STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore at West Meadow	255 Possum Park Road Newark, DE 19711

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on record review and interview, it was determined that for four (R1, R2, R3, R4) out of four residents reviewed for admission, the facility failed to provide services that meet the professional standard of quality as defined by the Delaware State Code regarding RN (registered nurse), LPN (licensed practical nurse) and NA (nurse aide)/ UA (unlicensed assistant) Duties for admission assessments. Findings include: Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024 .admission Assessments *. RN (registered nurse) . *Once a care plan is established, the LPN may do assessments. Updated 10/11/24Facility admission Assessment and Follow Up: Role of the Nurse policy included a document that listed all the evaluations in the facility EMR that were considered admission Evaluations. The list included: N Adv- Clinical Admission, N Adv- Skin Check, N Adv- Braden scale- for Predicting Pressure Ulcer Risk Evaluation, N Adv- Lift/Transfer Evaluation, N Adv -Fall Risk Evaluation, N Adv -Dehydration Risk Evaluation, N Adv- Elopement Evaluation, Hot Liquids Safety Data Collection, Functional Abilities and Goals, LCS Bedrail Evaluation, Trauma Informed Care and Baseline Care Plan.1. Review of R1's clinical record revealed:8/5/25 - R1 was readmitted to the facility.8/5/25 - E6 (LPN) documented and completed in R1's EMR the N Adv-Clinical Admission, N Adv-Braden Scale- for Predicting Pressure Ulcer Risk Evaluation, N Adv- Left/Transfer Evaluation, N Adv-Elopement Evaluation, Functional Abilities and Goals, and N Adv- Dehydration Risk Evaluation.The facility failed to have a registered nurse complete six of R1's admission evaluations.2. Review of R2's clinical record revealed: 10/26/25 - R2 was admitted to the facility.10/26/25 - E11 (LPN) documented and completed in R2's EMR the N Adv-Clinical Admission, N Adv-Braden Scale- for Predicting Pressure Ulcer Risk Evaluation, N Adv-Elopement Evaluation, N Adv- Fall Risk Evaluation and N Adv- Dehydration Risk Evaluation.The facility failed to have a registered nurse complete five of R2's admission evaluations.3. Review of R3's clinical record revealed: 10/10/25 - R3 was admitted to the facility.10/10/25 - 10/26/25 - E12 (LPN) documented and completed in R3's EMR the N Adv-Clinical Admission, N Adv-Trauma Informed Care, N Adv-Elopement Evaluation, N Adv- Fall Risk Evaluation, N Adv- Lift/Transfer Evaluation and N Adv-Dehydration Risk Evaluation.The facility failed to have a registered nurse complete six of R3's admission evaluations.4. Review of R4's clinical record revealed: 10/4/25 - R4 was admitted to the facility.10/4/25 - 10/26/25 - E6 (LPN) documented and completed in R4's EMR the N Adv-Clinical Admission, N Adv-Elopement Evaluation, N Adv- Fall Risk Evaluation, N Adv- Lift/Transfer Evaluation and N Adv-Dehydration Risk Evaluation.The facility failed to have a registered nurse complete five of R4's admission evaluations.10/29/25 12:35 PM - During an interview, E2 (DON) confirmed that E6, E11 and E12 had completed several of the facility's admission evaluations. 10/29/25 1:45 PM- The findings were reviewed during the exit conference with E1(NHA), E2 (DON), E3 (RDOCS), E4 (RN/UM) and E5 (RN/UM).

