

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085025	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/01/2026
NAME OF PROVIDER OR SUPPLIER Excelcare at Newark LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner, putting 78 residents who received meals from the kitchen (2 residents received nutrition via feeding tubes) out of 80 total residents at potential risk for unsanitary meal services. Findings include: 1. During an observation and interview on 03/29/26 from 9:25 AM through 10:28 AM, with the Dietary Manager (DM) revealed two Dietary Aides (DA) 1 and DA2 were observed not wearing beard/hair restraints while engaged in food preparation and dishwashing activities. The DM confirmed the two DAs were not wearing beard/hair restraints. 2. During an observation and interview with the DM on 03/31/26 from 8:55 AM through 11:36 AM, during the meal serving line revealed, DA1 and DA3 were not wearing beard/hair restraints. The DM stated beard/hair restraints should be worn at all times. The DM stated the facility was out of beard/hair restraints.</p>		

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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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure medications were stored in a secure manner to prevent unauthorized access when two of five medication carts were left unattended and unlocked. This deficient practice had the potential to affect all residents, staff, and visitors placing them at risk for unauthorized access to medications. Findings include: 1. During an observation on 04/01/26 at 4:53 AM revealed the medication cart was unlocked on the [NAME] Hall in front of room W102. Licensed Practical Nurse (LPN)4 was in the room with privacy curtain pulled. The medication cart was not visible from the room. There was one staff member Certified Nursing Assistant (CNA)4 down hall delivering linen to another room. At 4:59 AM LPN4 returned to the medication cart and secured it. She confirmed medication cart was left unlocked and could not be visualized from the resident's room. 2. During an observation on 04/01/26 at 5:56 AM revealed the medication cart at the nurses station was unlocked. The Assistant Director of Nursing (ADON) walked past the unlocked medication cart twice. At 6:00 AM the ADON went down the East Hall leaving no one at the nurses' station and the medication cart remained unlocked. At 6:05 AM the ADON returned to the nurses station locked the medication cart. During an interview on 04/01/26 at 6:05 AM with ADON revealed the medication cart at nurses station was shared by both nurses on the [NAME] and East Halls. She revealed it was an expectation that all medication and treatment carts when not in use must be kept locked. Review of the facility's policy titled Storage of Medication revised November 2020 revealed that compartments containing drugs and biologicals are locked when not in use. Unlocked carts should not be left unattended.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to ensure residents received written information regarding advanced directives and the right to accept or refuse medical and surgical treatments for two residents of two residents (Resident (R) 19 and R11) reviewed for advanced directives out of a total sample of 42. This failure places the residents at risk of not understanding their rights and options regarding care. Findings include: 1. Review of R19's admission Record, located under the Profile tab in the electronic medical record (EMR), revealed R19 admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and , major depressive disorder. Review of R19's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 02/20/26 and located under the MDS tab of the EMR, revealed R19 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating she was cognitively intact. Review of R19's EMR revealed no evidence to indicate R19 received written information regarding advanced directives. 2. Review of R11's admission Record, located under the Profile tab of the EMR, revealed R11 re-admitted to the facility on [DATE] with diagnoses including heart failure, stage three chronic kidney disease, malignant neoplasm of upper lobe, left bronchus, and pain. Review of R11's quarterly MDS, with an ARD of 01/29/26 and located under the MDS tab of the EMR, revealed R11 had a BIMS score of 12 out of 15, which indicated moderately impaired cognition. Review of R11's EMR revealed no evidence to indicate R11 received written information regarding advanced directives. During an interview on 10/30/26 at 10:35 AM, the Social Service Director (SSD) stated she did not have any written information that she provided to residents regarding the distinct types of advanced directives. There was no signature page to indicate a verbal explanation was provided or to indicate the residents understand they have the right to accept or refuse medical and surgical treatments. During an interview on 04/01/26 1:45 PM, the Admissions Director (AD) stated there was only one page in the admission packet that asked if a resident had an advanced directive or if they would like to formulate one. She stated she did not have any written information defining the types of advanced directives to provide residents with upon admission. During an interview on 04/01/2026 at 1:50 PM, the Administrator stated she was not aware of the regulatory guidance to provide written information regarding advanced directives and the right to accept and or refuse medical and surgical treatment to residents. She was not aware that her policy indicated this would be done. Review of the facility policy titled, Advanced Directives, revised November 2025 revealed, . The resident has the right to formulate and advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Providing the Resident with Written Information Concerning Advance Directives: . (2) Written information is provided in a manner easily understood by the resident or representative.