STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excelcare at Newark LLC	4949 Ogletown-Stanton Road Newark, DE 19713

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that for one (R4) out of three residents reviewed for death, the facility failed to promote and facilitate R4's self determination with respect to signing multiple consents upon his admission to the facility. Findings include:Review of R4's clinical record revealed: [DATE] - R4 was admitted to the facility on Friday evening shift with a diagnosis that included, but was not limited to prostate cancer with metastasized (spread) to the bone and brain. R4's facesheet revealed that he was listed as the Responsible Party. [DATE] (untimed) - A speech therapy evaluation and plan of treatment documented that R4's BIMS was a 14 out of 15, which represented that R4 had a normal cognitive function. [DATE] 1:22 PM - A BIMS evaluation was performed by E16 (former social worker) that documented a score of 10 out of 15, which represented that R4 had a moderate cognitive impairment. [DATE] - The admission MDS assessment documented R4's BIMS score as a 10. Review of the following signed facility consents revealed that R4 did not sign them despite that R4 was evaluated and documented as cognitively intact:-CPR/DNR documentation form was signed on [DATE] by FF1 (friend), E10 (LPN/Charge Nurse) and E11 (NP). -Consent to treatment was signed on [DATE] by FF1;-Care Management Services consent form was signed on [DATE] by FF1;-Consent to treat/assignment of benefits and receipt of notice of privacy practices was signed on [DATE] by FF1; and-Consents to administer influenza vaccination, pneumococcal vaccination, respiratory syncytial virus (RSV) vaccination and Covid-19 vaccination were signed by E10 (LPN/Charge Nurse) on [DATE] with the following handwritten documentation: verbal consent by [FF2, friend] family doesn't want vaccine. [DATE] 11:55 AM - During an interview, E10 (LPN/Charge Nurse) stated that she did not complete R4's admission on Friday evening. E10 stated that the admitting nurse should have obtained the signed consents as part of the admission process. E10 stated that she was told to complete the consents because they were not done. E10 stated that FF1 (friend) was here all the time and was referred to as a brother. E10 stated that she used the BIMS score that was documented 10, revealing that R4 was cognitively impaired. E10 stated that a resident with a BIMS score of 11 or lower cannot sign consents. When asked if she was aware of the BIMS score completed by the Speech Therapist (ST) on [DATE] that documented R4 as a 14/15, E10 stated that nobody shared the speech therapy BIMS score. E10 also stated that she learned later on that FF1 was not R4's real brother. [DATE] 9:25 AM - Finding was reviewed with E4 (VPO). The facility failed to promote and facilitate R4's self determination when obtaining multiple consents upon admission. [DATE] 4:20 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON) and E4.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, it was determined that for one (R1) out of three residents reviewed for change in condition, the facility failed to consult with R1's physician when R1 complained of shortness of breath and when oxygen therapy was initiated. Findings include:Cross refer F68411/13/25 - R1 was admitted to the facility with diagnoses including a right femur fracture.11/23/25 2:52 PM - E8 (COTA) documented in R1's clinical record, [R1] presents with labored breathing, oxygen saturation of 89% .session shortened.[R1] unable to participate.R1's clinical record lacked evidence that the medical provider was consulted of this new onset of respiratory distress.11/25/25 5:51 AM - A review of EMS documentation revealed a 911 call was made requesting emergency assistance for R1 at the facility.11/25/25 7:04 AM - An EMS Prehospital Care Report documented, .Nursing staff relayed at around 3am [sic] [R1] began complaining of SOB [shortness of breath].they [nursing staff] placed [R1] on 5 lpm [liters per minute] of oxygen via NRB [non-rebreather mask]. 