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: Millcroft Living Nursing Home

DATE SURVEY COMPLETED: October 29, 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 Complaint survey was conducted at this facility from October 28, 2025, to October 29, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was ninety (90). The sample size totaled four (4) residents.		11/28/2025.
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed October 29, 2025: F658, F755 and F760.		

Provider's Signature Folarin Osundina Title Director of Nursing Date 12/16/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	**255 POSSUM PARK ROAD , NEWARK, Delaware, 19711**

(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	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from October 28, 2025 to October 29, 2025. The deficiencies contained in this report are based on interview, observations and review of facility and other documentation as indicated. The facility census on the first day of the survey was ninety (90). Abbreviations/definitions used in this report are as follows: ED - emergency department; EEG - electroencephalogram, a test that measures the electrical activity of the brain; eMAR - electronic medication administration record; encephalopathy - a medical term that refers to a state of brain dysfunction that can manifest as confusion, agitation, memory loss or behavioral changes; lorazepam - a benzodiazepam medication that is used to treat anxiety; LPN - Licensed practical nurse; MAR - medication administration record; mg - milligrams; MRI - magnetic resonance imaging, a medical imaging technique that uses magnets and computer-generated radio-waves to create detailed images of the organs and tissues of the body; NA - nurse's aide; PCP - primary care provider; RN - registered nurse; UA - unlicensed assistant.	F0000		11/26/2025
F0658 SS = E	Services Provided Meet Professional Standards	F0658	Corrective Action	11/28/2025

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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F0658 SS = E	Continued from page 1 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 four (R1, R2, R3, R4) out of four residents reviewed for admission, the facility failed to provide services that meet the professional standard of quality as defined by the Delaware State Code regarding RN (registered nurse), LPN (licensed practical nurse) and NA (nurse aide)/ UA (unlicensed assistant) Duties for admission assessments. Findings include: "Delaware State Board of Nursing – RN, LPN and NA/UAP Duties 2024 …Admission Assessments *… RN (registered nurse) … *Once a care plan is established, the LPN may do assessments." Updated 10/11/24 Facility Admission Assessment and Follow Up: Role of the Nurse policy included a document that listed all the evaluations in the facility EMR that were considered Admission Evaluations. The list included: N Adv- Clinical Admission, N Adv- Skin Check, N Adv- Braden scale- for Predicting Pressure Ulcer Risk Evaluation, N Adv- Lift/Transfer Evaluation, N Adv -Fall Risk Evaluation, N Adv -Dehydration Risk Evaluation, N Adv- Elopement Evaluation, Hot Liquids Safety Data Collection, Functional Abilities and Goals, LCS Bedrail Evaluation, Trauma Informed Care and Baseline Care Plan. 1. Review of R1's clinical record revealed: 8/5/25 – R1 was readmitted to the facility. 8/5/25 – E6 (LPN) documented and completed in R1's EMR the N Adv-Clinical Admission, N Adv-Braden Scale- for Predicting Pressure Ulcer Risk Evaluation, N Adv-Left/Transfer Evaluation, N Adv-Elopement Evaluation, Functional Abilities and Goals, and N Adv- Dehydration Risk Evaluation.	F0658	Continued from page 1 R1, R3, and R4 are no longer residents in this facility, R2 continues to reside in the facility. The facility is unable to correct the deficiency for R1, R3, and R4. Corrective actions have been ensured by the Director of Nursing for R2. A new set of admission assessment was completed for R2 by a registered nurse. The Director of Nursing has completed staff education for all nursing staff members on the Delaware state code regarding Registered Nurse, Licensed practical nurse, Nurse aide/Unlicensed assistant duties for admission assessments and other assessments. Identification of other Residents All of our residents have the potential to be affected by this deficiency. The Director of Nursing or his designee will continue to communicate to nursing staffs the role and scope of practice of each license group when it comes to providing care to the residents. System Changes The Root Cause of the concern was the failure of the facility to have a registered nurse complete all of R1, R2, R3, and R4's admission assessments. The facility policy for "Comprehensive assessment and the care delivery process" (rev. 12.2016) was reviewed and found to meet professional standards. The facility system for completing resident's assessments by nursing staffs has been updated to ensure that the admission assessments are completed by Registered Nurses only. The Licensed practical nurse will notify the Registered Nurse supervisor of any newly admitted resident on their assignment. The Director of Nursing or Designee will continue to educate all staff on licensed nurses' scope of practice and the Delaware State code pertaining to their duties for resident's admission assessments. The Director of Nursing or designee will provide oversight to ensure ongoing compliance. Success Evaluation An audit of all newly admitted residents was completed by the Director of Nursing to ensure compliance with completion of the admission assessments. Audits will continue to be completed by the Director of Nursing or Designee. Audits will have a goal of 100% compliance.	

