STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. Building B. Wing	05/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regal Heights Healthcare & Rehab Center	6525 Lancaster Pike Hockessin, DE 19707

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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and policy review, the facility failed to protect the residents' right to be free of physical and/or sexual abuse for three of 13 residents (Resident (R)82, R140 and R23). R82 reviewed for abuse out of a total sample of 56. Resident (R)82 experienced physical abuse by R153, R140 experience sexual abuse by R48 and R23 experienced verbal abuse Certified Nurse Assistant (CNA) 28.The Findings Include:1. Review of R153's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia and depression. Review of R153's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 05/08/26 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated severely impaired cognition. Review of R153's Care Plan, initiated on 06/16/25 and located under the Care Plan tab of the EMR, revealed . The resident will not exhibit physical abuse more than twice per week for 90 days. Further review revealed the care plan was not updated after the December 2025 or March 2026 incident. Additionally, R153 was care planned prior to this for being verbally aggressive towards others and but there had been no updates since 2024. Review of R153's Nurses note, written on 06/14/25 by Registered Nurse (RN) 7 and located under the Notes tab of the EMR, revealed . Supervisor called to the unit following an altercation between R153 and her roommate R82. R153 was witnessed hitting her roommate while the roommate was laying down in bed. Staff immediately intervened. R153 was noted to be cursing at staff members but denied reasoning behind her actions. She was able to calm down. Room changes implemented. Staff reported R153 was calm moments prior when she approached staff at the desk and asked for a cup of water which was given to her. It was later noted that R153 had thrown the water on her roommate while she slept. Resident assessed, now calm. Review of R82's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia and depression. Review of R82's significant change MDS, with an ARD of 03/31/25 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15, which indicated no cognitive impairment. Review of R82's Nurses note, written on 06/14/25 by RN7 and located under the Notes tab of the EMR, revealed . R82 was noted being struck by roommate R153, while she slept in bed. Staff immediately intervened. R82 was initially concerned about roommates R153's behavior and kept (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stating I don't understand what I did to her. Denied pain. Small scratch to top of left hand noted. Area cleansed with NSS. No other injuries were noted. Nurse offered resident PRN medications and room change implemented. During an interview on 05/21/26 at 1:08 PM Licensed Practical Nurse (LPN) 21 stated R153 can be very unpredictable and will lash out with no warning. On 06/14/25 she was working when there was an incident with R153's roommate R82 at the time. She remembers R82 screaming after staff found R153 standing over R82 hitting her. During an interview on 05/21/26 at 3:47 PM RN7 stated she was the nurse manager working at the time of the incident that occurred on 06/14/25 between R153 and R82. She remembers staff coming to ger her after they observed R153 standing over R82 and hitting while she slept and the residents were immediately separated. 2. Review of R48's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia, and major depressive disorder. Review of R48's quarterly MDS, with an ARD of 05/07/26 and located under the MDS tab of the EMR, revealed a BIMS score of six out of 15, which indicated severely impaired cognition. Review of R48's Care Plan, initiated on 04/29/17 and located under the Care Plan tab of the EMR, revealed . The resident will have a decrease in behavior of making sexual comments or touching others. Further review revealed the care plan had not been updated with new interventions since 2017. Review of R140's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia. During an interview on 05/22/26 at 9:22 LPN25 said R48 will touches, grab and will violate women. He was unable to see but he would feel out. She said there was an incident when R48 grabbing R140's breasts and they were separated. She said it was documented in either progress notes or on the MAR, and the family was notified but she was unsure if it was reported to management. `3. Review of R23's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included anxiety and depression. Review of R23's quarterly MDS, with an ARD of 05/11/26 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15, which indicated no cognitive impairment. Review of the facility's 5 Day Follow Up, dated 01/22/26, revealed that a verbal exchange was witnessed by nursing staff. Further review revealed CNA28 was terminated after the incident. Review of statement written on 01/14/26 by LPN31 revealed she witnessed a verbal exchange between CNA28 and R23 that LPN31 described as escalated exchange of words after he asked for some ice. LPN31 further wrote that she witnessed CNA23 go behind R23 and yanked him to get him from the nurse's desk area and resident grabbed onto the nurse's desk resisting the move. An attempted phone interview was conducted on 05/22/26 at 12:28 with LPN31 but was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unsuccessful. During an interview on 05/19/26 at 1:05 PM R23 stated CNA28 came into his room and threw his covers back and was rude to him when he told her he