STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085027	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Silver Lake LLC	1080 Silver Lake Blvd Dover, DE 19904

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observations, interviews, record review and policy review, the facility failed to ensure a call light was within reach for one resident (Resident (R) 1) out of 39 sampled residents reviewed for call lights. This failure had the potential to create a situation where the resident would need help and could not reach the call light, causing the resident's needs to go unmet.Findings Include:Review of 1's Face Sheet located under the Profile tab of the electronic medical record (EMR), revealed admission date of 10/07/25 with diagnoses which included Schizophrenia and intellectual disabilities.Review of R1's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/24/25, located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated the resident was cognitively intact. R1 was dependent on staff for all Activities of Daily Living (ADLs).Review of the Care Plan located in the EMR under the Care Plan tab and dated 10/08/25 revealed, .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.During an observation on 1/21/26 8:55 AM, R1 was in her bed calling out, saying help repeatedly. Observed at the top of her bed was a long black tube with a white end that was attached to her bed. The tube had a place at the bottom to attach to the call light. The white end was close to her mouth, and the black tube was malleable. The call light was placed above her head, approximately six inches.During an observation and interview on 01/22/26 at 3:43 PM, Registered Nurse (RN) 9 stated R1's call light was used with her breath. The call light was placed above her head, approximately six inches from her mouth. She stated that for R1 to use her call light, it needed to be in a position where she could blow into it. RN9 moved the call light closer to R1's mouth until the call light was in R1's mouth. R1 blew into the call light, and the call light turned on.During an interview and observation on 01/22/25 at 3:30 PM, Certified Nurse Aide (CNA) 10 stated R1 required total care, and her call light needed to be near her mouth for it to work. CNA 10 agreed it was not in place.During an observation and interview on 01/23/25 at 10:10, CNA 10 came out of R1's room. R1 had her call light in front of her face, approximately six inches away. R1 stated she could not use her call light.During an interview and observation on 01/23/26 at 10:19 AM, Licensed Practical Nurse (LPN) 5 stated that if R1 needed help, she would usually call out. She stated her call light was important and should be within R1's reach. LPN5 stated R1 has the type of call light that worked when R1blew into it. LPN5 attempted multiple times to get the call light in the correct position, while R1 continuously stated she could not use it. LPN5 finally took the call light and bent it into a fashion that worked when R1 blew into it. R1 stated she knew where her call light was and could use it. During an observation on 01/23/26 at 10:37 AM and at 10:42 AM, R1 turned on her call light; there was no one in R1's room at the time.During an interview on 01/23/26 at 10:37 AM, RN5stated that it was important that R1's call light was within reach. RN5 stated that all staff who work with R1 should know where to place R1's call light so R1 can use it when necessary.During an interview on 01/23/26 at 8:19 AM, the Director of Nursing (continued on next page)

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DON) stated that call lights should always be within residents' reach.Review of the facility policy titled, Call Lights: Accessibility and Timely Response revised 07/2025 revealed, . Staff will ensure the call light is within reach of the resident and secured as needed.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview, record review, and facility policy review, the facility failed to ensure one of five residents (Resident (R) 11) reviewed for unnecessary medications, continued to receive as needed (PRN) psychotropic medication (lorazepam) beyond 14 days, without an evaluation and documentation of the clinical indications to use the medication beyond the 14 days. This failure had the potential to place the resident at risk of adverse consequences.Findings include:Review of R11's electronic medical record (EMR) located under the Profile tab indicated the facility admitted the resident on 11/04/24.Review of R11's EMR Orders located under the Orders tab dated 12/23/25 indicated, lorazepam 0.5 milligrams (mg) [antianxiety medication] and take one half tab (0.25 mg) to be administered every four hours PRN [as needed] for agitation and restlessness.Review of R11's EMR Medication Administration Record (MAR) located under the Orders tab dated 12/25 indicated the facility administered the lorazepam on 12/24/25 one dose; on 12/26/25 one dose; 12/29/25 one dose; and on 12/30/25 one dose.Review of R11 EMR titled MAR located under the Orders tab for the month of 01/26 indicated the facility administered the lorazepam on 01/01/26 one dose; 01/08/26 one dose; 01/09/26 one dose; 01/11/26 one dose; 01/12/26 one