28 AM - A lab report in the EMR revealed UA results were acknowledged and signed off by E5 (NP). An order placed by E5 included: "Macrobid (antibiotic) Oral Capsule 100 MG. Give 1 capsule by mouth two times a day for UTI for 7 Days to start 5/13/25 at 9AM". 5/14/25 6:02 PM - A lab report in the EMR revealed an E. Coli colony count >100,000 cfu/ml indicating a positive C&S. 5/14/25 10:06 PM - A nursing note written by E7 (RN) documented " ... Urine C&S result received. TeamHealth on call Physician paged. Waiting for call back ..." 5/14/25 11:36 PM - A nursing note written by E7 (RN) documented " ...E6 (NP) returned call and was made aware of Urine C&S result. New order received to D/C Macrobid and start Cipro 500mg BID X 5 days..." 5/16/25 11:37 AM - During an interview, R78 confirmed that she informed staff on 5/10/25 that she was experiencing burning with urination. R78 stated that a urine sample was collected, tested at the facility using a dipstick, and then sent to an outside laboratory for further analysis and culture. R78 reported that she continued to experience and report burning with urination following the initial complaint but was not started on any treatment at that time. R78 experienced dysuria and had a pending urine culture, meeting the minimum criteria for initiating antibiotic therapy in a resident without a urinary catheter. However, the facility failed to initiate	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 690	Continued From page 27 antibiotics despite the resident meeting these criteria. 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).	F 690		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R76) out of five residents sampled for medication review, the facility failed to limit a PRN psychotropic medication to 14 days. Findings include:	F 757	A. The lorazepam order for R76 was discontinued on 5/20. The provider entered a new lorazepam order, with a 14 -day stop date on 5/20/25. B. Director of Nursing or designee will	7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 757	Continued From page 28 Review of R76's clinical record revealed: 4/23/25 - R76 was admitted to the facility. 4/23/25 - A physician's order was written for lorazepam (anti-anxiety) 2 mg: give one tablet by mouth every twelve hours as needed for anxiety with an "indefinite" end date. 4/25/25 - A pharmacy communication documented that R76 was receiving a PRN psychotropic medication and did not have an indicated stop date. 4/25/25 - A physician's order was written for lorazepam 2 mg: give one tablet by mouth every 12 as needed for anxiety for 14 days. 5/9/25 - A physician's order was written for lorazepam 1mg: give one tablet by mouth every 12 hours as needed for anxiety with an "indefinite" stop date. 5/20/25 9:32 AM - During an interview, E5 (NP) confirmed the expectation for PRN psychotropic medication should have a 14 day stop date. E5 confirmed the aforementioned orders were written with an "indefinite" stop date. 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).	F 757	complete a facility wide audit by 6/24/25 for anyone on PRN psychotropic medications to ensure an appropriate stop date has been included. C. A root cause analysis, completed on 6/12/25, determined at the facility nursing staff and providers required additional education on psychotropic medications and long-term care regulations. Executive Director or designee will provide education to all providers and nursing staff by 7/3/25 regarding PRN psychotropic medications and the required re-evaluation for appropriateness. Director of Nursing or designee will also provide education to all new providers and nursing staff as part of the orientation and onboarding process. D. Director of Nursing or designee will complete daily audits on a 5 patient sample to ensure all psychotropic medications have proper stop dates. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results	F 773		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 773	Continued From page 29 CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined, for one (R78) out of one resident reviewed for laboratory services, the facility failed to promptly notify the ordering medical practitioner of laboratory results that fell outside of clinical reference ranges. Findings include: Cross refer F690. Review of R336's clinical record revealed: 5/10/25 8:13 PM - A nursing note written by E3 (RN) documented ... "Call placed to Team Health on call and spoke with E4 (on call provider) who gave order for Urinalysis (UA), Culture and Sensitivity (C&S). Order noted ..." 5/11/25 6:04 AM - Administration history notes documented R78's urine sample was collected. 5/12/25 5:00 AM - A lab report in the electronic medical record (EMR) revealed the lab collected	F 773	A. The ordering medical practitioner was notified of the urinalysis (UA) results for R78 on 5/13 and macrobid was started to address the UTI. R78 was not adversely affected by the deficient practice. B. Director of Nursing or designee will complete an audit by 6/24/25 to identify all patients with urinalyses ordered in last 7 days and ensure all results have been reported to the ordering provider. C. A root cause analysis, completed on 6/5/25, determined that the facility's existing lab process needed revision to ensure all labs are consistently reviewed and addressed in a timely manner. Executive Director will provide education to providers and facility nursing staff by 7/3/25 on the process for reviewing labs to ensure that all UA are address in a timely manner moving forward. Director of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 773	Continued From page 30 the urine sample from the facility. 