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: Regal Heights Healthcare & Rehab Center DATE SURVEY COMPLETED: July 24, 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 Follow-Up and Complaint Survey was conducted at this facility from July 23, 2025, through July 24, 2025. The survey process included observations, interviews, review of residents' clinical records and other documentation. The facility census on the first day of the survey was one hundred fifty-eight (158). The survey sample size totaled thirty (30) 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.** The facility was found to be in substantial compliance as of July 8, 2025. No deficiencies were identified at the time of the survey.		

Provider's Signature Sara J. Thompson, MHA Title Administrator Date 8/26/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING B. WING	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE , HOCKESSIN, Delaware, 19707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced Follow-Up and Complaint Survey was conducted at this facility from July 23, 2025, through July 24, 2025. The survey process included observations, interviews, review of residents' clinical records and other documentation. The facility census on the first day of the survey was one hundred fifty-eight (158). The survey sample size totaled thirty (30) residents. The facility was found to be in substantial compliance as of July 8, 2025.	E0000		08/08/2025
F0000	INITIAL COMMENTS An unannounced Follow-Up and Complaint Survey was conducted at this facility from July 23, 2025, through July 24, 2025. The survey process included observations, interviews, review of residents' clinical records and other documentation. The facility census on the first day of the survey was one hundred fifty-eight (158). The survey sample size totaled thirty (30) residents. The facility was found to be in substantial compliance as of July 8, 2025.	F0000		08/08/2025

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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