dose; 01/15/26 one dose in the morning and one dose in the afternoon; 01/16/26 one dose in the morning and one dose in the evening; 01/17/26 one dose was administered; 01/18/26 one dose was administered; and on 01/21/26 one dose was administered.During an interview on 01/23/26 at 10:29 AM, the Consultant Pharmacist stated that any time a PRN psychotropic medication was ordered, there needs to be a 14-day stop date. The Consultant Pharmacist stated the medical provider then to reassess the continued use and provide justification and this needed to then be documented in the clinical record. The Consultant Pharmacist stated the use of PRN psychotropic medication applied to residents who received hospice services.During an interview on 01/23/26 at 10:38 AM, the Director of Nursing (DON) stated the PRN for lorazepam did not require a 14-day end date since R11 received hospice services.Review of a facility's policy titled Use of Psychotropic Medications dated 02/18/25 indicated, .Psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and is subject to the limitations as noted.PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, until the attending physician or prescriber believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record reviews, interviews, and facility policy review, the facility failed to ensure a person-centered comprehensive care plan was developed for one of one resident (R)6 receiving wound care/treatment out of a total of 39 sampled residents. This deficient practice placed R6 at risk of worsening wounds, new wound development, and for unmet resident care needs and goals for care.Findings include:Review of R6's admission Record, located under the Profile tab of the electronic medical record (EMR) revealed admission date of12/02/25 with diagnoses that included cellulitis, end stage renal disease (ESRD), dependence on renal dialysis, and difficulty in walking.Review of R6's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/04/25 located in the EMR under the MDS tab reflected R6 was at risk of developing pressure ulcers/injuries and had one or more unhealed pressure ulcers/injuries (PU/PI) present upon admission to the facility. The MDS reflected R6 had two Stage 3 pressure ulcers (Full thickness tissue loss) and moisture associated skin damage (MASD), a non-pressure skin issue.Review of R6's Care Plan located in the EMR under the Care Plan tab initiated on 12/04/25 (revision on 01/16/26) indicated, The resident has potential impairment to skin integrity of the r/t ESRD, anemia, obesity, HTN [hypertension], diabetes, use of anticoagulants, and has actual skin breakdown to the right gluteal fold, and coccyx. I have a terminal prognosis r/t [related to] cancer of the lung. Further review of R6's Care Plan revealed it was not individualized and person-centered regarding treatment/services for Stage 3 pressure ulcers and MASD care.During an interview and record review on 01/23/26 at 9:17 AM, the MDS Coordinator (MDSC) stated that she initiated the comprehensive care plan based on a Care Area Assessment (CAA) that was triggered. The MDSC reviewed R6's admission MDS triggered CAAs for Pressure Ulcer. The MDSC reviewed the comprehensive care plan and confirmed that the care plan reflected objectives and interventions for the risk for pressure ulcers but did not have an objective and intervention to address actual wounds or a time frame to achieve desired outcomes. The MDSC stated that the care plan should reflect resident goals, desired outcomes, care/services provided, and specific services to be provided as reflected in the comprehensive assessment. The MDSC stated that she was responsible for the admission, quarterly, annual, and change in condition MDS completion. The MDSC stated that the Unit Managers reviewed the care plans for changes and updates.During an interview and record review on 01/23/26 at 10:24 AM, the Unit Manager (UM) stated that she tried to review the care plans for the residents assigned to his/her unit at least weekly. The UM said that she looked for care plans to address specific care needs, appropriate interventions that could prevent avoidable decline.During an interview on 01/23/26 at 11:59 AM, the Director of Nursing (DON) could not identify appropriate interventions in the care plan for delivery of care for the two actual Stage 3 wounds or MASD.Review of the facility's policy titled, Comprehensive Care Plans revised 02/18/25 revealed, .All CAAs triggered by the MDS will be considered in developing the plan of care . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on record review, interview and policy review, the facility failed to ensure residents maintained good hygiene for two (Resident (R) 20 and 75) of five residents reviewed for activities of daily living (ADL) in the sample of 39 residents. This failure has the potential for the residents to develop skin infections, social isolation, and a general decline in health.Findings included:1. Review of R20's Record of admission located in the Profile tab of the electronic medical record (EMR) revealed admission date 11/26/24 with diagnoses including major depressive disorder, Parkinson's disease, dizziness, anxiety, and difficulty in walking.Review of R20's Care Plan Report, dated 04/23/25 in the Care Plan tab in the EMR revealed, [R20] had an ADL self-care performance deficit due to activity intolerance. A care plan dated 04/24/25 revealed [R20] had potential for skin impairment due to decreased mobility, high blood pressure (HTN), fragile skin, and poor safety awareness. An intervention for this was to R20's skin will be assessed on a weekly basis on my scheduled bath day.Review of R20's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/25 and located in the MDS tab of the EMR, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident had intact cognition. The MDS also indicated R20 required set-up or clean-up assistance with showers and bathing.Review of Documentation Survey Report V2 dated 12/25 and located under the Tasks tab of the EMR, revealed under Shower/Bathing/Personal Care R75 had NA (not applicable) on Wednesday and Saturday during the month of December 2025.Review of Documentation Survey Report V2 dated 01/26 and located under the Tasks tab of the EMR, revealed under Shower/Bathing/Personal Care R20 had NA on Wednesday and Saturday during the month of January 2026.During the Resident Council meeting on 01/22/26 at 2:09 PM, R20 stated she should be getting a shower twice a week and this was not happening. She added there had been times when she gathered all her shower items, placed them on her over the bed table, and she ended up falling asleep only to wake in the morning realizing no one came and got her for her shower. She stated she should get showers on Wednesday and Saturday.During a follow-up interview with R20 on 01/23/26 at 8:50 AM, R20 stated she still had not received a shower She added no one had come to talk to her about it and she had not refused the shower.2. Review of R75s Record of Admission, located in the Profile tab of the EMR revealed admission date of 12/05/23 with diagnoses including seizures, major depressive disorder, and difficulty walking.Review of R75's Care Plan Report, dated 03/11/24 and found in the Care Plan tab in the EMR revealed, [R75] had an ADL self-care performance deficit due to disease process, general body weakness, impaired balance, limited mobility, and limited range of motion (ROM). A care plan dated 03/11/24 revealed [R75] had potential for skin impairment due to hypothyroidism, polyneuropathy, and use of anticoagulants. An intervention for this was to R75's skin will be assessed on a weekly basis on my scheduled bath day.Review of R75's quarterly MDS, with an ARD of 12/20/25 and located in the MDS tab of the EMR, revealed a BIMS score of 14 out of 15, which indicated the resident had intact cognition. The MDS also indicated R75 was independent with showers and bathing.Review of Documentation Survey Report V2 dated 12/25 and located under the Tasks tab of the EMR, revealed under Shower/Bathing/Personal Care R75 had NA on 12/22/25 and 12/25/25.Review of Documentation Survey Report V2 dated 01/26 and located under the Tasks tab of the EMR, revealed under Shower/Bathing/Personal Care R20 had NA on 01/05/26 and 01/22/26.During the Resident Council meeting on 01/22/26 at 2:09 PM, R75 stated she was not getting showers all the time. She added she will ask for them, but she still does not get them.During an interview on 01/23/26 at 8:15 AM, Certified Nurse Aide (CNA) 5 stated if the resident refused showers or baths she would reapproach the resident a second time. If the resident continues to refuse, she notified the nurse. She added she does document the refusal in the (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's chart.During an interview on 01/23/26 at 8:19 AM, CNA3 stated the resident is reapproached and if they continue to refuse a shower or bath the nurse is notified. She stated she will also document the refusal in the resident's chart.During an interview on 01/23/26 at 8:21 AM, CNA2 stated she will reapproach the resident and let the nurse know. She added if the resident does refuse all together then she documents it in the resident's chart. She added she did work with R75, and she will refuse at times, and she does document the refusal.During an interview on 01/23/26 at 9:51 AM, Registered Nurse (RN) 4 stated they really try to accommodate the resident. If the resident refused a shower or bath we see if they wanted it at a different time. Staff will also educate the resident about the importance of bathing. She added both the nurse and the CNA document the refusal in the resident's chart.During an interview on 01/23/26 at 8:19 AM, the Director of Nursing (DON) stated the expectation is for the CNA to ask the resident about their shower. If the resident refused the shower, the CNA should tell their nurse so they can reapproach the resident. She stated the nurse is responsible to verify the CNA offered the shower and whether the resident received a shower or the resident refused. The DON stated they recognized there was a problem. Review of the facility's policy titled, Activities of Daily Living dated 12/15/23 revealed, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Policy Explanation and Compliance Guidelines.6. The facility staff will document the provision of ADL care and/or refusals of care.