was independent and did not need any ADL or incontinent care. He stated that CNA28 said something rude to him and left his room. He stated a few minutes later that her went to the nurse's station to request some ice and was waiting for the nurse when CNA28 told him she would get the ice but he declined. CNA28 at that time became upset and came behind him and grabbed his wheelchair and pulled him back so hard that he had to grab ahold of the nurse's station. During an interview on 05/22/26 at 11:28 AM the Director of Nursing (DON) said all residents should feel safe and be kept safe and free from any resident-to-resident abuse. She stated she was unaware of R153 attacking R82 or R48 sexually fondling R140 or any other female residents. During an interview on 05/22/26 at 11:58 AM the Administrator stated she was unaware of any current issues with R48 or R153. She stated it was the facility's responsibility to ensure all residents were safe and free from any type of sexual fondling or physical aggression. She further stated she was unable to recall if she was aware of the incident that occurred on 06/14/25 with R153 and R82 or that staff observed R48 sexually fondling R140 or any other residents. Review of the facility's policy titled, Abuse Investigation and Reporting, dated July 2017, revealed, The Administrator will ensure that any further potential abuse, neglect, exploitation, or mistreatment is prevented .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to: 1.) report incidents and/or allegations of resident to resident physical and/or sexual abuse to the Administrator within two hours for three of 17 sampled residents (Resident (R) 82, R136, and R55) reviewed for abuse out of a total sample of 56, and 2.) report injuries of unknown origin to the State Survey Agency (SSA) for one of four residents (R34) reviewed for accidents out of a total sample of 56. This had the potential to allow for continued abuse.Findings Include:1. Review of R153's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia and depression. Review of R153's quarterly Minimum Data Set (MDS),with an assessment reference date (ARD) of 05/08/26 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated severely impaired cognition. a. Review of R82's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia and depression. Review of R82's significant change MDS, with an ARD of 03/31/25 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15, which indicated no cognitive impairment. Review of R153's Nurses note, written on 06/14/25 by Registered Nurse (RN) 7 and located under the Notes tab of the EMR, revealed, . Supervisor called to the unit following an altercation between [R153] and her roommate [R82]. [R153] was witnessed hitting her roommate while the roommate was laying down in bed. Staff immediately intervened. [R153] was noted to be cursing at staff members but denied reasoning behind her actions. She was able to calm down. Room changes implemented. Staff reported [R153] was calm moments prior when she approached staff at the desk and asked for a cup of water which was given to her. It was later noted that [R153] had thrown the water on her roommate while she slept. Resident assessed, now calm . During an interview on 05/21/26 at 1:08 PM, LPN21 stated on 06/14/25 she was working when there was an incident with R153's roommate at the time, R82. LPN21 stated she remembered R82 screaming after staff found R153 standing over R82 hitting her. LPN21 stated she reported it to the nurse supervisor. During an interview on 05/21/26 at 3:47 PM, RN7 stated she was the nurse manager working at the time of the incident that occurred on 06/14/25 between R153 and R82. RN7 stated she remembered staff coming to ger her after they observed R153 standing over R82 and hitting R82 while she slept, and the residents were immediately separated. RN7 stated she did not remember if she reported it but she should have. RN7 stated she thought she did but was unsure to whom it was reported. b. Review of R136's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia and anxiety disorder. Review of R136's quarterly MDS, with an ARD of 12/09/25 and located under the MDS tab of the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EMR, revealed a BIMS score of 15 out of 15, which indicated no cognitive impairment. Review of R136's Nurse's Note, dated 12/31/25 at 11:12 PM, written by LPN22, and located under the Notes tab of the EMR, revealed, . While doing oncoming rounds, upon exiting a resident's room, an aide came down the hall telling me [R136] reports to have been hit by her roommate, [R153]. Upon entering the room, this resident was seen lying in bed, when asked what took place, she states she attempted to pull the privacy curtain between both beds because the light on the other side of the room was too bright and bothering her, when her roommate started hitting her on her arm. Incident reported to RN supervisor . c. Review of R55's admission Record, located under the Profile tab of EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included anxiety disorder and major depressive disorder. Review of R55's quarterly MDS, with an ARD of 03/12/26 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15, which indicated no cognitive impairment. Review of R153's Nurse's Note, dated 3/17/26 at 2:07 PM, written by LPN24, and located under the Notes tab of the EMR, revealed, . [R153] hit roommate, [R55] in the chest. [R55] was moving the phone cord, and [R153] struck her in the chest. After, she started throwing things across the room. DON and Unit manager notified. During an interview on 05/22/26 at 9:03 AM, LPN24 stated R55 told her that she was trying to move the phone