



**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**

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NAME OF FACILITY: Delaware Bay Rehab & Healthcare Ctr

DATE SURVEY COMPLETED: December 16, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	<p>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</p> <p>An unannounced Follow-Up and Complaint Survey was conducted at this facility from December 15, 2025, through December 16, 2025. The facility census on the first day of the survey was one hundred and eleven (111). The survey sample size totaled three (3) residents.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p>		
3201.1.0	<p><b>Scope</b></p>		
3201.1.2	<p>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</p> <p><b>This requirement is met as evidenced by:</b></p> <p>The facility was found to be in substantial compliance with 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities as of December 2, 2025.</p>		

Provider's Signature

Title

NHA

Date

12/22/2025

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>085029</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED <b>12/16/2025</b>	
NAME OF PROVIDER OR SUPPLIER <b>DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>110 W. NORTH STREET , GEORGETOWN, Delaware, 19947</b>			
(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	
F0000	<b>INITIAL COMMENTS</b>  An unannounced Follow-Up and Complaint Survey was conducted at this facility from December 15 , 2025, 2025 through December 16, 2025. The facility census on the first day of the survey was one hundred and eleven (111). The survey sample size totaled three (3) residents.  The facility was found to be in substantial compliance with 42 CFR Part 483, Subpart B Requirements for Long Term Care Facilities as of December 2, 2025.		F0000			12/29/2025	

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
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