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to report an allegation of sexual abuse to the State Survey Agency (SSA) within the required two hour timeframe for one resident (Resident (R)110) out of 11 residents reviewed for abuse out of a total sample of 42 residents. This failure had the potential to delay a timely investigation and the implementation of appropriate protective measures, placing resident safety at risk and increasing the potential for further abuse. Findings include: Review of R110's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE] with diagnoses of cognitive communication deficit, and mild cognitive impairment. R110 discharged from the facility on 09/25/25. Review of R110's 5-day Entry Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R110 was cognitively intact. Review of the Grievance/Concern Form dated 09/18/25 and provided by the facility revealed R110's son called to report that sometime this week a male aide come into his mom's room in the middle of the night stating he needed to check if she was wet. Patient refused. A little later aide came back again and she refused. (missing second page). Review of the facilities Investigation Report dated 09/22/25 and provided by the facility indicated R110's assigned Certified Nursing Assistant (CNA)13 made an inappropriate verbal remark directed toward R110. Further review of the investigation report revealed that the CNA stated, you don't know what you are missing. Review of the Incident Tracking Form provided by the facility dated 09/22/25 at 8:21 PM revealed the following A police officer arrived at the facility and informed staff that they had received a complaint from a resident's family alleging that the resident may have been spoken to in a manner that was uncomfortable for her. Per the resident, the male staff who was assigned to her care said You don't know what you are missing when she refused incontinent care. During an interview on 03/30/26 at 4:03 PM, the Admissions Director (AD) stated that she had received a telephone call from R110's son on 09/18/25 who stated a male staff member entered his mother's room to provide incontinent care for R110 who refused and then the male returned again and the male aide made a comment which made R110 feel uncomfortable with the comment. Further interview with the AD she stated that immediately after concluding the telephone conversation with R110's son she informed the Director of Nursing (DON) of the R110's son's concern. The AD also stated that the facilities protocol is to immediately notify the Administrator and the DON of all grievance and abuse concerns. During an interview on 03/30/26 at 4:26 PM with the DON stated that she did not remember receiving the Grievance/Concern form related to R110's son's concerns. The DON further stated that she learned about the alleged abuse was on 09/22/25 when a Police Officer went to the facility after receiving an allegation of abuse at the facility. The DON further stated that she initiated the investigation on 09/22/25. The DON stated that the SSA should have been notified on 09/18/25 after immediately following the R110's son's grievance concerns. During an interview on 03/30/26 at 4:30 PM with the Administrator/Abuse Coordinator revealed she was not aware of R110's sons grievance concerns as she was out on leave. The Administrator confirmed that alleged violations involving abuse should have been reported to the State SSA within two hours after the allegation was made. During a second interview with the DON on 03/31/26 at 8:52 AM the DON confirmed that the SSA was notified of the abuse allegation on 09/22/25 four days after the R110's grievance allegation. The DON further stated that it is the facility's policy to report alleged violations involving abuse to be reported to the SSA within two hours after the allegation was made. CNA13 was unable to be interviewed as he was on vacation during the survey. Review of the facility's policy titled, Abuse/Neglect-Exploitation Mistreatment and Misappropriation of Property Prevention, dated 06/15/25, revealed it was the policy of the facility that each resident be free from verbal, sexual, physical, and mental abuse, and (continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>mistreatment. The policy indicated that alleged violations involving abuse were to be reported to the State Survey Agency within two hours after the allegation was made.