STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085015	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seaford Center	1100 Norman Eskridge Highway Seaford, DE 19973

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview it was determined that for two (R26 and R50) out of three residents reviewed for personal property the facility failed to provide reasonable protection of resident belongings from loss. Findings include: The facility policy on personal property last updated 8/15/23 indicated Personnel will identify and record the patients/residents' belongings upon admission to the Center. All items bought into the Center will be listed on the Inventory of Personal Effects form and kept in the patient's clinical chart. Any additional items brought into the Center after admission must be added to this list. Any loss will be documented on the property loss form and then referred to the Administrator. 1. Review of R26's clinical record revealed: 6/4/25 - A quarterly MDS assessment documented that R26 was mentally intact. 9/2/25 11:10 AM - During an interview, R26 disclosed he had several items of clothing missing. R26 stated, I have five sweatpants, one hoodie, two sweatshirts, four t-shirt's gone. R26 stated staff said they were looking into it, the lady across from desk said that but it's been a couple weeks, and I haven't heard anything. 9/3/25 - Review of an undated inventory list for R26 was absent of any record of the residents clothing. All areas for documenting clothing were blank. 9/4/25 12:44 PM - During an interview, E8 (CNA) confirmed that R26 had reported missing clothing, a few weeks ago and that a property loss form was not created. E8 stated, We just check the lost and found. The surveyor then accompanied E8 to the unit's lost and found area and located one pair of sweat paints labeled with R26's name. E8 confirmed them as belonging to R26. 9/4/2025 12:56 PM - During an interview, E9 (RN) unit manager confirmed that R26 said he had missing clothing and the staff located a gray sweater and gray pants. E9 confirmed that staff did not complete a property loss form for R26 and that the inventory belonging list should be completed on admission and updated whenever new items are provided, E9 reported R26 had several belongings including a cell [phone], clothing, clippers and maybe some sunglasses. R26's inventory list lacked documentation regarding any of those belongings. 2. Review of R50's clinical record revealed: (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/7/19 - R50 was admitted to the facility. 7/24/25 – A quarterly MDS documented a BIMS of 15, and that R50 was cognitively intact 9/2/25 12:22 PM - R50 stated shirt, pants, underwear, and a cowboy jersey are missing, 9/2/25 12:25 PM – During an observation, no underwear and no cowboy jersey were located in the resident's room. Observed one shirt, two pairs of pants, and a sweatshirt. 9/4/25 2:30 PM - E4 (Housekeeping director) confirmed that he was going to buy R50 some clothes. 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview, record review, and review of other facility documentation, it was determined that for one (R50) out of one resident reviewed for grievances, that the facility failed to ensure prompt efforts were made to resolve the resident's concerns. Findings include:Review of R50's clinical record revealed:3/7/19 - R50 was admitted to the facility. 5/4/24 2:30 PM - A grievance/concern log documented that R50 stated he was unsure where the clothing could have gone, it is possible that the laundry misplaced the clothing. On May 7, 2024, E4 (housekeeping Director) checked the laundry room and did not find any missing clothing.7/24/25 - A quarterly MDS documented a BIMS of 15, and that R50 was cognitively intact9/2/25 12:22 PM - During an interview, R50 stated, my underwear, shirts, pants, and cowboy jersey were missing. 9/4/24 2:30 PM - During an interview with E4 he stated he was going today to buy R50 some clothes.9/4/24 2:45 PM - An interview with E3 (Quality Manager) confirmed the facility lacked evidence of a prompt response/resolution for R50's missing shirt, pants, underwear, and a cowboy jersey that was reported on 5/4/24.9/5/25 12:50 PM - E6 (NPE) stated in an interview that if a resident reports a missing item, E6 will complete a grievance log, interview the resident, and obtain written statements from the involved staff. The grievance documentation will then be submitted to the NHA.9/9/25 2:00 PM - Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, it was determined that for three (R4, R28 and R74) out of three residents reviewed for a level II PASRR, the facility failed to ensure that a referral for a level II PASRR screening was required following a new diagnosis for a mental health disorder. Findings include:1. Review of R4's clinical record revealed: 5/9/25 - A notice of PASRR level I screening outcome documented the following mental health diagnoses: major depression (recurrent, unspecified), anxiety disorder (suspected), 6/7/25 - R4 was admitted to the facility with diagnoses including but not limited to, bipolar disorder, anxiety disorder and depression. 