cord when R153 started yelling and hit R55 in the chest. LPN24 stated when she went into the room, R153 was still yelling and there were items that had been thrown on the floor. LPN24 stated she said the unit manager at the time had her write a progress note about the incident, but she did not report it. LPN24 stated she assumed the unit manger did. 2. a. Review of R48's admission Record, located under the Profile tab of EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia, and major depressive disorder. Review of R48's quarterly MDS, with an ARD of 05/07/26 and located under the MDS tab of the EMR, revealed a BIMS score of six out of 15, which indicated R48 was severely cognitively impaired. b. Review of R140's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia. Review of R140's quarterly MDS, with an ARD of 03/25/25 and located under the MDS tab of the EMR, revealed a BIMS score of 04 out of 15, which indicated severe cognitive impairment. Review of R48's Medication Administration Record (MAR), for the period from August 2025 until May 2026 revealed a total of six documented incidents of sexual inappropriate behavior towards others. The last date documented occurred on 05/07/26. There was no documentation to show which residents had been affected by R48's sexual inappropriate behaviors. During an interview on 05/22/26 at 9:22, LPN25 stated there was an incident when R48 was in his wheelchair and she heard a female resident screaming and she observed R48 feeling on the resident's breasts. LPN25 stated she could not remember who the resident was and she did not report it. LPN25 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated she assumed other staff that observed it reported it. LPN25 stated she did remember observing R48 grabbing R140's breasts, and the residents were separated. LPN25 stated the incident was documented in either progress notes or on the MAR, and the family was notified. She stated she was unsure if it was reported to management. Review of facility reportable log revealed none of the incidents involving R153 or R48 had been reported. During an interview on 05/22/26 at 10:15 AM, the Social Services Director (SSD) stated she was unaware of any incidents involving residents in the last year or longer and was confident if there had been any issues involving residents, she would have been made aware of it. The SSD stated she would expect staff to report any behaviors they observed and document on the MAR. The SSD stated she was unaware there were any documented sexual inappropriate behaviors that had been documented on the MAR or that staff had observed R48 fondling female residents. During an interview on 05/22/26 at 11:28 AM, the Director of Nursing (DON) stated staff should immediately report any physical aggression between residents or sexually inappropriate behaviors to their supervisor. The DON stated when one or more staff were aware of the same incident, she would expect both staff to report the incident. During an interview on 05/22/26 at 11:58 AM, the Administrator stated she was unaware of any current issues with R48 or R153, and she confirmed that none of the incidents involving these resident-to-resident incidents of physical and sexual abuse had been reported. The Administrator stated it was the responsibility of the facility to follow their abuse protocol and ensure the safety of all residents. Review of the facility's policy titled, Abuse Investigation and Reporting, dated July 2017, revealed,. all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state, and federal agencies (as defined by current regulations) . 3. Review of R34's admission Record, located under the Profile tab of the EMR, revealed R34 was admitted to the facility on [DATE] with diagnosis of dementia with behavioral disturbance, type 2 diabetes, and repeated falls. Review of R34's quarterly MDS, with an ARD of 02/23/26 and located under the MDS tab of the EMR, revealed a BIMS score of zero out of 15, which indicated that her cognitive function was severely impaired. Review of R34's Care Plan, initiated on 05/21/26 and located under the Care Plan tab of the EMR, revealed R34 was dependent on staff for leisure involvement and required prompting and encouragement to engage. It also revealed R34 had dementia, constant re-direction was needed, had a very short attention span in groups, and strolled around the unit. Review of the incident report dated 01/26/26 at 5:30 AM, reported by RN3, revealed R34 was noted with a bruise of unknown origin to her right shin. R34 was noted with a gray bruise to the right shin measuring 6.0 centimeters (cm) by 4.0 cm with a maroon-red line through the center of the gray bruise. R34 was unable to state the reason for the bruise. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the document titled, CNA Statement, dated 01/26/26, revealed that R34 was asleep in bed prior to finding the bruise of unknown origin. The document was not signed by any staff member. Review of the incident report dated 11/06/25 at 8:00 PM, reported by LPN12, revealed during activities of daily living (ADL) care, CNA 16 noticed bruises to R34's right breast and left upper arm. R34 was also noted with a contusion to her left great toenail. Review of the document titled, Wound Notification, dated 11/06/25 revealed that LPN12 assessed R34 and found a bruise on the right outer breast and left arm measuring a length of 4.2 cm by width of 3.2 cm. The bruises were noted to be of unknown origin. Review of the document titled Staff Statement, dated 11/06/25 by LPN12, stated During ADL care, staff noticed bruises to resident's right breast and left upper arm. Resident had no idea what had happened to her breast or to her arm. Her breast was noted to be purple in nature and left upper arm seems to be purple also. Resident grimaced when breast was touched and stated, it hurts. During an interview on 05/21/26 at 3:49 PM, the Administrator stated the facility found no documented evidence that R34's injuries of unknown origin had been reported to the SSA. Review of the facility policy titled, Investigating Resident Injuries, on page one of two, stated, . All resident injuries are investigated and on page one of two under item seven, stated, If the nursing and medical assessment determines an injury of unknown source the investigation will follow the protocols set forth in our facility's established abuse investigation guidelines.