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to conduct a thorough investigation of an abuse allegation for one resident (Resident R110) out of 11 residents reviewed for abuse out of a total sample of 42 residents. This deficient practice placed residents at risk for ongoing abuse and failed to ensure residents' safety. Findings include: Review of R110's Face Sheet located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted on [DATE] with a diagnosis of cognitive communication deficit and mild cognitive impairment. The resident was discharged from the facility on 09/25/25. Review of R110's 5-day Entry Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R110 was cognitively intact. Review of the Grievance/Concern Form dated 09/18/25 and provided by the facility revealed R110's son called to report that sometime this week a male aide came into his mom's room in the middle of the night stating he needed to check if she was wet. Patient refused. A little later the aide came back again and she refused., (missing second page). Review of the facilities Investigation Report dated 09/22/25 provided by the facility indicated R110's assigned Certified Nursing Assistant (CNA) 13 made an inappropriate verbal remark directed toward R110 after the resident refused an incontinence check/change. Further review of the investigation report revealed that the male CNA had stated, you don't know what you are missing. Although the facility conducted resident interviews receiving care provided by the alleged male CNA, the interview process lacked specifics to the allegation. Interview questions were general in nature (e.g., whether residents had concerns or complaints or if the CNA had been inappropriate), and did not include targeted questions related to potential sexual abuse, such as inappropriate sexual remarks, unwanted touching, or sexual advances. Questions asked to the residents provided care by the alleged CNA were: 1. Have you had any concerns or complaints with your 11-7 CNA. 2. Has . (11-7 CNA ever been inappropriate or spoken to you inappropriately? No other questions were documented. Review of [NAME] 2 State Police Report dated 09/23/25 and provided by the facility revealed the victim reports that she may have been touched inappropriately by a staff member while he was checking her. Review of the typed statement by the Social Services Director (SSD) dated 09/22/25 indicated that the SW had spoken with R110 and indicated that R110 explained that about 4:00 AM the week prior the aide went into her room to check her diaper left the room and then returned and stated, you don't know what you missed. The typed statement indicated R110 was asked if she felt safe in the facility and the resident replied, it was hard to answer. No other questions were documented. Review of the typed statement by the SSD dated 09/23/25 indicated the SSD had spoken with R110 and asked if R110 felt safe in the facility the resident's response was documented as right now talking with you, yes. No further questions were documented on the written statement. Review of a typed interview dated 09/23/25 conducted with the roommate of R110 revealed the roommate was asked the following question: Can you tell me if you heard or know of any problem with A bed and her male CNA on the 11 to 7 shift? No other questions regarding the alleged allegations were asked to R110 or documented. In a typed statement dated 09/25/25 indicated the SSD was following up with R110 to ask how R110 was feeling and doing. The statement indicated R110 stated she was happy as can be. It is also documented that the SSD asked the resident felt safe in the facility and the resident replied, I feel safe now because I am going. (sic) No further questions were documented on the written statement. During an interview on 03/30/26 at 4:03 PM with the Admissions Director (AD) stated she was not aware that the second page of the Grievance/Concern report was missing. The AD further stated that she did not have a copy of the second page of Grievance/Concern Form dated 09/18/25. The AD also stated that she did not keep a copy of the Grievance/Concern report and did not keep any documentation regarding the grievance called in by R110's son. The AD stated that she gave Grievance/Concern to the Director of Nursing (DON) (continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>immediately following the call with the resident's son. During an interview on 03/30/26 at 4:26 PM with the DON stated she did not remember receiving the Grievance/Concern report and did not know the second page of the Grievance/Concern dated 9/18/25 was missing. The DON further stated that she learned about the alleged abuse on 09/22/25 when a Police Officer went to the facility after receiving an allegation of abuse at the facility and initiated the investigation. During an interview on 03/30/26 at 4:30 PM with the Administrator/Abuse Coordinator the Administrator revealed she were not aware of R110's sons grievance concerns as she was out on leave. The Administrator also stated she did not know that the second page of the Grievance/Concern Form was missing and stated she would try to locate the missing page. During a follow up interview with the DON on 03/31/26 at 4:46 PM revealed that a skin assessment was completed on R110 on 09/22/25 per her instruction and there were no positive findings of abuse. The DON also stated that the male assigned CNA was re-assigned and was not to enter the resident's room. Additionally, the DON stated that other residents assigned to the male CNA had no complaints reported. The DON stated that the male CNA was interviewed and denied touching the resident inappropriately and denied making the comment you don't know what you're missing after R110 refused the incontinence check. The DON stated that per policy the male CNA was suspended pending the investigation. During a follow-up interview 04/01/26 at 1:30 PM with the Administrator/Abuse Coordinator the Administrator revealed she was unable to find the missing second page of the Grievance/Concern Form. CNA13 was unable to be interviewed as he was on vacation during the survey. Review of the facility's policy titled, Abuse/Neglect -Exploitation Mistreatment and Misappropriation of Property Prevention, dated 06/16/25, revealed .under VII. Reporting/Response: indicates When an allegation or suspicion of one of the activities set out in the definitions herein occurs the facility shall: 2. Have evidence that all alleged violations are thoroughly investigated.