STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Post Acute	3034 South Dupont Blvd Smyrna, DE 19977

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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 - 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 (R30) out of five residents reviewed for abuse, the facility failed to report an injury of unknown source to the State Agency within the required timeframe. Findings include:Review of R30's clinical record revealed:4/1/23 - R30 was admitted to the facility.3/8/26 1:00 PM - A facility reported incident documented that R30 had an injury of unknown origin determined by a positive x-ray report of a fractured right hip.3/8/26 8:35 PM - A Radiology Results Report documented an acute fracture to R30's right hip. 3/9/26 12:59 AM - A facility reported incident was submitted to the State Agency 12 hours after incident occurred. 5/8/26 12:28 PM - During an interview, E2 (DON) confirmed that the aforementioned report was not submitted to the State Agency within the appropriate timeframe. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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	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 (R30) out of three residents reviewed for quality of care, the facility failed to ensure care/treatment in accordance with professional standards of practice. Review of R30's clinical record revealed:4/1/23 - R30 was admitted to the facility. 3/8/26 10:48 AM - An SBAR (provider communication note) documented that R30 was observed with right hip discomfort and swelling noted. The SBAR also documented the provider was notified and awaiting a return call. 3/8/26 3:22 PM - A telephone physician's order for R30 documented diagnostic imaging x-ray of bilateral hips with two views. 3/8/26 8:35 PM - A radiology results report documented that x-ray was obtained and completed at 5:03 PM on 3/8/26. The results indicated and acute fracture of R30's right hip. 3/8/26 11:09 PM - A nursing progress note documented that R30 had a positive fracture to the right hip and was sent to the hospital for further evaluation. 5/8/26 10:13 AM - At this time multiple attempts were made to contact E28 (LPN) to determine the time line of events regarding R30's change in status and were unsuccessful. 5/8/26 10:24 AM - During an interview, E14 (CNA) stated when providing care to R30 on 3/8/26 she noticed R30 was showing signs and symptoms of pain when turning during incontinence care. E14 stated that R30's right hip was not sitting evenly with the left hip when she was laying supine in the bed and that the resident was grimacing while receiving care. E14 stated she reported her observations to the nurse on duty after completing care. 5/8/26 10:51 AM - During an interview, C2 (Technician) confirmed they [mobile diagnostic imaging] received the physician's order for x-ray at 3:22 PM on 3/8/26, x-ray was completed at 5:03 PM, and the results were sent to the facility at 8:35 PM on 3/8/26. 5/8/26 12:28 PM - During an interview, E2 (DON) confirmed that R30 had a positive x-ray for right hip fracture and was sent to the hospital for treatment. It was unclear based on interview and record review why the facility sent R30 to the hospital 15 hours after change in condition was observed. This resulted in R30 not receiving care in a timely manner. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview, record review and review of other facility documentation, it was determined that for one (R109) out of seven residents reviewed for accidents, the facility failed to provide adequate supervision and implement safe bed mobility practices to prevent a fall. As a result, R109 fell from the bed, sustained a head laceration, required hospital transfer, and received six sutures causing harm to the resident. Findings include:Review of R109 clinical record revealed:6/9/25 - R109 was admitted to the facility with diagnoses including seizures, gastrostomy tube, tracheostomy, anxiety, and muscle spasms.A care plan last updated 6/10/25 documented ADL self-care deficit related to physical limitations. Interventions included assistance with daily hygiene, grooming, dressing, oral care, and eating as needed. The care plan further documented R109 required a two-person assist for transfers and bed mobility. Additionally, the care plan documented R109 was at risk for falls related to poor safety awareness, seizure and adjustment to a new environment. Interventions included assessing for fall risk on admission, quarterly, and as needed.10/1/25 - The medical record was updated to include a diagnosis of multiple sclerosis.12/13/25 - A quarterly Minimum Data Set (MDS) assessment documented in GG0120 Functional Abilities that R109 was dependent, with helper doing all of the effort and the resident doing none of the effort to complete the activity, or the assistance of two or more helpers was required for the resident to complete the activity. The assessment documented R109 was dependent for eating, oral hygiene, toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The assessment further documented in GG0170 Mobility that R109 was dependent for roll left and right, sit to lying, lying to sitting on side of bed, bed-to-chair transfers, and tub/shower transfers.1/5/26 - A facility collected statement written by E23 (CNA) documented during the 0615 check and change [R109] was noted to have a large liquid bowel movement. [E10 (CNA)] and I began to assist [R109]. [E10] pulled [R109] towards her (to the left side) and then rolled her onto her right side (towards me) to position her in the middle of the bed. [E10] removed