12/19/25 8:00 AM - During an interview, E7 (LPN) stated, I answered the call bell. [R1]'s roommate said that [R1] can't breathe. I saw [R1] and she didn't look well. [R1] said she couldn't breathe. [R1] was at 88%. I put her on O2 [oxygen] at 2 liters.It was between 3:00 and 4:00 AM. It was before my break .The facility lacked evidence of documentation of consultation with R1's medical provider when she complained of shortness of breath, had a low oxygenation saturation level and was started on oxygen therapy.12/19/25 11:17 AM - During an interview (E8) stated, I remember [R1] did not do therapy that day [11/23/25]. I asked why she couldn't do therapy. [R1] told me she couldn't do therapy because of her breathing. I checked her vitals and put them in my note. I told the nurse whose cart was immediately outside of [R1]'s room.The facility lacked evidence that R1's physician was consulted when R1 complained of shortness of breath when it was reported to nursing staff on 11/23/25.12/23/25 11:58 AM - Findings were confirmed with E1, E2, and E3. 12/23/25 4:20 PM - Findings were reviewed during the exit conference with E1, E2, E3 and E4.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, it was determined that for one (R4) out of three residents reviewed for death, the facility failed to ensure all the required IDT (interdisciplinary team) members contributed to the 11/14/25 care plan conference. Findings include: Review of R4's clinical record revealed: 11/14/25 10:58 AM - The facility's unsigned and incompleted Care Conference Summary documented that Therapy discussed the resident's progress. Discharge planning was discussed. Nursing went over the resident's care. Under Section D. IDT participants who contributed to plan of care lacked evidence of that a specific Physician/Nurse Practitioner/Physician Assistant contributed and how they contributed. 12/22/25 10:30 AM - During an interview, E12 (SSD) stated that the only facility participants that attended R4's care plan conference was E12 from social services, [name of E10, LPN/Charge Nurse] and an unidentified therapy person. E12 stated that E15 (dietician) provided input ahead of the conference as she would not be present. E12 also stated that R4 had two individuals with him (FF1 and FF2). 12/22/25 11:55 AM - During an interview, E10 (LPN/Charge Nurse) stated that the Provider (Physician/NP) did not participate in R4's care plan conference or Provider input. E10 stated that if there are concerns by the resident during the conference, they would be shared with the Provider after the care conference. 12/23/25 9:25 AM - Finding was reviewed with E4 (VPO). The facility failed to ensure all required IDT members contributed to R4's care plan conference. 12/23/25 4:20 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON) and E4.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and other documentation as indicated, it was determined that for one (R1) out of three residents reviewed for change in condition, the facility failed to ensure that the proper assessments, interventions, and timely notifications to the medical provider were done when R1 was observed with changes in her clinical status. R1, a resident who previously did not require oxygen, complained of shortness of breath to nursing staff between 3:00 AM and 4:00 AM on [DATE]. The facility lacked evidence that R1's vital signs or respiratory status were monitored, and that the provider was consulted during this time. R1 was transferred to the hospital approximately two hours later. R1 was unresponsive when she arrived at the emergency room and later expired at the hospital. Due to this failure, an Immediate Jeopardy (IJ) was called on [DATE] at 12:00 PM, with an abatement date of [DATE] at 4:15 PM. Findings include:Cross refer F580A review of R1's clinical record revealed:[DATE] - R1 was admitted to the facility with diagnoses including a right femur fractureXXX[DATE] 2:52 PM - E8 (COTA) documented in R1's clinical record, [R1] presents with labored breathing, oxygen saturation of 89% .session shortened.[R1] unable to participate.XXX[DATE] 9:16 PM - A Daily Skilled Charting note entered by E9 (LPN) documented, .O2 sats [saturation] 93% Date: [DATE] 22:10 [10:10 PM] .R1's documented oxygen saturation level, obtained approximately twenty-four hours earlier, was not a current reading. [DATE] 5:47 AM - A facility document that listed messages that were sent to R1's provider documented E5 (RN) left a message stating, [R1] is having a hard time breathing [sic] wants to go to the hospital.XXX[DATE] 5:51 AM - A review of EMS documentation revealed a 911 call was made requesting emergency assistance for R1 at the facility. [DATE] 6:25 AM - A review of hospital documentation revealed R1 arrived at the emergency roomXXX[DATE] 7:04 AM - An ED (Emergency Department) Physician Record documented, [R1] presents to the emergency department unresponsive. [DATE] 7:10 AM - An EMS Prehospital Care Report narrative documented, .