6/8/25 - A care plan documented that R4 was at risk for complications related to the use of psychotropic drugs for depression and is at risk for distressed/fluctuating mood symptoms related to depression. 6/9/25 - An initial psychiatric evaluation documented depressed mood and listed the following medications for depression: doxepin 25 mg daily at bedtime, lurasidone 20 mg daily, sertraline 75 mg daily. 6/25/25 - In the electronic chart under active diagnoses, it was documented that R4 had the following diagnoses: bipolar disorder and depression. 7/26/25 - A re-admission five-day MDS assessment documented that R4 had a diagnoses of bipolar disorder and depression. 9/3/25 1:30 PM - During an interview E3 (Quality Manager), confirmed that R4 required a referral for a Level II PASRR due to a new onset of depression and bipolar disorder in June 2025, and acknowledged that the referral should have been completed but was not. 9/4/25 10:04 AM - During an interview, E7 (Social Worker Director) confirmed that R4 required a referral for a level II PASRR. 2. Review of R74s clinical record revealed: 1/26/10 - R74 was admitted to the facility with diagnosis including but not limited to, generalized anxiety disorder. 10/9/24 - A PASRR level I screening outcome review documented a mental health diagnosis of anxiety disorder. 5/19/25 - An admission record documented a new onset diagnosis of major depressive disorder. 6/15/25 - A care plan revision documented resident will demonstrate improved mood state .by the next review. 8/14/25 - A significant change MDS documented, active diagnoses of major depressive disorder and (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	schizophrenia. 9/3/25 - During an interview, E3 (Quality Manager), confirmed that R74 required a referral for a Level II PASRR due to a new onset of major depressive disorder in May and acknowledged that a referral should have been completed but was not. 9/4/25 10:04 AM - During an interview, E7 (Social Worker Director) confirmed that R74 required a referral for a level II PASRR. 3. Review of R28's clinical record revealed: 10/12/19 – R28 was admitted to the facility. 2/15/25 – A facility's electronic charting system documented under active diagnosis new diagnosis of depression for R50. 6/9/25 – R28's quarterly MDS documented a new diagnosis of depression. 9/3/25 2:00 PM - An interview was conducted with E6 (SW), who confirmed that she did not have access to the facility's electronic system to place a referral for a PASRR Level II. E6 also confirmed that a PASRR Level II was not completed for the new diagnosis of depression. 9/3/25 2:44 PM - During an interview, E3 (Quality Manager) stated that an internal audit was initiated in August for all residents requiring a referral for a PASRR Level II. E3 confirmed that no PASRR Level II had been completed in response to the new diagnosis of depression. 9/9/25 2:00 PM – Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, it was determined that for one (R113) out of thirty residents reviewed in the investigative sample, the facility failed to develop a care plan to address an identified concern. Findings include: Review of R113's clinical record revealed:10/11/24 - R113 was admitted to the facility.3/20/25 12:00 AM - A wound note by E12 (Wound NP) documented that R113 was non-compliant with turning and repositioning and tells staff to leave her alone.3/27/25 3:59 AM - A wound note by E12 (Wound NP) documented that R113 was non-compliant with turning and repositioning and tells staff to leave her alone.9/4/25 11:08 AM - During an interview, E12 (Wound NP) stated that R113 would refuse to have her wounds touched and resisted care.9/4/25 12:09 PM - During an interview, E16 (NP) stated that R113 was resistant to care and refused to get out of bed.9/4/25 11:43 AM - During an interview, E17 (wound nurse) stated that R113 was behavioral, resistant to care and would refuse to allow staff to turn and reposition her.9/4/25 12:25 PM - A review of R113's care plan lacked evidence for refusals of care that included individualized objectives, goals, and timeframes to meet R113's needs.9/5/25 10:40 AM - During an interview, E18 (CNA) stated that R113 was very behavioral, would constantly refuse care and refuse to get out of bed.9/5/25 10:51 AM - During an interview, E6 (RN) stated that R113 refused care and treatments and confirmed that a care plan for refusals should have been completed for her.9/9/25 2:00 PM - Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation and interview it was determined that for one (R79) out of ninety-one residents screened during the initial pool process the facility failed to ensure that medications were administered in accordance with professional standards. Findings include: The facility policy on medication guidelines last updated January 2025 indicated, The resident is always observed after administration to ensure that the dose was completed ingested. 