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F0658 SS = E	Continued from page 2 The facility failed to have a registered nurse complete six of R1's admission evaluations. 2. Review of R2's clinical record revealed: 10/26/25 – R2 was admitted to the facility. 10/26/25 – E11 (LPN) documented and completed in R2's EMR the N Adv-Clinical Admission, N Adv-Braden Scale-for Predicting Pressure Ulcer Risk Evaluation, N Adv-Elopement Evaluation, N Adv- Fall Risk Evaluation and N Adv- Dehydration Risk Evaluation. The facility failed to have a registered nurse complete five of R2's admission evaluations. 3. Review of R3's clinical record revealed: 10/10/25 - R3 was admitted to the facility. 10/10/25 - 10/26/25 – E12 (LPN) documented and completed in R3's EMR the N Adv-Clinical Admission, N Adv-Trauma Informed Care, N Adv-Elopement Evaluation, N Adv- Fall Risk Evaluation, N Adv- Lift/Transfer Evaluation and N Adv- Dehydration Risk Evaluation. The facility failed to have a registered nurse complete six of R3's admission evaluations. 4. Review of R4's clinical record revealed: 10/4/25 – R4 was admitted to the facility. 10/4/25 - 10/26/25 – E6 (LPN) documented and completed in R4's EMR the N Adv-Clinical Admission, N Adv-Elopement Evaluation, N Adv- Fall Risk Evaluation, N Adv- Lift/Transfer Evaluation and N Adv- Dehydration Risk Evaluation. The facility failed to have a registered nurse complete five of R4's admission evaluations.	F0658	Continued from page 2 Audits will be completed daily until 100% compliance from Monday to Friday, and weekend admissions will be completed on the following Mondays for 4 weeks, then daily every other week until 100% compliance is achieved for 4 weeks. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

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F0658 SS = E	Continued from page 3 10/29/25 12:35 PM – During an interview, E2 (DON) confirmed that E6, E11 and E12 had completed several of the facility's admission evaluations. 10/29/25 1:45 PM- The findings were reviewed during the exit conference with E1(NHA), E2 (DON), E3 (RDOCS), E4 (RN/UM) and E5 (RN/UM).	F0658		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R1) out of four residents reviewed for	F0755	Corrective Action R1 is no longer a resident in the facility. The facility is unable to correct the deficiency for R1. The Director of Nursing has completed education for all nursing staff members, the facility Medical Director, and Pharmacy account manager on the timely acquiring and receiving of medication for residents. System changes are in place to prevent future occurrence. Identification of other Residents All Residents have the potential of being affected by this deficiency. No other residents were affected. The Director of Nursing or his designee will continue to ensure that all residents are provided pharmaceutical services in a timely manner. System Changes The Root Cause of the concern was the failure of the facility to provide timely pharmaceutical services that included acquiring and receiving medication (Lorazepam) to meet R1's needs. The facility policy for "Administering Medications" (rev. 04.2019) was reviewed and found to meet professional standards. The facility system for acquiring resident's medication on admission by nursing staffs has been updated to ensure that all medications are received in a timely manner. The admission nurse will notify pharmacy account manager of any new admission that is admitted to the hospital from our independent living section to effect a change in profile to make sure that medications are delivered to the right place. The MD will ensure that medication scripts are written with dosages to reflect what is in the facility's emergency box. The Director of Nursing or designees will provide oversight to ensure ongoing compliance.	11/28/2025