[R1] contact delayed due to no one answering the doorbell.Nursing staff relayed at around 3am [sic] [R1] began complaining of SOB [shortness of breath].they [nursing staff] placed [R1] on 5 lpm (liters per minute) of oxygen via NRB [non-rebreather mask].[R1]'s [oxygen] saturation was in the 60's and had improved to the 80's.EMS placed [R1] on 15 lpm.En route, [R1] began declining and BLS administered [sic].XXX[DATE] 7:30 AM - E5 documented in R1's clinical record, [R1] c/o [complained] of SOB, [R1] put on oxygen, still remained low 65% at 5 liters. Applied non-rebreather and went up to 90%. [R1] insisted on going to the hospital.[R1] sent to ER.sp02 [sic] 90%.[DATE] 8:00 AM - During an interview, E5 stated, I was on break at 4:00 am. E7 [LPN] told me to check on [R1]. [E7] said [R1] can't breathe. [E7] put [R1] on oxygen. [E6, RN Supervisor] and I went in after my break. [R1] was okay, she was on NC (nasal cannula) 2 liters. [R1] said she was hungry. [R1] ate a snack, and I went to start med pass. [R1] again said she couldn't breathe. We titrated [oxygen] up to 3 liters and it [R1's oxygenation level] went up to 92%. The Surveyor asked, What time did this occur? E5 stated, I don't remember the exact time. E5 then stated, [R1] went down to 65% on 3 liters. [E6] put [R1] on a non-rebreather at 6 liters. The Surveyor asked, What time was [R1] put on the non-rebreather? E5 stated, I can't recall the exact time. I called the provider when [R1] went down again. After that I called 911. The Surveyor asked, Did you take [R1]'s vitals or do an assessment? E5 stated, I took her vitals around 4:30 am. I assessed [R1]'s lungs and they sounded diminished. I kept checking her pulse ox [pulse oximeter]. The Surveyor asked, Were the assessment and pulse ox readings documented? E5 stated, I did not document it.[DATE] 10:26 AM - During an interview, E7 stated, I answered the call bell. [R1]'s roommate said that [R1] can't breathe. I saw [R1] and she didn't look well. [R1] said she couldn't breathe. [R1] was at 88%. I put her on O2 [oxygen] at 2 liters. [R1] went up to 92%. I told her nurse [E5]. It was between 3:00 and 4:00 AM. It was before my break. The Surveyor asked, Were any vitals or oxygen saturation readings documented? E7 stated, I did not document them.The facility lacked evidence of documentation of R1's vital signs even though she complained of difficulty breathing and exhibited signs of respiratory distressXXX[DATE] 11:17 AM - During an interview, E8 stated, I remember [R1] did not do therapy that day [[DATE]]. I asked why she couldn't do therapy. [R1] told me she couldn't do therapy because of her breathing. I checked her vitals and put them in my note. I told the nurse whose cart was immediately outside of [R1]'s room. The nurse took [R1]'s pulse ox again.R1's clinical record lacked evidence of nursing documentation of R1's shortness of breath, inability to participate in therapy, any interventions that were implemented or notification to the medical provider on this date. [DATE] 11:00 AM - An undated facility document entitled, Nursing Competencies Identified Through Facility Assessment

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, it was determined that for one (R4) out of one resident reviewed for death, the facility failed to ensure R4 had a completed and signed resident agreement upon admission to the facility. Findings include: Review of R4's clinical record revealed: 11/7/25 - R4 was admitted to the facility on Friday evening shift with a diagnosis that included, but was not limited to prostate cancer with metastases to the bone and brain. R4's facesheet revealed that he was listed as the Responsible Party. 12/2/25 9:40 PM - A nursing note documented that R4 passed away in the facility. Review of R4's 11/7/25 DE (Delaware) admission Packet revealed that it was unsigned and incomplete. A written statement by E14 (admission Director) revealed, On November 10th patient [R4] was asleep when trying to do the admission agreement; went back in the afternoon and was still sleeping. On November 11th patient refused due to being tired. Facesheet from the hospital had 2 people listed as siblings that we did not find out they were NOT family members until the brother came in the day he [R4] passed away. Agreement. was in progress until the day patient passed away. 12/23/25 9:25 AM - Finding was reviewed with E4 (VPO). The facility failed to ensure R4's medical record included a completed and signed DE admission Packet, a legal document that clearly communicated the resident's rights, facility's policies and described the healthcare services to be provided to the resident. 12/23/25 4:20 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON) and E4.