the soiled brief and cleaned [R109] off, then walked the soiled brief to the linen/trash cart which was located at the entrance of the door to toss it away. [R109] continued to have diarrhea, I turned to grab a new brief and gown off the chair, which was located right behind me. As I turned back around, I noticed [R109] falling from the bed, hitting her head on the drawer of the nightstand. While falling, [R109] continued to actively pass a large amount of liquid stool, I called out for help and [E10] turned around to assist me. The supervisor was notified.1/5/26 at 6:49 AM - A progress note documented this nurse was called to the room it was noted that [R109] was laying on the floor on her back . [R109] is not able to verbalize what happen. In the process of doing personal care there were two aids present. One aid stated that she turned to place dirty laundry in the basket and the other aid turned to get her night gown off the chair. The bed was at waist level and R109 was lying on her right side when [R109] fell off the bed onto the floor. She had a deep laceration to her left temple. There was minimal red drainage. [R109] did not display [signs and symptoms] of pain. The On-call doctor was notified, and resident was sent out to get sutures to the open wound. [R109's] family member was also notified.1/5/26 - A facility collected statement by E10 documented After providing care for [R109] I stepped away to put the dirty linen in the linen basket located at the threshold of the room door. When I turned back into the room, I did not see the resident in the bed. She was on the floor. I called for help.1/5/26 - The facility reported incident documented that at approximately 6:30 AM resident rolled out of bed. RN assessment completed a laceration to the left forehead was noted first aid applied, neuro checks initiated. Family and NP notified. Resident sent to ED for evaluation and treatment.A care plan was revised on 1/6/26 that included interventions provide adequate lighting; and fall mats on floor at bedside while in bed perimeter mattress to bed, Date Initiated: 1/6/26.1/7/26 - A progress note in R109's clinical record written by E19 (NP) documented in a follow up visit that Patient was sent to the ED s/p fall out of (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	bed with left forehead laceration. Per ED notes Reportedly, patient was being changed in bed by nursing home staff and somehow slipped out of bed hitting her forehead.1/9/26 - A 5 day follow up from the facility documented that R109 Loss of balance r/t underlying medical condition - COVID causing increased weakness and inability to hold side lying position further compromised by dx of muscle spasms and multiple sclerosis. The staff interview revealed that, the resident rolled out of bed to the floor. RN assessment completed, and the resident was noted with a laceration to the left side of her forehead. First aid was rendered, and the resident was transferred to the ER for further evaluation. NP and family were notified. The resident was seen and examined at the ER, and all tests completed were negative for any additional injury related to the fall. The resident is an assist of x2 for bed mobility, and per the investigation findings, the resident was provided care utilizing two staff members prior to resident rolling OOB. After care provided, the resident was placed on her side in secure position. Staff was still present in the room although was unable to physically prevent the resident from rolling from bed to the floor. Both CNAs are familiar with the resident as they were her routine caregivers. The resident returned from the hospital post evaluation with sutures to laceration on forehead. Therapy was consulted to evaluate post return. Safety measures were reassessed. Interventions: Perimeter mattress, Fall mats, PT eval.5/8/26 9:20 AM - During an interview with E10 (CNA), E10 revealed staff were providing incontinent care to R109 when additional linen was needed due to continued loose stool and the linen cart was positioned near the doorway. E10 stated R109 was positioned in the bed at approximately waist height and was unable to reposition herself or assist with movement. E10 further stated R109 required two-person assistance for care and positioning. E10 stated one CNA was positioned on the opposite side of the bed while care was being provided and additional linen was obtained due to continued diarrhea. E10 stated staff attempt to gather needed supplies prior to beginning care; however, additional linen was needed during the care activity due to the resident's condition. E10 stated staff try not to leave bedside during care activities. E10 stated the incident happened suddenly and E10 did not directly observe the fall; however, the other CNA observed R109 fall from the bed. E10 stated precautions for R109 included two-person assistance and maintaining the resident in an upright position related to the tracheostomy. E10 further stated staff had discussed the mattress following the incident, including a control button related to mattress inflation and deflation, and stated there had not been prior in-service education regarding the mattress function. E10 stated staff immediately notified the nurse and supervisor following the incident.Despite the facility's investigation indicating R109 had been placed in a safe position and centered in the bed, record review and staff interviews confirmed R109 continued to receive incontinent care related to ongoing diarrhea at the time of the incident. Staff interviews revealed R109 had not yet been dressed and incontinent