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F0755 SS = D	Continued from page 4 Pharmacy services, the facility failed to provide pharmaceutical services that included acquiring and receiving a medication (lorazepam) to meet R1's needs during her 8/5/25 admission. Findings include: Facility Pharmacy Information document stated, "Pharmacy Order Timeline – New Orders, Admission Orders or Refills ordered by 11 AM have a delivery window of 9 PM to 11 PM… Controlled Substances Orders – Controlled substances can only be sent upon valid script from a prescriber or a verbal order from a prescriber or an agent of the prescriber. (Note Agents of the prescriber may NOT order CII, only CII, CIV and CV.)" Issued Jan-2024 The U.S Drug Enforcement Agency (DEA) listed lorazepam as a Schedule VI medication. Drugs, substances, and certain chemicals used to make drugs are classified into five (5) distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. 15-Oct-2025 Review of R1's clinical record revealed: 8/5/25 11:59 AM – R1's [Hospital] Discharge summary documented, "… Medications at discharge… lorazepam 2 mg (milligrams) oral tablet, 1 tablet by mouth 2 times a day. Please contact PCP (primary care provider) for refill. 2 weeks sent to [pharmacy]…". 8/5/25 – R1 was readmitted to the facility with diagnoses including, but were not limited to, diabetes and anxiety disorder. 8/5/25 – C1 (DO) ordered lorazepam tablet 2 mg by mouth two times a day for anxiety for 14 days. 8/5/25 10:20 PM – E6 (LPN) documented in R1's EMR, "eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Medication not available." 8/6/25 9:39 AM – E7 (LPN) documented in R1's EMR, "eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Resident new admit, waiting for pharmacy to deliver."	F0755	Continued from page 4 Success Evaluation An audit of all newly admitted residents was completed by the Director of Nursing to ensure compliance with timely acquiring of all medication on admission. Daily audits for all new admissions will continue to be completed by the Director of Nursing or Designee for 4 weeks; Audits will always have a goal of 100% compliance; followed by every other day audits for two weeks; and then 2 times per week for 2 weeks. Audit goal is a 100% compliance. Additional audits will be completed as needed based upon the level of compliance. The results of the audits will be reviewed by the Quality Assurance Team.	

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F0755 SS = D	Continued from page 5 8/7/25 – C1 (DO) documented in R1's EMR Initial History and Physical note, "…History of Present Illness… At the time of my examination, the patient was out of bed sitting in her chair. She [R1] was focused on her lorazepam therapy that she apparently takes chronically for her anxiety. Apparently, a prescription was not sent from the hospital at time of admission, no documentation in her discharge summary indicates that it was sent…Diagnosis and Assessment: …Anxiety disorder- appears chronic in nature, concern regarding lorazepam therapy as patient previously hospitalized with encephalopathy secondary to benzodiazepine use, will reduce lorazepam dosing to 1 mg twice daily…". 8/7/25 2:56 PM – E8 (LPN) documented in R1's EMR, "eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Unit manager called pharmacy, meds (medication) will be delivered in (sic) the next shift." The facility failed to provide pharmaceutical services that assured that R1 received her medication (lorazepam) in a timely fashion to meet her needs. R1 went two days in the facility without her ordered lorazepam and missed four doses of this medication. 8/7/25 11:08 PM – E9 (RN) documented in R1's EMR, "Health Status note- resident seized and was sent to the hospital." 8/7/25 11:09 PM – E6 (LPN) documented in R1's EMR, "eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Medications was (sic) delivered at the time the patient was having a medical emergency and she could not swallow." 8/9/25 12:28 PM – Upon R1's re-admission to the facility, R1's [hospital] discharge summary stated, "Narrative Summary of hospital course - … 88 yo (year old) F (female) with pmh (past medical history) of anxiety… who returned from her nursing facility due to concern for witnessed seizure-like activity. Patient had missed a few doses of her chronic lorazepam for an unclear reason…She (R1) presented to the hospital with concern for seizure activity…".	F0755		