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, document review, and policy review, the facility failed to investigate: 1.) incidents of resident to resident physical and/or sexual abuse for three of 17 sampled residents (Resident (R) 82, R136, and R55) reviewed for abuse out of a total sample of 56 after R153 physically assaulted R82, R136, and R155; 2.) injuries of unknown origin for one of three residents (R34) reviewed for accidents out of a total sample of 56; and 3.) a potential incident of neglect for one of three residents (R172) reviewed for accidents out of a total ample of 56. These failures placed residents at continued risk of abuse and neglect.Findings Include: 1. Review of R153's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia and depression. Review of R153's quarterly Minimum Data Set (MDS),with an assessment reference date (ARD) of 05/08/26 and located under the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 00 out of 15, which indicated severely impaired cognition. a. Review of R82's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia and depression. Review of R82's significant change MDS, with an ARD of 03/31/25 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15, which indicated no cognitive impairment. Review of R153's Nurses note, written on 06/14/25 and located under the Notes tab of the EMR, revealed, . Supervisor called to the unit following an altercation between [R153] and her roommate [R82]. [R153] was witnessed hitting her roommate while the roommate was laying down in bed. Staff immediately intervened. [R153] was noted to be cursing at staff members but denied reasoning behind her actions. She was able to calm down. Room changes implemented. Staff reported [R153] was calm moments prior when she approached staff at the desk and asked for a cup of water which was given to her. It was later noted that [R153] had thrown the water on her roommate while she slept. Resident assessed, now calm . b. Review of R136's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia and anxiety disorder. Review of R136's quarterly MDS, with an ARD of 12/09/25 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15, which indicated no cognitive impairment. Review of R136's Nurse's Note, dated 12/31/25 at 11:12 PM and located under the Notes tab of the EMR, revealed, . While doing oncoming rounds, upon exiting a resident's room, an aide came down the hall telling me [R136] reports to have been hit by her roommate, [R153]. Upon entering the room, this resident was seen lying in bed, when asked what took place, she states she attempted to pull the privacy curtain between both beds because the light on the other side of the room was too bright and bothering her, when her roommate started hitting her on her arm. Incident reported to RN supervisor . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Review of R55's admission Record, located under the Profile tab of EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included anxiety disorder and major depressive disorder. Review of R55's quarterly MDS, with an ARD of 03/12/26 and located under the MDS tab of the EMR, revealed a BIMS score of 15 out of 15, which indicated no cognitive impairment. Review of R153's Nurse's Note, dated 3/17/26 at 2:07 PM and located under the Notes tab of the EMR, revealed, . [R153] hit roommate, [R55] in the chest. [R55] was moving the phone cord, and [R153] struck her in the chest. After, she started throwing things across the room. DON and Unit manager notified. 2. a. Review of R48's admission Record, located under the Profile tab of EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia, and major depressive disorder. Review of R48's quarterly MDS, with an ARD of 05/07/26 and located under the MDS tab of the EMR, revealed a BIMS score of six out of 15, which indicated R48 was severely cognitively impaired. b. Review of R140's admission Record, located under the Profile tab of the EMR, revealed the resident was admitted to the facility on [DATE] with diagnoses which included unspecified dementia. Review of R140's quarterly MDS, with an ARD of 03/25/25 and located under the MDS tab of the EMR, revealed a BIMS score of 04 out of 15, which indicated severe cognitive impairment. Review of R48's Medication Administration Record (MAR), for the period from August 2025 until May 2026 revealed a total of six documented incidents of sexual inappropriate behavior towards others. The last date documented occurred on 05/07/26. There was no documentation to show which residents had been affected by R48's sexual inappropriate behaviors. During an interview on 05/22/26 at 9:22, Licensed Practical Nurse (LPN) 25 stated she did remember observing R48 grabbing R140's breasts, and the residents were separated. LPN25 stated the incident was documented in either progress notes or on the MAR, and the family was notified. During an interview on 05/22/26 at 11:28 AM, the Director of Nursing (DON) stated