STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bay Terrace Rehabilitation and Health Center	889 South Little Creek Road Dover, DE 19901

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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interviews, record review, and review of other documentation as indicated, it was determined that for one (R2) out of three residents sampled for discharge, the facility failed to ensure durable medical equipment and home health services were in place prior to R2's discharge. R2 was discharged from the facility on 2/9/26 at 6:00 PM and transported home via medical transport services and assisted up the stairs to a three-story residence by transport, where no caregiver support was in the home. On 2/11/26, R2 was found in the home by the home health agency nurse in unsafe conditions. The facility's failure to confirm home health services and the availability of caregiver support to perform required care and assistance placed R2 in a situation with the potential for serious harm or injury. An immediate jeopardy (IJ) was identified starting on 2/9/26. Based on the facility's investigation, documented response, completion of in-service training, and staff interviews, the facility's date of abatement for the Immediate Jeopardy was determined to be 2/20/26. Findings include: A facility policy titled Transfer and Discharge (including AMA) dated 9/2025 documented A post discharge plan of care that is developed with the participation of the resident, and the resident's representative(s) which will assist the resident to adjust to his or her new living environment. Orientation for transfer or discharge must be provided and documented to ensure safe and orderly transfer or discharge from the facility in a form or manner that the resident can understand.Review of R2's clinical record revealed:1/16/26 - R2 was admitted to the facility with diagnoses including spinal stenosis, cervical disc disorder, muscle weakness, carpal tunnel syndrome and a recent post-fasciotomy to the right arm. 1/22/26 - A review of a five-day admission MDS assessment documented R2 was cognitively intact with a BIMS of 14/15. 2/9/26 2:21 PM - A progress note titled Late Entry for 2/11/26 authored by E3 (SW) documented [R2] will have a safe discharge home with services and supports in place to assist with continuity of care, person-centered goals and psychosocial well-being. Further review of the progress note revealed referrals for home health care, skilled nursing services and DME equipment were made. Additionally, the progress note documented family members were in attendance at the discharge care plan. R2's clinical record lacked evidence of confirmation by the facility that services were in place prior to R2's discharge from the facility. 2/9/26 7:43 PM - A progress note documented The resident has been discharged from the facility. Discharge paperwork was reviewed with the resident and the resident verbalized understanding. No further concerns were received the d/c (sic) paperwork was signed and a copy handed to the resident. Medications were called to the pharmacy and will be delivered at the resident's house. The resident left the unit with medical transportation at 6:00 PM with his personal belongings and received evening meds from the floor nurse.2/11/26 8:43 AM - A progress note titled Late Entry authored by E3 documented 5:13 PM, [E5 (HHA RN)] called to update E3 on the status of staffing resident with HHA (Home Health Aide). [E5] has been in touch with the VA (Veterans Administration) who is currently working on authorization for HHA (Home Health Agency Services). [E5] shared that he forgot to mention to [E3] that (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 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	VA service required PCP (Primary Care Physician) script (sic). [E5] confirmed a nurse will visit [R2] tonight 2/11/26.2/11/26 2:40 PM - A review of a progress note for R2 revealed the facility reached out to [R2] to discuss discharge concerns. [R2] informed the facility the hospital bed had not been delivered until the morning of 2/10/26 and that therapy, RN and HHA had not shown up as of time of the call and had not heard anything from the VA. In addition, the progress note documented [E3] to follow up with [R2] after outreach to providers.2/17/26 2:23 PM - During an interview, E3 reported [R2's] significant other and stepchildren were visiting on the day of the resident's baseline care plan and reported they would be there to support [R2].2/19/25 9:25 AM - A telephone interview with the DME provider confirmed the hospital bed was ordered for R2 on 2/6/26 was not delivered until 2/10/26. 2/19/26 9:39 AM - A telephone interview with R2 revealed that the resident returned to the hospital. R2 stated, I live in a three-story home. I don't think that was fair the way they sent me home. I needed a caretaker. Nobody was home when I got there. I can't use my hands. I had to call my sister-in-law to help me get washed up and fix a meal so I had something to eat that night, and she moved some furniture around to make room for the bed that didn't come until the next day, but she couldn't stay long. R2 then stated, The nurse was supposed to be at my house but was not there until a couple of days after I was home.2/19/26 10:02 AM - During a phone interview FM1 (Significant Other) stated, [R2] lives alone, no one lives with [R2]. FM1 then stated, I have my own health issues I'm dealing with, I can't take care of [R2]. [R2] arrived home alone, nobody was with [R2].2/19/26 10:37 AM - A telephone interview with E5 revealed a referral was received for R2 2/6/26. E5 then stated, The nurse is in the home within 48 hours of discharge.2/19/26 12:05 PM - During an interview E4 (DOR) stated, I do believe that [R2] needed more assistance based on [R2's] difficulty with fine