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	04/23/2026

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview it was determined that for one (R83) out of three residents reviewed for abuse the facility failed to ensure immediate reporting of an allegation of abuse. Findings include: The facility policy on abuse last updated January 2026 indicated, Reporting of all alleged violations to the Administrator, state agency, adult protective services, and to all other required agencies (e.g. law enforcement when applicable) within specific time frames! a. Immediately but not later than two hours after the allegation is made.6/12/25 3:31AM - An incident note in R83's clinical record documented that R83 made an allegation of physical staff to resident abuse against E8 (CNA). 6/12/25 11:21 AM - The facility reported an allegation of staff to resident physical abuse involving R83 that allegedly occurred at 2:35 AM to the State Agency; an estimated nine hours after the allegation occurred. 4/23/26 11:06 AM - During an interview with E6 (RN) it was confirmed that R83's allegation of abuse was not immediately reported to the State Agency. E6 stated, When the [DON] came in, she told me I should have reported it right away and not waited for the day shift. 4/23/26 11:14 AM - During an interview, E2 (DON) confirmed the findings and that the facility verbally educated E6 (RN) on reporting time frames. 4/23/26 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and at the exit conference.

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview it was determined that for one (R83) out of three residents reviewed for abuse the facility failed to ensure residents were protected from further abuse when the facility failed to remove an employee from resident care immediately after an allegation of abuse. Findings include: The facility policy on abuse last updated January 2026 indicated, Protection of Resident. Room or staffing changes if necessary to protect residents from the alleged perpetrator. 6/12/25 11:21 AM - The facility reported an allegation of staff to resident physical abuse involving R83 and E8 (CNA). 4/23/26 9:26 AM - Review of E8's (CNA) timesheet revealed that after the allegation of physical abuse involving R83, E8 remained in the facility working with residents until 7:05 AM. 4/23/26 10:56 AM - During an interview, E7 (LPN) the nurse assigned to R83's unit at the time of the incident confirmed that E8 (CNA) remained caring for patients after R83 made an accusation of physical abuse against R83. E7 stated, She had dementia and a care plan for false accusations what she said didn't make sense, so we stopped him from caring for her room through the rest of the shift. 4/23/26 11:06 AM - During an interview, E6 (RN) confirmed that E8 (CNA) remained caring for residents after R83 made an allegation of physical abuse. E6 stated, I told [E8] to care for other patients E6 then explained that [E2 (DON)] verbally educated her that accused staff must be removed to protect all residents. 4/23/26 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and at the exit conference.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, it was determined that for one (R10) out of seven residents reviewed for ADL (Activities of Daily Living), the facility failed to provide ADL care for dependent residents. Findings include:Review of R10's clinical record revealed:3/26/25 - R10 was admitted to the facility with a diagnosis of terminal prostate cancer and delirium.1/12/26 - A review of R10's care plan documented that the resident had a self-care deficit for ADLs. 3/24/26 - A quarterly MDS documented that the resident was dependent for personal hygiene.4/15/26 7:10 AM - A progress note documented that R10 was restless all night and was smearing his feces with his hands.4/20/26 9:45 AM - An observation of E5 (CNA) providing a bed bath to R10 revealed dark debris beneath three fingernails on the resident's left hand4/21/26 9:00 AM - An observation of R10's left hand had dark debris beneath three of his fingernails. 4/21/26 10:15 AM - During an interview, E5, CNA stated that during the resident's bed bath, she shaved the resident (R10) and washed his entire body. She confirmed that she did not check or clean the resident's fingernails during the bath and stated she would complete this task immediately. 4/21/26 10:20 AM - E4 (LPN) confirmed that R10's left hand had dark debris beneath three fingernails. E4 stated she has not seen a nailˆcleaning device available for use in a long time.4/21/26 10:20 AM - During an interview, E2 (DON) confirmed that the fingernails for R10 were not cleaned during the bath.4/23/263:00PM - Findings were reviewed with E1 (NHA), E2 (DON) and at the exit conference.