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 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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, it was determined that for one (R1) out of four residents reviewed for Pharmacy services, the facility failed to provide pharmaceutical services that included acquiring and receiving a medication (lorazepam) to meet R1's needs during her 8/5/25 admission. Findings include:Facility Pharmacy Information document stated, Pharmacy Order Timeline - New Orders, admission Orders or Refills ordered by 11 AM have a delivery window of 9 PM to 11 PM. Controlled Substances Orders - Controlled substances can only be sent upon valid script from a prescriber or a verbal order from a prescriber or an agent of the prescriber. (Note Agents of the prescriber may NOT order CII, only CII, CIV and CV.) Issued Jan-2024The U.S Drug Enforcement Agency (DEA) listed lorazepam as a Schedule VI medication. Drugs, substances, and certain chemicals used to make drugs are classified into five (5) distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential. 15-Oct-2025Review of R1's clinical record revealed:8/5/25 11:59 AM - R1's [Hospital] Discharge summary documented, . Medications at discharge. lorazepam 2 mg (milligrams) oral tablet, 1 tablet by mouth 2 times a day. Please contact PCP (primary care provider) for refill. 2 weeks sent to [pharmacy].8/5/25 - R1 was readmitted to the facility with diagnoses including, but were not limited to, diabetes and anxiety disorder. 8/5/25 - C1 (DO) ordered lorazepam tablet 2 mg by mouth two times a day for anxiety for 14 days. 8/5/25 10:20 PM - E6 (LPN) documented in R1's EMR, eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Medication not available.8/6/25 9:39 AM - E7 (LPN) documented in R1's EMR, eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Resident new admit, waiting for pharmacy to deliver.8/7/25 - C1 (DO) documented in R1's EMR Initial History and Physical note, .History of Present Illness. At the time of my examination, the patient was out of bed sitting in her chair. She [R1] was focused on her lorazepam therapy that she apparently takes chronically for her anxiety. Apparently, a prescription was not sent from the hospital at time of admission, no documentation in her discharge summary indicates that it was sent. Diagnosis and Assessment: .Anxiety disorder- appears chronic in nature, concern regarding lorazepam therapy as patient previously hospitalized with encephalopathy secondary to benzodiazepine use, will reduce lorazepam dosing to 1 mg twice daily.8/7/25 2:56 PM - E8 (LPN) documented in R1's EMR, eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Unit manager called pharmacy, meds (medication) will be delivered in (sic) the next shift.The facility failed to provide pharmaceutical services that assured that R1 received her medication (lorazepam) in a timely fashion to meet her needs. R1 went two days in the facility without her ordered lorazepam and missed four doses of this medication. 8/7/25 11:08 PM - E9 (RN) documented in R1's EMR, Health Status note- resident seized and was sent to the hospital.8/7/25 11:09 PM - E6 (LPN) documented in R1's EMR, eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Medications was (sic) delivered at the time the patient was having a medical emergency and she could not swallow.8/9/25 12:28 PM - Upon R1's re-admission to the facility, R1's [hospital] discharge summary stated, Narrative Summary of hospital course - . 88 yo (year old) F (female) with pmh (past medical history) of anxiety. who returned from her nursing facility due to concern for witnessed seizure-like activity. Patient had missed a few doses of her chronic lorazepam for an unclear reason.She (R1) presented to the hospital with concern for seizure activity.10/28/25 3:04 PM - During an interview, C4 (facility's pharmacy account manager) stated, C5 (hospital discharging physician) escribed (electronically prescribed) the lorazepam order on 8/5/25 at 1:38 PM. It came to our pharmacy. The pharmacy did not have this patient residing in the SNF (skilled nursing facility). Their (R1's) profile was in the IL (independent living). We did not have any allergy information so we had to call the IL to get allergies. On 8/6/25, the facility called and was told there was no script (prescription). The script was associated with the IL. The problem was [R1] was profiled as residing in the IL, where she normally lives. The pharmacy did not know she had been to the hospital and was now in rehab at the SNF. We (pharmacy) typically try not to admit or move the patients in the profiles until they are actually in the facility as this creates an insurance reimbursement issue if the resident ends up not showing up at the facility. On 8/7/25, the facility got the MD (medical doctor) to fill out a new script. He (C1, DO) wrote for 1mg (milligram) of lorazepam BID (twice a day) but the formulation of lorazepam in the E box (emergency medication box) was 0.5 mg, the pharmacy could not release the medication. The script (prescription) has to match the drug formulation in the E box exactly or regulation or we cannot release the