5/12/25 10:38 AM - A lab report in the EMR revealed the urine sample was received from the facility. 5/12/25 6:41 PM - A lab report in the EMR revealed abnormal UA results with moderate blood, positive nitrates, and 10-20 white blood cells was reported to facility with C&S pending. 5/13/25 9:28 AM - A lab report in the EMR revealed the UA results were acknowledged and signed off by E5 (NP). 5/16/25 10:10 AM - During an interview, E9 stated when laboratory results are received, they are uploaded into Point Click Care (facility's charting system) and faxed to the nursing unit. The nurse is responsible for reviewing the results and notifying the provider. If results return during the day shift (before 7:00 PM), the nurse typically provides verbal notification with a copy of the results to the provider while they are rounding on the unit. If results return after 7:00 PM, Monday through Thursday, and 7:00 PM Friday through 7:00 AM Monday, the nurse contacts the Team Health on call service to report the findings and obtain any necessary orders. Following provider notification, the nurse is expected to document the interaction in a progress note, including who was notified, the lab results communicated, and any orders received. 5/16/25 3:14 PM - During an interview, E12 (MD) stated that it is standard practice for the dayshift charge nurse to monitor for any pending lab results and provide the provider with a printed copy of any abnormal findings that require	F 773	Nursing or designee will ensure that all new hires and newly contracted providers are educated on the process at orientation. E. Director of Nursing or designee will complete daily audits of a 5 patient sample to ensure any urinalyses have been properly reported and addressed. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 773	Continued From page 31 follow-up. If providers have already left for the day, it is expected that the nurse will notify the Team Health on call provider of any abnormal lab results that return after 7:00 PM, Monday through Thursday, and 7:00 PM Friday through 7:00 AM Monday. E12 (MD) confirmed that the facility lacked documentation indicating that a provider was notified when the abnormal UA lab result was received. 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).	F 773		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880		7/3/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 880	Continued From page 32 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 880	Continued From page 33 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R336) out of five residents observed during medication administration the facility failed to use enhanced based precautions for a resident with a central line. Findings include: A facility policy issued 3/27/24, to be implemented by 4/5/24 titled " Enhanced Barrier Precautions ...designed to reduce transmission of multidrug -resistant organisms that employs targeted gown and glove use during high contact resident care activities...device care or use: central line, urinary catheter, feeding tube." Review of R336's clinical record revealed: 5/8/25 - R336 was admitted to the facility with a diagnosis of a stroke. 5/12/25 - A care plan for R336 revealed enhanced barrier precautions related to the presence of a central line for the administration of an antibiotic. 5/15/25 1:54 PM - During medication administration, E13 was observed entering R336's room and administered IV Merrem through a central line. E13 completed hand hygiene and applied gloves, but did not put on the required personal protective equipment which includes a gown in addition to the gloves. 5/15/25 2:05 PM - During an interview, E13 confirmed that he did not wear a gown and that a	F 880	A. R336 was not adversely affected by this deficient practice. E13 was re-educated on proper enhanced barrier precaution guidelines. B. All patients on enhanced barrier precautions have the potential to be affected by this deficient practice. C. A root cause analysis, completed on 6/12/25, determined that not all staff were consistently following the facility's established Enhanced Barrier Precaution policy and would benefit from re-education. Executive Director will provide education to all staff on enhanced barrier precautions by 7/3/25. Director of Nursing or designee will ensure all newly hired employees are educated on enhanced barrier precautions as part of the orientation process. D. Director of Nursing or designee will complete daily audits using a sample of 5 staff members to ensure compliance with enhanced barrier precautions. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 staff member sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 staff member sample until 100% compliance is achieved for 3 consecutive audits. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. BUILDING _____ B. WING _____	C 05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	300 BANNING STREET DOVER, DE 19904

(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 880	Continued From page 34 gown and gloves should be worn due to R36 being on enhanced barrier precautions. 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).	F 880	QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	

ASPEN

SEVERITY/SCOPE GRID

Name: CENTER AT EDEN HILL, LLC
300 BANNING STREET
DOVER, DE 19904

Provider 085057

Survey Date 05/20/2025

Survey Event ID: LA1D11

Survey Types Recertification, Complaint Investig.

SUMMARY OF DEFICIENCIES

Level 4	**J**	**K**	**L**
Level 3	**G**	**H**	**I**
Level 2	**D** F0551 F0578 F0609 F0656 F0657 F0658 F0684 F0690 F0773 F0880 F0757	**E** F0550	**F**
Level 1	**A**	**B**	**C**