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F0755 SS = D	Continued from page 6 10/28/25 3:04 PM - During an interview, C4 (facility's pharmacy account manager) stated, "C5 (hospital discharging physician) escribed (electronically prescribed) the lorazepam order on 8/5/25 at 1:38 PM. It came to our pharmacy. The pharmacy did not have this patient residing in the SNF (skilled nursing facility). Their (R1's) profile was in the IL (independent living). We did not have any allergy information so we had to call the IL to get allergies. On 8/6/25, the facility called and was told there was no script (prescription). The script was associated with the IL. The problem was [R1] was profiled as residing in the IL, where she normally lives. The pharmacy did not know she had been to the hospital and was now in rehab at the SNF… We (pharmacy) typically try not to admit or move the patients in the profiles until they are actually in the facility as this creates an insurance reimbursement issue if the resident ends up not showing up at the facility… On 8/7/25, the facility got the MD (medical doctor) to fill out a new script. He (C1, DO) wrote for 1mg (milligram) of lorazepam BID (twice a day) but the formulation of lorazepam in the E box (emergency medication box) was 0.5 mg, the pharmacy could not release the medication. The script (prescription) has to match the drug formulation in the E box exactly or regulation or we cannot release the medication. So although there was lorazepam available in the facility, we could not release the medication. We needed the script to say lorazepam 0.5mg four tablets for a 2 mg dose in order to use the meds (medication) for the E box." 10/29/25 1:15 PM – During an interview, E10 (RN) stated that on 8/7, she had requested that C1 write a new script with the available formulation in the E box for the lorazepam, which was 0.5 mg but he [C1] said he had already written one for 1mg lorazepam. The facility failed to provide routine and emergency drugs to R1. 10/29/25 1:45 PM- The findings were reviewed during the exit conference with E1(NHA), E2 (DON), E3 (RDOCS), E4 (RN/UM) and E5 (RN/UM).	F0755		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F0760	"Past Noncompliance - no plan of correction required"	08/08/2025

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F0760 SS = G	Continued from page 7 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R1) out of four residents reviewed for pharmacy services, the facility failed to ensure R1 was free of a significant medication error. This failure resulted in a harm in which R1 seized and was transferred to the hospital on 8/7/25 with benzodiazepine withdrawal from missing four doses of lorazepam. Based on a review of the facility's corrective actions taken and completed on 8/8/25 at 11:20 PM, it was determined that this incident was past non-compliance. Findings include: 8/5/25 11:59 AM – R1's [Hospital] Discharge summary documented, "... Medications at discharge... lorazepam 2 mg (milligrams) oral tablet, 1 tablet by mouth 2 times a day. Please contact PCP (primary care provider) for refill. 2 weeks sent to [pharmacy]...". 8/5/25 – R1 was readmitted to the facility with diagnoses including, but were not limited to, diabetes and anxiety disorder. 8/5/25 – C1 (DO) ordered lorazepam tablet 2 mg by mouth two times a day for anxiety for 14 days. 8/5/25 10:20 PM – E6 (LPN) documented in R1's EMR, "eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Medication not available." 8/6/25 9:39 AM – E7 (LPN) documented in R1's EMR, "eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Resident new admit, waiting for pharmacy to deliver." 8/7/25 – C1 (DO) documented in R1's admission "History and Physical note- ... History of Present Illness-... She [R1] was focused on her lorazepam therapy that she apparently takes chronically for anxiety. Apparently, a prescription was not sent from the hospital at the time of admission, no documentation in her discharge summary indicates that it was sent...Diagnosis and Assessment: ...Anxiety disorder -...concern regarding lorazepam therapy	F0760		