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Based on record review and interview, it was determined that for one (R1) out of four residents reviewed for pharmacy services, the facility failed to ensure R1 was free of a significant medication error. This failure resulted in a harm in which R1 seized and was transferred to the hospital on 8/7/25 with benzodiazepine withdrawal from missing four doses of lorazepam. Based on a review of the facility's corrective actions taken and completed on 8/8/25 at 11:20 PM, it was determined that this incident was past non-compliance. Findings include:8/5/25 11:59 AM - R1's [Hospital] Discharge summary documented, . Medications at discharge. lorazepam 2 mg (milligrams) oral tablet, 1 tablet by mouth 2 times a day. Please contact PCP (primary care provider) for refill. 2 weeks sent to [pharmacy].8/5/25 - R1 was readmitted to the facility with diagnoses including, but were not limited to, diabetes and anxiety disorder.8/5/25 - C1 (DO) ordered lorazepam tablet 2 mg by mouth two times a day for anxiety for 14 days. 8/5/25 10:20 PM - E6 (LPN) documented in R1's EMR, eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Medication not available.8/6/25 9:39 AM - E7 (LPN) documented in R1's EMR, eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Resident new admit, waiting for pharmacy to deliver.8/7/25 - C1 (DO) documented in R1's admission History and Physical note- . History of Present Illness-. She [R1] was focused on her lorazepam therapy that she apparently takes chronically for anxiety. Apparently, a prescription was not sent from the hospital at the time of admission, no documentation in her discharge summary indicates that it was sent. Diagnosis and Assessment: .Anxiety disorder -.concern regarding lorazepam therapy as patient previously hospitalized with encephalopathy (a condition that causes brain disfunction) secondary to benzodiazepine use.8/7/25 2:56 PM - E8 (LPN) documented in R1's EMR, eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Unit manager called pharmacy, meds (medication) will be delivered in (sic) the next shift.8/7/25 11:08 PM - E9 (RN) documented in R1's EMR, Health Status note- resident seized and was sent to the hospital.8/7/25 11:09 PM - E6 (LPN) documented in R1's EMR, eMAR- Administration note- Lorazepam tablet 2 mg- give 1 tablet by mouth two times a day for anxiety x 14 days. Medications was (sic) delivered at the time the patient was having a medical emergency and she could not swallow.8/8/25 11:57 AM - C2 (hospital NP) documented in R1's hospital EMR, .Chief complaint- seizure -like activity without history. History of present Illness: .Upon chart review, it is noted that it was recommended that the patient be weaned off lorazepam. Patient [R1] states that she has not received any lorazepam since returning to the facility as they have been 'out of it'. Patient presents to the ED (emergency department) from a skilled nursing facility with witnessed seizure-like activity. Patient has no history of prior seizures. Patient states that she has been taking lorazepam for 20 years, her physician recently retired and the practice has been taken over by another physician. She states that there had been a discussion about weaning off of her lorazepam, but she wants to fire the doctor because she does not feel she should be weaned off.8/8/25 1:54 PM - C3 (hospital MD) documented in R1's EMR neurology consult, . Assessment/Plan: .New onset seizure- suspected secondary to holding Ativan (lorazepam) (has been on ativan for many years and missed several days of dose). The facility self-identified this issue and took the following corrective actions: - Educated staff members on the rights of medication administration- Enacted daily audits of all new admission patients for medication supply at the Monday to Friday morning clinical meetings- Educated staff members on the process to follow if medication is not available- Tasked admission staff with confirming all new admission patients come from the discharging facility with necessary prescriptions, that the prescription was sent to their facility pharmacy and confirm with the facility pharmacy that he prescription was received- Tasked [facility pharmacy] with notifying the facility for any new admission medication that requires a prescription and the prescription was not sent directly from the discharging facility- Educated staff members that the providers are to be informed immediately for a recognized failure in obtaining necessary medication- Educated the providers that prescriptions for medications from the Emergency supply box(E Box) must be written in the exact formulation of the drug supplied in the emergency supply box. The facility alleged that all these corrective actions were completed by 8/8/25 at 11:20 PM. The surveyor confirmed education with staff during interviews. 8/9/25 - R1 was re-admitted to the facility after hospitalization. 8/11/25 - C1 (DO) documented in R1's EMR re-admission History and Physical note- . History of Present Illness- . The patient was readmitted there [hospital] with reported seizure-like activity. There appeared to be some issues obtaining patient's chronic benzodiazepine therapy from the pharmacy in