care activities were ongoing when the fall occurred. Additionally, interview statements contained varying accounts regarding the resident's positioning immediately prior to the fall, including documentation that R109 was positioned side-lying as well as statements that the resident had been centered in the bed. Regardless of the exact positioning, the resident remained dependent on staff and continued to require two-person assistance and supervision during the care activity.5/8/26 at 1:08 PM - During an interview on E4 (CNA) stated that residents requiring two-person bed mobility require one staff member on each side of the bed during care. E4 further stated that if one staff member needed to step away, the resident should first be returned to a safe position in the bed and the bed lowered prior to staff leaving bedside. E4 stated staff received education regarding fall prevention through demonstrations and in-person training.5/8/26 at approximately 1:15 PM - During an interview with E24 (Nurse Educator) confirmed the above and E24 provided state agency with documentation of a training on 12/3/25 that documented Education for all staff that transfer/care status must be followed at all times if a resident requires a 2 person assist, they must not provide care/transfer alone. When asked what you would do if you had to step away during a two-person activity E24 confirmed that you would return the resident to a safe position move to the center of the bed, by lowering the bed to the floor. Additionally, E24 provided documentation on (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	an Inservice initiated on 1/5/26. When providing care for resident on low air loss mattress, ensure in STATIC mode prior to providing care and resident is in the middle of the bed.5/11/26 at 9:38 AM - During an interview on E2 (Director of Nursing) stated that one aide stepped away from the bedside to place soiled linen in the linen cart outside the room while the second aide turned away from the resident to retrieve clothing. E2 confirmed the bed remained waist high during the care activity. E2 stated the facility believed R109's diagnoses, including multiple sclerosis with spasticity and COVID diagnosis, contributed to the fall.5/11/26 - During interviews conducted on E11, E12, and E13 (CNAs) stated that residents requiring two-person bed mobility require two staff members at bedside during care. Staff further stated that if one caregiver needed to leave or step away from the bedside, the resident should first be repositioned safely in the center of the bed and the bed lowered prior to staff stepping away.5/8/26 and 5/11/26 - Attempts were made during the survey to interview E23 (CNA); however, those attempts were unsuccessful.5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that for one (R155) out of one resident reviewed for hydration, the facility failed to ensure that R155 was offered sufficient fluids to maintain proper hydration. This failure resulted in harm with R155 being transferred to the hospital on [DATE] with diagnoses of dehydration and AKI (acute kidney injury). Findings include:The BUN (blood urea nitrogen) lab measures the amount of urea nitrogen in the blood. The BUN is directly related to the metabolic function of the liver and the excretory function of the kidney . BUN levels also may vary according to the state of hydration, with increased levels seen in dehydration and decreased levels seen in overhydration. Mosby's Diagnostic and Laboratory Test Reference 2023. Review of R155's clinical record revealed:6/12/25 - R155 was admitted to the facility. 6/17/25 - A care plan documented that R155 was at risk for nutrition/hydration risk related to dementia, hypokalemia, hyponatremia, aphasia, hemiparesis, hemiplegia, and cerebral vascular accident (CVA) with the following interventions: honor food and beverage preferences as able; provide and serve diet, snacks and fluids as ordered; provide assistance with meal tray set up and/or feeding assistance; provide nutrient-relevant medications and supplements as ordered; and Registered Dietician (RD) to make dietary recommendations as needed. 6/17/25 11:12 AM - A nutrition assessment documented the recommended fluid intake for R155 was 2050 mL/day. The nutrition assessment further identified R155 was at risk for malnutrition and dehydration related to diagnoses of dementia, hemiplegia, and hemiparesis. The assessment additionally referenced laboratory results obtained on 6/16/25 which documented the following values: Sodium 148 (high) and Potassium 3.1 (low). The assessment further documented the provider ordered additional oral fluids for two weeks related to the electrolyte imbalance. 9/18/25 - A quarterly MDS documented that R115 had a BIMs score of 3 indicating severe cognitive impairment and required supervision or touching assistance for eating/drinking. 