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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. Based on record review and interview it was determined that for one (R85) out of three residents reviewed for hospitalization the facility failed to provide appropriate care and monitoring consistent with professional standards of practice. When the facility failed to monitor and restrict fluid intake for R85 admitted with active diagnosis of heart failure. Findings include:Review of R85's clinical record revealed:4/19/25 through 4/29/25 - R85 was hospitalized for multiple conditions, including heart failure. 4/29/25 - R85 was admitted to the facility with multiple diagnoses including congestive heart failure and kidney disease requiring dialysis.4/30/25 - An admission assessment completed by E11 (RN) documented that R85 had congestive heart failure.4/30/25 - R85's baseline care plan revealed that R85's diagnosis of congestive heart failure lacked interventions.5/1/25 - A nutrition assessment documented that R85 was receiving therapeutic, regular textured meal plan with 1500 mL fluid restriction . Will continue to monitor oral intake, weight, skin integrity, and labs as available for significant changes and reassess as needed. Review of R85's physicians orders and dietary intake lacked evidence of an order for fluid restriction.5/1/25 12:05 PM - A progress note in R85's clinical record written by E10 (MD) documented The patient remains generally weak and clinically deconditioned. The patient has multiple complex co morbidities to include heart failure placing the patient at high risk for re admission [to hospital] without proper care. The patient will require frequent clinical evaluations, neglecting regular monitoring and management may result in symptom exacerbation and re-hospitalization. Assessment/Plan strict intake and output's daily weights.5/5/25 - An admission MDS assessment documented that R85 was cognitively intact, experiencing shortness of breath and had an active diagnosis of heart failure. 5/5/25 - A physician's order was written for R85 be restricted to 1500ml of fluid per day at the request of R85's responsible party.5/6/25 11:15 AM - A nurses note in R85's clinical record documented that the resident was sent to the hospital from the dialysis center for chest pain and shortness of breath.4/23/26 1:41 PM - During an interview, E10 (MD) confirmed that R85 should have been placed on fluid restriction on admission. 4/23/26 1:48 PM - During an interview, E11 (RN) confirmed that residents admitted with congestive heart failure and on hemodialysis are usually placed on fluid restrictions. E11 was unable to recall why R85 was not placed on fluid restrictions on admission.4/23/26 1:54 PM - During an interview, E2 (DON) confirmed that R85 should have been placed on fluid restriction and monitoring prior to 5/5/26. E2 stated Most residents with congestive heart failure would have had a fluid order but [R85] did not have one. E2 then stated that an order for fluid restriction was written on 5/5/24 because It was just noticed. The fluid restriction was not in timely.4/23/26 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and at the exit conference.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, it was determined that for one (R72) out of five residents sampled for medication review, the facility failed to ensure that the residents were free from unnecessary meds when a Protonix order was used in excessive dose. Findings include: Review of R72's clinical record revealed:1/26/26 - R72 was admitted to the facility.1/27/26 - A physician's order for Protonix 40 mg give one by mouth two times a day for GERD (gastro-esophageal reflux disease). 2/22/26 - A physician's order for Protonix 40 mg give one tablet by mouth once daily for GERD. 3/30/26 - A Monthly Consultant Pharmacist Report documented two Protonix orders seen please clarify if both are current orders. Report was signed off and acknowledged by provider. 4/22/26 11:52 AM - During an interview, E10 (MD) confirmed the Consultant Pharmacist Report was reviewed and confirmed that the Protonix order daily was to be discontinued. 4/22/26 11:54 AM - During an interview, E3 (ADON) confirmed that R72 had two active Protonix orders from 2/22/26 to 3/30/26 when the second order was discontinued which totaled 37 additional doses. E3 stated that E2 (DON) or herself were responsible to review the monthly pharmacy reviews and implement any changes that were initiated by E10. 4/22/26 12:11 PM - During an interview, C1 (Pharmacy Technician) confirmed that R2 had two active Protonix orders on the aforementioned dates and that the pharmacy dispensed and delivered those medications to the facility. 4/22/26 12:45 PM - During an interview, E2 (DON) stated that the expectation was that E3 or herself would monitor the monthly pharmacy reviews and address any changes to be implemented. E2 stated that E3 runs a daily report to monitor all new prescription orders and that occasionally nurses on 11:00 PM to 7:00 AM shift will monitor them as well. E2 could not articulate how the how the discrepancy in the medication order was missed. 4/23/26 3:00 PM Findings were reviewed with E1 (NHA), E2 (DON) and at the exit conference.