STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Healthcare & Rehab Center	801 N. Broom Street Wilmington, DE 19806

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that for one (R11) out of two residents reviewed for ADLs (Activities of Daily Living) and one (R27) out of six residents reviewed for abuse, the facility failed to follow the plan of care. For R11, a soiled and wet dressing was not changed per the physician's order. For R27, the facility failed to ensure re-admission orders on 6/28/25 were reviewed by on call provider and transcribed accurately. Findings include: 1. Review of R11's clinical record revealed: 6/19/25 - R11 was re-admitted to the facility and required assistance with personal care. 3/26/25 - A review of R11's quarterly MDS assessment revealed that R11 had intact cognition. 6/20/25 - R11 had a physician's order to cleanse the right wrist skin tear with NSS pat dry apply Xeroform (gauze dressing for wounds with drainage) and CDD daily and PRN (when necessary) every evening shift. 6/26/25 9:00 AM - During an observation, R11 was seen from the shower room being wheeled to the nurses' station by staff. R11 was observed with a soiled and soaked dressing on the right wrist dated 6/25/25. 6/26/25 9:05 AM - R11 was observed calling E6 (RN) who walked by and asked the nurse if he was getting a treatment on the skin tear. R11 stated, I just had a shower and showed E6 his right wrist. 6/26/25 9:06 AM - E6 was seen and heard responding to R11 saying, The dressing was changed yesterday (6/25/25) by the wound nurse. If you want it change, it is scheduled for the 3-11 shift so that will be done this afternoon. E6 was observed walking away leaving R11 in the Nursing station. 6/26/25 9:10 AM - In an interview, R11 told the surveyor that he thought the nurse [E6] would change his dressing. R11 further stated, I raised my wrist so she can see that the dressing was soiled, wet and needed to get changed. She [E6] said the afternoon staff will do it. She just walked away, you saw her! 6/26/25 9:30 AM - In a follow up observation, R11's right wrist was still noted with the same soiled and wet dressing. R11 told the surveyor, She [E6] is not going to do anything about this now. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/26/25 9:35 AM - During an interview, E2 (DON) confirmed that R11's skin tear dressing should be changed not just per schedule but also when it is visible wet or soiled. E2 further stated, . The nurse [E6] should change R11's soiled and wet dressing. 6/30/25 4:10 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 2. Review of R27's clinical record revealed: 6/28/25 7:10 PM - A nurse's note by E9 (LPN) documented, Resident returned from the ER [emergency room] . Discharge dx [diagnosis] provided by the ER was cellulitis [infection] at the PEG tube site . Bacitracin [antibiotic] ointment is to be applied topically to the PEG site twice daily for 10 days for cellulitis . 6/28/25 11:37 PM - A physician's order by E9 was entered in R27's electronic medical record as apply to Peg-site BID [twice a day] x [times] 10 days Dx Cellulitis every day and evening shift for Dx Peg-site cellulitis for 10 days. The facility failed to accurately transcribed the ER discharge order in R27's electronic medical record. 7/1/25 10:30 AM - During an interview, R27 reported that nursing staff on the previous night shift was not aware of the new physician's order for her Peg tube area. 7/1/25 1:15 PM - During an interview, E9 (LPN) confirmed that he entered R27's physician's order for Bacitracin ointment. E9 confirmed that he did not review the ER discharge order with the facility's on-call provider before entering it in her medical record. 7/1/25 2:50 PM - During an interview, E11 (RN/House Supervisor) confirmed that she did not review or handle R27's readmission on [DATE] as E9 (LPN) stated that he would take care of it. E11 confirmed the facility's process when readmitting a resident from the ER/hospital to call the facility's on-call provider, review the discharge orders with the provider then enter the orders in the resident's electronic health record. 7/1/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E7 (RN Regulatory Nurse) and E8 (Clinical Services).

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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 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review, it was determined that for one (R73) out of two residents reviewed for dental, the facility failed to provide the opportunity for follow up dental services. Findings include: Review of R73's clinical record revealed: 2/11/23 - R73 was admitted to the facility with diagnoses including dementia. 10/13/24 - A review of P1's (Dental) Report of Consultation documented, . Pt [R73] refused dental exam and treatment today .Recommendation: Pt would need pre-sedation prior to further treatment or dental exam. A handwritten note was also noted on the same consultation report documenting, . check oral cavity for follow up need .resident need a follow up, nursing to make apt (appointment). 11/19/24 - R73 had a physician's order to consult dental for evaluation and treatment as indicated. 11/25/24 - R73's annual MDS assessment revealed that his cognition was moderately impaired. 6/24/25 - During a telephone interview, FM1 (Family Member) stated, Dad [R73] never had any dental consults since last year. I was not notified. Last time I saw him, his teeth looked like never been cleaned by the dentist for a year now. 6/26/25 2:00 PM - In an interview, E1 (NHA) confirmed that R73's follow up dental appointment was not done until today and that [P1] will see him later today. 6/30/25 4:10 PM - Findings were reviewed with E1 (NHA) and E2 (DON).