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F0760 SS = G	Continued from page 8 as patient previously hospitalized with encephalopathy (a condition that causes brain disfunction) secondary to benzodiazepine use…". 8/7/25 2:56 PM – E8 (LPN) documented in R1's EMR, "eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Unit manager called pharmacy, meds (medication) will be delivered in (sic) the next shift." 8/7/25 11:08 PM – E9 (RN) documented in R1's EMR, "Health Status note- resident seized and was sent to the hospital." 8/7/25 11:09 PM – E6 (LPN) documented in R1's EMR, "eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Medications was (sic) delivered at the time the patient was having a medical emergency and she could not swallow." 8/8/25 11:57 AM – C2 (hospital NP) documented in R1's hospital EMR, "…Chief complaint- seizure -like activity without history… History of present Illness: …Upon chart review, it is noted that it was recommended that the patient be weaned off lorazepam. Patient [R1] states that she has not received any lorazepam since returning to the facility as they have been 'out of it'. Patient presents to the ED (emergency department) from a skilled nursing facility with witnessed seizure-like activity. Patient has no history of prior seizures. Patient states that she has been taking lorazepam for 20 years, her physician recently retired and the practice has been taken over by another physician. She states that there had been a discussion about weaning off of her lorazepam, but she wants to fire the doctor because she does not feel she should be weaned off…". 8/8/25 1:54 PM – C3 (hospital MD) documented in R1's EMR neurology consult, "…Assessment/Plan: …New onset seizure- suspected secondary to holding Ativan (lorazepam) (has been on ativan for many years and missed several days of dose)…". The facility self-identified this issue and took the following corrective actions:	F0760		

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(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
F0760 SS = G	Continued from page 9 - Educated staff members on the rights of medication administration - Enacted daily audits of all new admission patients for medication supply at the Monday to Friday morning clinical meetings - Educated staff members on the process to follow if medication is not available - Tasked admission staff with confirming all new admission patients come from the discharging facility with necessary prescriptions, that the prescription was sent to their facility pharmacy and confirm with the facility pharmacy that he prescription was received - Tasked [facility pharmacy] with notifying the facility for any new admission medication that requires a prescription and the prescription was not sent directly from the discharging facility - Educated staff members that the providers are to be informed immediately for a recognized failure in obtaining necessary medication - Educated the providers that prescriptions for medications from the Emergency supply box(E Box) must be written in the exact formulation of the drug supplied in the emergency supply box. The facility alleged that all these corrective actions were completed by 8/8/25 at 11:20 PM. The surveyor confirmed education with staff during interviews. 8/9/25 – R1 was re-admitted to the facility after hospitalization. 8/11/25 – C1 (DO) documented in R1's EMR re-admission "History and Physical note- … History of Present Illness- … The patient was readmitted there [hospital] with reported seizure-like activity. There appeared to be some issues obtaining patient's chronic benzodiazepine therapy from the pharmacy in a timely fashion at the time of admission. She apparently went 48 hours without a dose of her lorazepam therapy. Workup at the hospital was largely unremarkable and included EEG monitoring and MRI imaging. She was evaluated by the neurology team who recommended ongoing benzodiazepine therapy without changes at this time…Diagnosis and Assessment: Seizure- appears to be related to benzodiazepine withdrawal".	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085021	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENCORE AT WEST MEADOW	255 POSSUM PARK ROAD , NEWARK, Delaware, 19711

(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
F0760 SS = G	Continued from page 10 8/14/25 – C1 (DO) documented in R1's EMR progress note, "…Diagnosis and Assessment: Benzodiazepine dependence-secondary to prolonged use of high-dose lorazepam therapy, resulting in withdrawal seizure requiring hospitalization…". 10/29/25 9:45 AM – A review of R1's MAR revealed the 8/5/25 8PM, 8/6/25 9 AM and 8/7/25 9 AM lorazepam doses were documented as not given/ see nurses notes. The 8/6/25 8 PM lorazepam dose did not have any documentation in the MAR or progress notes regarding this medication. 10/29/25 10:39 AM – During an interview, E2 (DON) confirmed that R1 did not receive any doses of lorazepam from 8/5/25 to 8/7/25. 10/29/25 1:45 PM- The findings were reviewed during the exit conference with E1(NHA), E2 (DON), E3 (RDOCS), E4 (RN/UM) and E5 (RN/UM).	F0760		