9/2/25 9:16 AM - Upon entry into R79's room, the surveyor observed six pills on top of the bedside table. R79 stated I don't know what these are do you? The surveyor left the room and immediately returned with E13 (LPN) who confirmed leaving R79's medications without ensuring they were ingested. 9/9/25 2:00 PM - Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, it was determined that for one (R12) out of two residents reviewed for positioning, the facility failed to turn and reposition the resident and promote the healing of a pressure ulcer in accordance with professional standards of practice to prevent skin breakdown. Findings include:Review of R12's clinical record revealed:6/20/25 - R12 was admitted to the facility with diagnoses including stroke, dementia, muscle weakness, adult failure to thrive and a stage 3 sacral pressure ulcer.6/27/25 - An admission MDS documented that R12 was totally dependent for turning and repositioning. R12 had impairments on both sides for the upper and lower extremities. 7/12/25 - A nursing Braden Scale documented R12 with a score of 9.0 (9.0 or below is a very high risk for development of a pressure ulcer).8/20/25 - A care plan for R12 was documented to include turning and repositioning, as well as performing a skin check every 2 hours.On the following dates and times, R12 was observed lying in bed on his back with the head of the bed upright (approx. 45 - 60 degrees) without any positioning pillows or wedges on 9/2/25: 9:45 AM, 10:50 AM, 11:55 AM, and 12:15 PM. 12:50 PM and 2:01 PM.R12 was observed lying in bed on his back for four hours without any turning.9/4/25 11:08 AM - During an interview, E12 (Wound NP) stated that turning and repositioning is expected every 2 hours even with an air mattress. E12 stated that for R12 the facility has wedges or pillows to reposition him, but he has wiggled to angle himself in bed.9/9/25 12:20 PM - During an interview, E14 (CNA) stated that for R12, they can use pillows or wedges and that it is not a problem to get him off his back.The facility failed to ensure that R24 was turned and repositioned every two hours.9/9/25 2:00 PM - Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, it was determined that for one (R12) out of one resident reviewed for tube feeding, the facility failed to utilize a feeding tube in accordance with current professional standards of practice. Findings include:Review of the facility's policy and procedure titled Enteral Feeding: Administration by Pump, last revised 2/24/25, documented, . 15.3.2 Fill in the information on the container's label (patient's name, room number, date, start time, and flow rate) . 15.3.3 Label the administration set with start date and time .Review of R12's clinical record revealed:6/20/25 - R12 was admitted to the facility with diagnoses including but not limited to stroke, dementia, dysphagia, adult failure to thrive and severe protein-calorie malnutrition.6/27/25 - An admission MDS documented that R12 was on a mechanically altered diet with a feeding tube. 8/20/25 - A care plan for R12 documented that he has an enteral feeding tube to meet nutritional needs.9/2/25 10:57 AM - A direct observation revealed that Jevity 1.2 cal (a type of tube feeding) was infusing for R12 using a feeding pump. The Jevity 1.2 cal bottle was not labeled with the date, time or initials of the staff who began the infusion.9/2/25 12:54 PM - During an interview, E10 (RN) stated that the overnight shift hangs the feeding and they are supposed to date, time and initial it. E10 confirmed that there wasn't a date, time or initials on R12's tube feeding.9/9/25 2:00 PM - Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, it was determined that for one (R13) out of one residents reviewed for respiratory care, the facility failed to ensure R13's oxygen mask and nebulizer equipment were stored in a protective plastic bag. Findings include:Review of the facility's policy and procedure titled Nebulizer: Small Volume, last revised 11/1/23, documented, . 21.1 Place in treatment bag labeled with patient name and date.Review of R13's clinical record revealed:4/10/24 - R13 was admitted to the facility.4/8/25 - A physician order for R13 documented ipratropium-albuterol solution 0.5 - 2.5 mg/3mL, inhale 3mL orally every 6 hours as needed for shortness of breath or wheezing.8/20/25 - A care plan documented R13 as receiving respiratory treatments as ordered due to a history of COPD (chronic obstructive pulmonary disease).8/29/25 - A significant change MDS documented that R13 received respiratory therapy. 9/2/25 10:39 AM - An observation noted R13's oxygen mask with nebulizer unit attached sitting on top of the bedside table. There was no protective bag available for the oxygen mask and nebulizer unit to be placed into.9/2/25 10:42 AM - During an interview, E10 (RN) confirmed that the oxygen mask with nebulizer unit was sitting on the bedside table and not in a protective bag. E10 stated the respiratory therapist usually puts them in a bag with the resident's name and date on it.9/9/25 2:00 PM - Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.