motor skills.2/19/26 1:13 PM - During an interview, E3 was asked, Did you inform the agency what date services for [R2] needed to start? E3 stated, No I always give them a discharge date , and they contact the resident to set up the date. E3 then stated, I was assuming [R2] was going to get a call from the agency and the VA. E3 confirmed, I did not call to confirm the delivery of the hospital bed prior to [R2's] discharge.2/19/26 1:51 PM - During an interview E1 (NHA) reported contacting [E5] to inquire about [R2] not getting services. E1 then stated, E5 reported the agency received a call from someone that [R2] didn't need their level of care. E1 then stated, I was under the impression that FM1 and the son were going to be at home with [R2] and that the agency would be providing [R2] support through the VA.2/19/26 2:06 PM - During a telephone interview E7 stated, The referral for [R2] was received on 2/6/26 with a discharge date of 2/9/26 and start of care was requested for 2/11/26. In addition, E7 stated, I was called about the condition of [R2] I advised [E6] to call APS (Adult Protective Services). E7 then reported receiving a call on 2/10/26 from a family member of [R2], and they reported the facility said [R2] would have twenty-four-hour care. E7 then reported I can't say how the facility translated the care to the family, but I told them We do not do private duty, and that [E5] had already reached out to the VA for additional support services. E7 reported R2 agreed to go back to the hospital. 2/20/26 9:12 AM - During a telephone interview E6 (HHA RN) reported arriving to R2's home between 7:40 PM - 7:50 PM on 2/11/26. E6 stated, [R2] was sitting on the couch wearing an undershirt, a pull-up brief, and socks. [R2] reported not eating in two days, and that a friend had come by and brought a cheeseburger, and that was all [R2] had eaten. E6 reported that the cheeseburger was half-eaten. E6 then stated, [R2] said there was no food in the house, and if there was [R2] said, 'I couldn't get up to fix it. In addition, E6 stated, [R2] said I can't open my medications, and I can't open bottles. E6 reported assisting R2 to use the urinal to urinate, and that [R2] could not grip anything with the right hand and [R2] didn't have the fine motor skills to open a bottle. E6 (continued on next page)

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F 0627 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reported contacting E7 (Agency Director) and explained the unsafe conditions that R2 was found in. E6 then spoke to R2 and explained why R2 should not be home alone, and asked R2 to call 911. E6 reported waiting with R2 until emergency medical transport arrived to take the resident to the hospital for further evaluation. 2/20/26 10:11 AM - During another telephone interview FM1 stated, On the day [R2] was being discharged my son who lives in Chesapeake, Virginia brought me to the nursing home to give [R2] his house keys when [R2] got home the transport people helped him into the house. I did not go to [R2's] house my son drove me back to my house and then got in the car and drove back to Chesapeake, Virginia and no, my son did not go to [R2's] house.2/20/26 2:20 PM - An immediate jeopardy was identified. 2/20/26 - 2/24/26 - Through interviews and record reviews, the Surveyor confirmed the facility had regained compliance on 2/20/26. 2/20/26 - The facility identified residents affected or likely to be affected by an inappropriate discharge from the facility. Audits of discharge documentation related to home health services, appropriate caregiver/family support, and any necessary services to meet residents' care needs for the last 7 days were reviewed by the NHA in order to determine if any residents were affected. All discharges planned within the next 72 hours were reviewed by the Administrator, DON, Director of Social Services, and the Director of Rehabilitation to ensure home health services, appropriate care/giver/family support, and necessary services to meet the resident's care needs are in place before discharge. Actions to Prevent Occurrence/Reoccurrence: The facility took the following actions to prevent an adverse outcome from recurring. Root cause analysis was determined to be failure to have a robust discharge care plan meeting with the Interdisciplinary team, with the resident and resident representative.The procedure for safe and effective discharge planning was reviewed with the IDT.Discharge planning IDT will be re-educated on the policy and procedure to ensure sufficient preparation and orientation to ensure a safe discharge. Residents who are scheduled to be discharged within 14 days will be reviewed to ensure appropriate discharge planning is in place.Residents who are scheduled to be discharged in the next 14 days will be reviewed to ensure support for ADLs is in place, durable medical equipment is available prior to or on the discharge date , medications are available upon discharge, and identified needs/support are available.Two times a week, residents who are scheduled for discharge will be reviewed to ensure safe discharge is in place. Any issues identified will be addressed accordingly.Weekly, during utilization review, NHA/Designee will oversee discharge planning to ensure preparation and services are in place prior to discharge.2/20/26 - The facility's response initiated for R2's inappropriate discharge to home included audits, educational in-services to the IDT team and staff interviews with E1 (NHA), E2 (DON), E3, (SW), E4 (DOR), E8 (ADON) and E9 (RNAC) confirmed education received for a residents discharge from the facility to the community and or other facility transfers, the facility's date of abatement for the immediate jeopardy was determined on 2/20/26. 2/24/26 2:15 PM -Findings were reviewed with E1 (NHA), E2(DON), and E8 (ADON) at the exit conference.