

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/12/2025
NAME OF PROVIDER OR SUPPLIER  Excelcare at Wilmington LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6th Street Wilmington, DE 19805	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0646</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the appropriate authorities when residents with MD or ID services has a significant change in condition.</p> <p>Based on record review and interview, it was determined that for one (R1) out of nine residents reviewed for resident rights, the facility failed to initiate a PASARR (Pre-admission Screening and Resident Review) review when R1 was started on a new anti-psychotic medication. Findings include: 7/5/23 - R1's PASARR determined that R1 required a PASARR level II without specialized services. 7/7/23 - R1 admitted to the facility with a diagnoses, including but was not limited to, bipolar disorder. 1/19/24 - Delusional disorder was added to R1's diagnoses list as evidenced by dates on R1's facility facesheet. This diagnosis was not documented on R1's 7/5/23 PASARR evaluation. 3/6/25 - C1 (psychiatrist) documented in R1's progress notes, .Patient on Zyprexa (olanzapine) for off-label use was discontinued. 8/21/25 - C1 ordered Rexulti (an atypical anti-psychotic medication) 2mg (milligrams) by mouth at bedtime for delusional disorder. The facility failed to request a new PASARR evaluation when R1's behaviors significantly escalated and he began to exhibit delusional behavior, which required a new psychiatric medication. 9/29/25 3:20 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON), E3 (Regional Director of Operations), E4 (Regional Director of Clinical Services) and E5 (ADON).</p>

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/12/2025
NAME OF PROVIDER OR SUPPLIER  Excelcare at Wilmington LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 2801 W. 6th Street Wilmington, DE 19805	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  085002	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/12/2025
NAME OF PROVIDER OR SUPPLIER  Excelcare at Wilmington LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  2801 W. 6th Street Wilmington, DE 19805	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and Interview, it was determined that for two (R1 and R2) out of nine residents reviewed for resident rights, the facility failed to ensure the medical records were in accordance with professional standards by being accurate. 1. Review of R1's clinical record revealed:7/7/23 - R1 was admitted to the facility with diagnoses, including bit was not limited to, bipolar disorder.8/29/25 11:45 AM - From reading the facility's investigation report, there was a heated interaction between R1 and R4 during a room change. 8/29/25 2:53 PM - E8 (LPN) documented in R1's progress notes, Incident note: Officer [name] responded to the facility and interviewed [R1]. No case number is being assigned at this time.8/29/25 - E8 (LPN) documented in R1's Behavior Monitoring Record under Psychotropic use target behavior: agitation. At the end of each shift note frequency- # of times behavior occurred. On 8/29/25 for dayshift, E8 documented 0 instances of agitated behavior.The facility failed to accurately document R1's behaviors on 8/29/25 dayshift. 9/22/25 3:29 PM - E5 (ADON) documented in R1's progress notes, Resident displayed aggressive behaviors both verbal and physical. Resident came out of his room towards a staff member who was standing in the nurse's station with a knife on his L (left) hand and started waving at the staff member. No triggers identified. Resident was unprovoked.9/22/25 - E7 (LPN) documented in R1's Behavior Monitoring Record under Psychotropic use target behavior: agitation. At the end of each shift note frequency- # of times behavior occurred. On 9/22/25 for dayshift, E7 documented 0 instances of agitated behavior.The facility failed to accurately document R1's behaviors on 9/22/25 dayshift. 9/26/25 10:45 AM - During a telephone interview, R4 stated that he was moving rooms on 8/29/25 before lunchtime, R1 came into his room as he was packing his belongings and was agitated and aggressive. R1 was telling him to get out of his room. R4 stated, [R1] backed me into the corner. R4 confirmed that he requested that the facility call the police on his behalf.2. Review of R2's clinical record revealed:9/10/25 - R2 was admitted to the facility with diagnoses, including but not limited to, stroke and aphasia (a language disorder that affects a person's ability to speak, understand, read and write). 9/10/25 - E6 (MD) ordered in R2's EMR, NPO (nothing per oral) diet, NPO texture, NPO consistency.9/11/25 3:37 AM - R2's EMR under the Tasks tab has documented a PO (per oral) intake of 120 mls (milliliters).9/13/25 1:41 AM - R2's EMR under the Tasks tab has documented a PO intake of 120 mls. 9/15/25 1:47 AM - R2's EMR under the Tasks tab has documented a PO intake of 360 mls.9/15/25 4:30 AM - R2's EMR progress note documented, .The resident noted alert, oriented, open eyes equally, pupils' equal round and reactive to light, nonverbal, but able to responds (sic) to questions been asked via gestures (nodding) to indicate understanding.9/15/25 10:50 PM - R2's EMR progress note documented, Patient alert and responsive but nonverbal.9/16/25 3:10 PM - R2's EMR health status note documented, Patient alert and responsive but nonverbal.9/17/25 2:21 AM - R2's EMR under the Tasks tab has documented a PO intake of 120 mls.The facility failed to ensure that R2's medical record was accurately documented. On four separate occasions, staff documented that R2 was drinking fluids when R2 was ordered to be NPO. 9/19/25 1:26 PM - R2's EMR health status note documented, .Observed the patient lethargic and slow to respond.9/19/25 4:55 PM - E9 (physician assistant) documented in R2's EMR, .He [R2] is awake and aphasic, able to nod or shake head for certain questions appropriately.Physical exam: .Neuro: .Speech clear. Labs: refer to chart. The facility failed to ensure that R2's medical record was accurately documented according to professional standards. Within the body of the same note, the provide [E9] documented that R2 was aphasic and able to nod or shake head to questions and that R2's speech was clear. 9/29/25 1:47 PM - During an interview, E2 (DON) stated that the CNAs documentation on the Tasks regarding PO (per oral) input was erroneous. When a patient is NPO, that task should be resolved so the CNAs do not document any PO intake. E2 also stated, He [R2] could shake his head yes or no to questions.he was nonverbal. Had verbal aphasia. E2 also stated that R2 was only here nine days and did not have any lab work during that time. The facility failed to ensure that R2's medical record was accurately documented as the provider [E9] in his 9/19/25 note referenced Labs : refer to chart; however there were no recent lab results from the last nine days in R2's chart. 9/29/25 3:20 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON), E3 (Regional Director of Operations), E4 (Regional Director of Clinical Services) and E5 (ADON).</p>		