9/18/25 1:35 PM - A quarterly nutritional assessment documented that R155 had maintained stable weight since admission, had good oral food and fluid intake and remains on mechanical soft diet with no chewing or swallowing difficulty. No other nutrition concerns at this time and continue to monitor R155's nutritional status. The daily totals obtained from CNA task flow sheet for R155's fluid intake:10/1/25 - 1360 mL.10/2/25 - 720 mL.10/3/25 - 960 mL.10/4/25 - 1360 mL.10/5/25 - 1360 mL.10/6/25 - 960 mL.10/7/25 - 840 mL.10/8/25 - 480 mL.10/9/25 - 2000 mL.10/10/25 - 480 mL.10/11/25 - 1200 mL.10/12/25 - 920 mL.10/13/25 - 240 mL.10/14/25 - 1120 mL.10/15/25 - 1440 mL.10/16/25 - 720 mL.10/17/25 - 240 mL.10/18/25 - 960 mL.10/19/25 - 1680 mL.10/20/25 - 480 mL.10/20/25 1:00 AM - A provider's progress note documented that R155 was seen due to nursing reported R155 was noted with increased fatigue and slow to respond. The provider plan documented to check CBC, CMP, Vit D and B12 lab levels and encourage fluids. Despite provider recommending encouraging fluids, the facility failed to implement provider recommendation and lacked the evidence of increased monitoring and implementing approaches to increase hydration. The daily totals obtained from CNA task flow sheet for R155's fluid intake:10/21/25 - 0 mL.10/21/25 10:39 AM - A laboratory results report documented that R155 had the following lab values: BUN level 42 mg/dL, creatinine 1.50 mg/dL, and sodium 159 mmol/L. 10/21/25 2:22 PM - A progress note documented that labs were reviewed by provider and indicative of hypernatremia and AKI, fluid resuscitation was unsuccessful and initiated a new order to send R155 to the hospital.10/21/25 2:44 PM - A progress note documented that R155 was sent to the hospital via ambulance. 10/21/25 4:49 PM - A hospital progress note documented that R155 had lab values of BUN of 40 mg/dL and creatinine 1.5 mg/dL upon arrival to emergency department. The progress note further documented that R155 was being admitted with diagnosis of AKI, hypernatremia, hypokalemia and dehydration. The progress note documented the plan to correct was IV fluid resuscitation during admission. 10/21/25 1:00 AM - A provider progress note documented that R155 was seen for increased fatigue, lab review, and slow to (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	respond. The progress note documented that R155's lab values were as follows: BUN 42 mg/dL, creatinine 1.50 mg/dL and Sodium 159 mmol/L. The provider recommended IV (intravenous) fluid resuscitation and to send R155 to hospital if unable to establish an IV line. 5/11/26 1:02 PM - During an interview, E14 (CNA) stated the expectation is for staff to record any fluids provided during meals and hydration rounds in the electronic system. E14 stated that staff was to report any changes noted in intake by residents to the nurse when observed. 5/11/26 1:07 PM - During an interview, E15 (CNA) stated the expectation is for staff to record all fluid intake and report any changes to the nurse.5/11/26 1:10 PM - During an interview, E16 (LPN) stated that R155 required assistance from staff with eating and drinking and had a good appetite. E16 further stated that nurses were expected to monitor resident's intake and report any changes to the Unit Manager or dietician. 5/11/26 1:15 PM - During an interview, E17 (RN) stated that resident's not meeting fluid volume goals are to be reported to the Unit Manager who will notify the provider and/or dietician to evaluate resident. E17 stated that she was unable to recall who attempted to initiate the IV line on R155 and stated the orders were not placed in the system due to unsuccessful insertion of the IV. E17 stated typically the orders would be added to EMR after the IV line was established. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, it was determined that for one (R153) out of six residents reviewed for pharmacy services, the facility failed to provide pharmaceutical services to meet the needs of each resident. Findings include: Review of R153's clinical record revealed:1/9/26 - R153 was admitted to the facility. 1/9/26 - A physician's order documented nafcillin sodium (antibiotic) in dextrose intravenous solution 2GM/100mL: Use 2 gram intravenously every 8 hours for pneumonia for 15 days. 1/10/26 - A review of the January MAR documented H on the aforementioned nafcillin order for 12:00 AM and 8:00 AM dose due to medication not available from pharmacy. The MAR lacked evidence of a hold order for the dose on 1/9/26 at 4:00 PM. 1/13/26 - A physician's order documented cefazolin sodium injection solution 2 GM: Use 2 gram intravenously three times a day for endocarditis and bacteremia prophylaxis. 1/13/26 11:41 PM - A progress note documented that cefazolin was on order from the pharmacy. The MAR documented 8 for the 10:00 PM dose with the aforementioned progress note. 5/8/26 12:10 PM - During an interview, C1 (Pharmacy) confirmed that the nafcillin was delivered on 1/10/26 and the cefazolin was delivered on 1/14/26 by the pharmacy currier. 5/8/26 1:36 PM - During an interview, E26 (LPN) stated the admitting nurse was responsible for calling pharmacy regarding any new medication orders from admission. E26 stated at times medications would have to be requested STAT (immediately) to receive them from pharmacy quickly. E26 stated she did not recall if there was a delay in receiving R153's IV medications. 5/8/26 1:49 PM - During an interview, E27 (LPN) stated she assisted in admitting R153 to the facility and cannot recall if there was any issue receiving R153's medications. E27 stated they do have medication on site in the back up pharmacy if its needed, but it has limited options of medications. 5/8/26 2:02 PM - During an interview, E2 (DON) stated the facility was having issues with the pharmacy and deliveries delayed for the medications. E2 confirmed that R153's delay in delivery was around the time the facility was experiencing delays, which resulted in the facility switching locations of pharmacy delivery. 5/11/26 1:30 PM - During an interview, E19 (NP) stated that the antibiotics R153 were ordered by the provider at the hospital and would have had to be ordered from pharmacy. E19 confirmed that he approved medications to be held due to the delay in delivery from pharmacy. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).