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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 observation, interview and record review it was determined that for one (R10) out of two residents reviewed for dental services the facility failed to provide assistance with dental services. Findings include: The facility policy on Dental Services last updated 9/1/22 indicated, Centers will provide or obtain from an outside resource routine and emergency dental services to meet the needs of each patient. Review of R10's clinical record revealed: 5/8/25 - R10 was admitted to the facility with Medicaid as a source of coverage. 5/15/25 - An admission MDS assessment documented that R10 was cognitively intact and broken natural teeth. 5/31/25 - A care plan was created for R10's dental problems related to broken, loose and carious teeth. Dental referrals as needed was listed as an intervention. 9/2/25 9:30 AM - During an interview, R10 stated, Supposedly they have a dentist, I talked to the unit manager [E9 (RNUM)] and I haven't heard anything it's been a couple of weeks. 9/4/25 10:12 AM - During an interview, E7 (SSD) reported being unaware of a request for dental services from R10. E7 then provided a list of residents who'd requested to be seen by the facility's contracted dentist at the next scheduled visit. Review of the list dated, 8/25/25 revealed R10 was not scheduled to be seen by the dental provider. 9/4/25 11:45 AM - During an interview, E9 (RNUM) unit manager for R10 confirmed knowledge of R10's need for assistance to see a dentist. E9 stated, I reached out to [E7 (SSD)] yesterday and asked that [R10] be put on the list. 9/4/25 11:52 AM - During an interview, with both E9 (RNUM) and E7 (SSD) it was confirmed that E7 was not aware of R10's need for assistance with dental services. E7 stated she would email the facilities dental provider that day to attempt to add R10 to the list of residents to be seen. 9/4/25 1:44 PM - E7 (SSD) provided an updated dental provider schedule that documented R10 was now added to the list of residents to be seen by the dentist next visit. 9/9/25 2:00 PM - Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview it was determined that for one (R47) out of three residents reviewed for wound care the facility failed to ensure adherence to practices that prevent the spread infection. Findings include: The CDC's webpage entitled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to prevent the spread of Multidrug-resistant Organisms (MDRO's) indicated Enhanced Barrier Precautions: Examples of high-contact resident care activities requiring gown and glove use for EBP include wound care: any skin opening requiring a dressing. (Face protection may also be needed if performing activity with risk of splash or spray). https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/ppe.htmlReview of R47's clinical record revealed: 8/21/25 - R47 was admitted to the facility with multiple conditions including Hidradenitis Suppruativa (HS - a chronic inflammatory skin condition characterized by painful lumps, abscesses [pus filled areas] and scarring) and was being treated for wound infections related to the diagnosis. 8/22/25 - A physician's order was written for R47 to be placed on Enhanced Barrier Precautions. 8/22/25 - A physician's order was written for R47 to receive Clindamycin gel, an antibiotic for three months, apply to groin topically twice a day to the infected wounds. 9/2/25 10:03 AM - During initial pool screening, R47's sheets were observed with moderately sized circular pale pink stains. R47 explained having open wounds that sometimes drained. 9/4/25 - 10:26 AM - E17 (IP) was made aware that a dressing change observation would occur. 9/4/25 10:39 AM - During a dressing change observation, E17 (IP) and E6 (NPE) entered R47's room to complete a dressing change. E17 was observed without a face covering. E17 placed a clean drape on R47's bedside table and placed the dressing change supplies, a medicine cup of the wound cleaning agent ordered, a tube of the antibiotic ointment, several packs of gauze and a cell phone. The cell phone glass was in a case, the face of the cell phone had an opaque, appearance, with fingerprints and smears visible on its face. 9/4/25 10:49 AM - During the same dressing change E6 (NPE) removed R47's soiled dressings, E17 (IP) then poured the cleaning agent from a medicine cup onto gauze held by E6. The open mouth of the cup created a potential for splashing. E6 cleaned R47's wounds removed her gloves and changed to another pair of gloves. E17 then opened a pack of gauze, pulled the gauze from the pack touching it directly with her gloved hand and handed it to E6 to pat R47's wounds dry. E17 then grabbed the cell phone and took pictures of the wounds, leaning in very closely to R47's wounds that were prone to drainage and abscess. E17 again opened a pack of gauze, pulled the gauze from the pack touching it directly with her gloved hand squeezed antibiotic ointment on the gauze and applied it to R47's wounds. E17 then covered R47's wound. 9/4/25 11:10 AM - During an interview, E17 (IP) confirmed that she did not wear a face covering and touched a cell phone during the dressing change. E17 disputed the use of a face covering because [R47's] wound was not being irrigated, and the phone was cleaned before. At no point prior to the dressing change did the surveyor observe the phone being cleaned. When the surveyor attempted to indicate the smears on the phone E17 began cleaning and wiping the phone. 9/9/25 2:00 PM - Findings were reviewed with E1 (NHA) and E3 (Quality Manager) during the exit conference.