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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 record review, interview and policy review, the facility failed to ensure one resident (Resident (R) 71) of two residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene out of a total survey sample of 39 residents. This failure has the potential for the residents to develop a general decline in health.Findings include:1. Review of R71's admission Record located in the electronic medical records (EMR) under the Profile tab indicated admission date 01/06/23, with diagnoses of dementia with agitation.Review of R71's Care Plan located in the EMR under the Care Plan tab dated 12/17/25 indicated that the resident has an Activities of Daily Living (ADL) self-care performance deficit related to (r/t) limited mobility.Review of R71's quarterly Minimum Data Set (MDS) located in the EMR with an Assessment Reference Date (ARD) of 10/16/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of nine out of 15 which resident was cognition was moderately impaired. The assessment indicated the resident was dependent on staff for baths/showers.Review of the POC (Plan of Care) Response History located in the EMR under the Task tab indicated the task for the resident was Shower/Bathing/Personal Care Monday and Thursday 7-3. The follow up question indicated, Was a shower given revealed the resident refused a shower on 12/25/22, 12/29/25, 01/01/26, 01/05/26, 01/08/26, 01/12/26, 01/15/26 and 01/19/26.During an interview on 01/20/26 at 3:10 PM, R71 stated she would like a shower, but she never gets one. She stated she only received sponge baths.During an interview on 01/22/26 at 3:30 PM, Certified Nursing Assistant (CNA) 10 stated she received the shower schedule with her resident assignment sheet. She stated she would ask the resident if they wanted a shower and if they refused, she would notify the nurse.During an interview on 01/22/26 at 3:43 PM, Registered Nurse (RN) 9 stated if a resident refused their shower she would attempt to educate the resident. If they continued to refuse, she would document the refusal and inform the family. She stated she would use the shower sheet to know who needed a shower for her shift.During an interview on 01/22/26 at 3:47 PM, RN8 stated if a resident refused a shower the CNA should tell her and she would document the refusal. RN8 stated she did not see any documentation in R71's EMR indicating she had refused her shower.During an interview on 01/22/26 at 3:57 PM, Unit Manager (UM) stated when a resident is scheduled for their shower and they refuse, the CNA should let the nurse know. The nurse should then speak with the resident to encourage her to take a shower. If the resident continues to refuse, the nurse should document the resident's refusal. The UM confirmed, upon review of the EMR there were multiple occasions where the CNA documented that the resident refused a shower but there was not any nursing documentation indicating they were aware of the refusal and that the nurse had spoken with the resident to discuss the refusal.During an interview on 01/23/26 at 8:19 AM, the Director of Nursing (DON) stated the expectation for the CNA was to ask the resident about their shower. If the resident refused the CNA should tell their nurse so they can reapproach the resident. She stated the nurse is responsible for verifying with the CNA showers offered and whether the resident received a shower or the resident refused. The DON stated they recognized there was a problem During an observation and interview on 01/23/2026 at 12:30 PM, R71 stated she had not had a shower in the last few days. R71's hair appeared oily and pungent.Review of the facility's policy titled, Activities of Daily Living revised 12/15/23 revealed, .A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, interviews, and facility policy review, the facility failed to follow care plan interventions to set the low air loss (LAL) mattress at 150 for one of one (Resident (R)66) out of a total of 39 sampled residents. This deficient practice placed R66 at risk of worsening non-pressure wounds, new wound development, and for unmet resident care needs and goals for care.Findings include:Review of R66's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R66 admitted to the facility on [DATE], initial admission date 06/05/25, with diagnoses that included Type 2 diabetes mellitus with foot ulcer, non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin, non-pressure chronic ulcer of right ankle with unspecified severity, non-pressure chronic ulcer of left heel and midfoot with other specified severity, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side.Review of R66's Care Plan located in the EMR under the Care Plan tab initiated on 09/02/25 (revision on 