any incident of a resident sexually groping another resident or physical assaults would immediately initiate an investigation, and staff should ensure that the residents involved along with all other residents were safe. She stated staff should have monitored the aggressor resident's behaviors and taken statements from anyone in the general area and continued monitoring until they had completed the investigation and decided if abuse occurred. During an interview on 05/22/26 at 11:58 AM, the Administrator was asked to provide the investigative files for the incidents of physical and sexual abuse. She confirmed that none of the incidents involving these resident-to-resident incidents of physical and sexual abuse had been investigated. The Administrator stated it was the responsibility of the facility to follow their abuse protocol and ensure the safety of all residents. Review of the facility's policy titled, Abuse Investigation and Reporting, dated July 2017, revealed,. all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. Building B. Wing	05/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regal Heights Healthcare & Rehab Center	6525 Lancaster Pike Hockessin, DE 19707

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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and/or injuries of unknown source (abuse) shall be . thoroughly investigated by facility management . The Administrator will ensure that any further potential abuse, neglect, exploitation, or mistreatment is prevented . Review of the facility policy titled, Investigating Resident Injuries, on page one of two, stated, . All resident injuries are investigated and on page one of two under item seven, stated, If the nursing and medical assessment determines an injury of unknown source the investigation will follow the protocols set forth in our facility's established abuse investigation guidelines. 3. Review of R172's quarterly MDS with an ARD of 09/09/25, located under the MDS tab of the EMR, revealed R172 had a BIMS score of zero out of 15, which indicated he was severely cognitively impaired. Review of R172's Progress Notes located under the Prog Notes tab of the EMR dated 09/28/25 at 11:35 AM, revealed the following documentation, Writer was called to resident's room by nurse to assess resident. Writer walked in resident room and observed resident on floor lying on his back. CNA giving care stated that while she was giving the resident care the resident fell off of his bed. Writer assessed resident no bruises and no injuries noted. V/S [vital signs] recorded and within normal ref [reference] range. POA [power of attorney] and MD [medical doctor] on-call notified. MD agreed to send resident to hospital to rule out head injury. Review of R172's hospital records, dated 09/28/25, provided by the facility, revealed R172 had imaging studies and had no injuries. Review of the intake form, provided by the facility and submitted to the State Agency (SA), regarding a fall without injury for R172, revealed the report was submitted to the SA on 09/28/25 at 1:28 PM. Review of the facility's investigative documentation, provided by the facility, dated 10/03/25, and submitted to the SA, indicated the conclusion, Resident is an [AGE] year old male here for continued care and follows with hospice services. Nursing staff report patient with a witnessed fall on 9/28/2025 and was sent to the emergency room for evaluation. Resident is seen today resting in bed in no acute distress. Resident with no visible signs of injury and his neurological status is at baseline. He was evaluated in the emergency room and per discharge orders patient CT [cat scan] scan head neck pelvis were negative for acute injury and chest x-ray was also negative. Resident with witnessed fall out of bed. Resident had been changed and treatment applied by nurse and CNA. Nurse had left room and CNA went to secure brief and turned resident in order to grab brief from underneath resident when resident moved his leg with heel boot on rotated over other leg [the CNA crossed one leg over the other one when turning the resident] and resident rolled out of bed onto fall mat. The investigation did not include the names of the CNA and nurse that cared for R172. The investigation did not include review of R172's care plan that identified R172 required the assistance of two staff for bed mobility and toileting and had a low air loss mattress. During an interview on 05/22/26 at 1:16 PM, the Director of Nursing (DON) reviewed the facility investigation and stated, I did not work here at the time of this incident. I am responsible for investigating incidents. The names of the staff involved should have been included in the investigation. The care plan should have been reviewed to identify that two people were required for repositioning and care. Neglect is not providing care that you know someone is supposed to have. This could be neglect. This was not a thorough investigation. Staff were not identified. Staff were not documented as suspended. It should tell the whole story. There was no perpetrator identified. If two (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	people were required, then two people should have been providing care the entire time. The plan of care should have been reviewed. Review of the facility's undated policy titled, Abuse Investigating and Reporting, indicated The individual conducting the investigation will, as a minimum: . review the resident's medical record to determine events leading up to the incident . Reporting. Notices will include, as appropriate: . the names of all persons involved in the alleged incident, and what immediate action was taken by the facility.