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and facility policy review, the facility failed to ensure care plans were revised to accurately reflect the resident's code status for two of two residents (Resident (R) 19 and R11) reviewed for care planning out of a total sample of 42. This failure had the potential to cause residents to not receive appropriate care and treatment. Findings include:1. Review of R19's admission Record, located under the Profile tab in the electronic medical record (EMR), revealed R19 admitted on [DATE] with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, major depressive disorder, chronic obstructive pulmonary disease (COPD), and pain in thoracic spine. The admission Record, indicated R19 was a Full Code. Review R19's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 02/20/26 and located under the MDS tab of the EMR, revealed R19 had a Brief Interview for Mental Status (BIMS) score of 15 of 15, indicating she was cognitively intact. Review R19's Physician Orders, dated March 2026 and located under the Orders tab of the EMR, revealed R19 was a Full Code. Review of the Care Plan, initiated on 06/01/22 and located under the Care Plan, tab of the EMR, revealed . Psychosocial Well-Being: Advance Directive: DNR [do not resuscitate] .2. Review R11's admission Record, located under the Profile tab of the EMR, revealed R11 re-admitted to the facility on [DATE] with diagnoses including heart failure, stage three chronic kidney disease, malignant neoplasm of upper lobe, left bronchus, and pain. Review R11's quarterly MDS, with an ARD of 01/29/26 and located under the MDS tab of the EMR, revealed R11 had a BIMS score of 12 out of 15, which indicated moderately impaired cognition. Review of R11's Physician Orders, dated March 2026 and located under the Orders tab of the EMR revealed R11 was a Full Code.Review of R11's Care Plan, dated 06/07/23 and located under the Care Plan tab of the EMR, revealed . Psychosocial Well-Being: Advance Directive: DNR. During an interview and record review on 03/31/26 at 9:37 AM, Licensed Practical Nurse (LPN) 2 verified the care plan should not indicate R19 and R11 had a DNR status and confirmed the orders indicated the resident were a full code. LPN2 stated the nurses and unit managers usually updated the care plans. During an interview on 03/31/2026 at 11:32 AM, the Assistant Director of Nursing (ADON) confirmed the care plans were not correct for R19 and R11 and did not reflect the current code status. The ADON stated the nurses and unit managers usually updated the care plans. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, revealed, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition changes.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure that one (Resident (R)8) of four residents reviewed for falls was safely transferred using a Hoyer (mechanical lift) out of a total sample of 42 residents. This failure has the potential to cause the resident to sustain an injury. Findings include: Review of R8's admission Record located in the electronic medical records (EMR) under the tab titled Profile revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease with hemiplegia and hemiparesis, abnormalities of gait, and falls. Review of R8's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/13/26 located in the EMR under the MDS tab revealed the resident had a Brief Interview for Mental Status (BIMS) score of 12 out of 15 points, which indicated the resident had moderately impaired cognition. The resident was assessed as being totally dependent on staff for activities of living (ADLs) care needs. The resident was assessed to require transfers with a Hoyer lift. Review of R8's Care Plan with a revision date of 10/22/24 located in the EMR under the Care Plan tab revealed the resident required two staff members for bed mobility and Hoyer lift transfers. During an observation 04/01/26 at 10:30 AM revealed Certified Nursing Assistant (CNA)7 used the Hoyer lift by herself to transfer R8 from the bed to a shower stretcher so the resident could be taken to the shower room. CNA7 had to reposition the lift several times to move the lift closer to the stretcher. The resident was swinging the lift sheet holding onto the lift with his good arm. During an interview on 04/01/26 at 1:57 PM with Licensed Practical Nurse (LPN)3 revealed CNA7 had already reported that she had failed to have another staff member present while transferring the resident from the bed to shower stretcher. LPN3 stated the resident was care planned to have two staff members present for bed mobility and transfer. The LPN stated she assumed another staff member was in the room assisting CNA7. During an interview on 04/01/26 at 2:00 PM CNA7 revealed she found it difficult to get someone to help as everyone was busy. CNA7 stated she knew the resident required two persons to assist; she knew what she did was wrong that why she did a self-report.</p>		