12/18/25) indicated, the resident has potential for impairment to the skin integrity related to CKD (chronic kidney disease), diabetes, hemiplegia, limited mobility, history of skin breakdown, PVD (Peripheral Vascular Disease), anemia, HTN (hypertension), and has actual skin breakdown right medial foot and right heel. Interventions included low air loss mattress set at 150.During an observation on 01/22/26 at 12:51 PM, the Infection Preventionist (IP) stated that the pump settings for LAL mattresses were based on the resident's weight unless otherwise written in the physician orders. The IP said the residents were at risk of delayed wound healing or worsening of wounds if the LAL mattresses were too hard or too soft.Record review of an Order Listing dated 01/23/26 provided by the Director of Nursing (DON) reflected all residents with LAL mattresses and the physician ordered setting. The Order Listing indicated R73's LAL setting was 150.During an observation on 01/23/26 at 8:15 AM, R73's LAL mattress was set between 200 - 240.During an interview on 01/23/26 at 11:21 AM, the Unit Manager (UM) said that the nurses and nurse aides checked the residents' LAL mattresses to ensure that they functioned appropriately during rounds.Review of the facility's policy titled, Use of Support Surfaces revised 03/13/23 revealed, Policy: Support surfaces will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries. Support surface refers to a specialized mattress, mattress overlay, or chair cushion designed to manage pressure, shear, microclimate, or friction forces on tissue. for powered devices, orthose requiring air, the licensed nurse will check each shift and prn (as needed) for proper functioning and/or inflation. guidelines for support selection may be utilized in obtaining physician orders.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, interviews, and facility policy review, the facility failed to follow physician orders and care plan interventions for one of one Resident (R)73 to set the low air loss (LAL) mattress at 250 out of 39 sampled residents. This deficient practice placed R73 at risk of worsening pressure wounds, new wound development, and for unmet resident care needs and goals for care.Findings include:During an observation on 01/21/26 at 1:45 PM, R73's LAL pump was set at greater than 300.Review of R73's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R73 admitted to the facility on [DATE], initial admission date 05/20/21, with diagnoses that included morbid (severe) obesity due to excess calories, cellulitis of left lower limb, and paraplegia (paralysis that affects the lower half of the body).Review of R73's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/29/25 located in the EMR under the MDS tab reflected R73 was at risk of developing pressure ulcers/injuries and had one or more unhealed pressure ulcers/injuries (PU/PI) present upon admission to the facility. The MDS reflected R73 had one Stage 4 pressure ulcers (Full thickness tissue loss with exposed bone, tendon, or muscle).Review of R73's EMR revealed in Orders under the Orders tab a verbal order dated 07/26/25 indicated, Low air loss mattress set at 250 every shift for wound, check setting and function.Review of R73's Care Plan located in the EMR under the Care Plan tab initiated on 11/16/22 (revision on 01/22/26) indicated, the resident has potential for altered skin integrity . and has actual skin breakdown to right medial gluteal fold, excoriation to bilateral buttocks, and left glute and left glute fold. Interventions included, low air loss mattress keep setting at 250.During an interview on 01/22/26 at 12:51 PM, the Infection Preventionist (IP) stated that the pump settings for LAL mattresses were based on the resident's weight unless otherwise written in the physician orders.During an observation and interview on 01/22/26 at 1:00 PM, the IP visualized R73's LAL and confirmed the pump was set between 300 and 350 and the static setting was turned on. The IP said that the static setting on the air mattress provided a stable and firm support surface. The IP said that it should only be used to allow a resident to have a firm surface when transferring from the bed. The IP said that R73's static setting should not be turned on.During an observation and interview on 01/22/26 at 1:05 PM, Licensed Practical Nurse (LPN)4 said that she checked R73's LAL pump each shift and that it was checked that morning. LPN4 said that the LAL setting should be at 250, as she pointed out a piece of tape with 250 written on it placed across the top of the pump. LPN4 visualized the LAL pump and confirmed it was set between 300 and 350 and the static pressure was turned on. LPN4 that she would go check the physician orders. LPN4 returned and stated the setting was supposed to be at 250.During an interview on 01/23/26 at 10:30 AM, the IP agreed that the pump setting between 300 - 350 was too high. She stated that the static setting was a firm mode and defeated the purpose of the alternating pressure therapy.Review of the facility's policy titled, Use of Support Surfaces revised 03/13/23 revealed, Policy: Support surfaces will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries.Support surface refers to a specialized mattress, mattress overlay, or chair cushion designed to manage pressure, shear, microclimate, or friction forces on tissue. for powered devices, orthose requiring air, the licensed nurse will check each shift and prn (as needed) for proper functioning and/or inflation. guidelines for support selection may be utilized in obtaining physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085027	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Silver Lake LLC	1080 Silver Lake Blvd Dover, DE 19904

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy review, the facility failed to ensure the indwelling urinary catheter tubing and collection bag were not in contact with the floor and a securement device was in place for one resident (Resident(R)24) of one resident reviewed for indwelling urinary catheters out of 39 sampled residents. This failure placed the residents at risk for transmission of infection to the urinary tract or injury from tension, pulling, and accidental dislodgement of the catheter from the bladder.Findings include:During observations on 01/20/26 at 1:00 PM, 01/21/26 at 9:37 AM, and 01/21/26 at 2:37 PM, R24's indwelling urinary catheter rested on the floor hanging from the right side of the bedframe. There was not a securement device in place to immobilize the catheter tube against the skin on R24's right or left thigh.Review of R24's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R24 was admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy, unspecified hydronephrosis, and retention of urine.Review of R24's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/13/25 located in the EMR under the MDS tab reflected R24 had an indwelling urinary catheter.Review of R24's Care Plan located in the EMR under the Care Plan tab initiated on 09/07/24 (revision on 01/17/26) indicated, the resident has a 16 French [16F] coude (curved-tip tube) indwelling catheter for enlarged prostate/retention and obstructive uropathy. Interventions include, Catheter strap. Change catheter strap weekly; Catheter Strap - check placement of catheter strap every shift.During an interview and observation on 01/21/26 at 2:55 PM, Licensed Practical Nurse (LPN)4 said that her responsibility was to make sure that the certified nursing assistants (CNAs) provided catheter care to residents. LPN4 said that she did not assess R24 to see if a catheter securement strap was in place. R24 was sitting up to the right side of the bed. LPN4 pulled back the cover placed across R24's lap and lower legs revealed that there was no catheter securement strap in place and the catheter drainage bag rested on the floor. LPN4 said that she would let the on-coming nurse know that R24 did not have a catheter securement strap in place. LPN4 did not attempt to replace a catheter securement strap.During an interview and observation on 01/21/26 at 3:15 PM, RN1 pulled the covers back to reveal that she replaced the securement strap to R24's left thigh. When the covers were pulled back, the indwelling catheter tubing was under R24's right thigh. RN1 repositioned the tubing from under R24's right thigh to under the right knee. A securement strap was observed on the left thigh. RN1 said that she was informed by LPN4 during shift change report that R24 did not have a securement strap in place. RN1 said that R24 was at risk of injury if the catheter tubing is pulled or could be yanked from the insert site.During an interview on 01/22/26 at 12:51 PM, the Infection Preventionist (IP) stated that resting an indwelling catheter drainage bag on the floor placed the resident at risk of bacterial contamination.Record review of LPN4's annual competency training dated 07/25/25 revealed LPN4did not have a competency skill check off for indwelling catheters.Review of the facility's policy titled, Indwelling Catheter Care revised 08/11/24 revealed, Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. 6. Ensure straps are snug but not tight.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, document review, and policy review, the facility failed to ensure chicken salad sandwiches were served at the proper temperature. This deficient practice had the potential to affect 112 out of 114 residents.Findings included:During the second kitchen observation and interview on 01/22/26 from 11:54 AM to 12:15 PM, the following were made with the Dietary District Manager (DDM):A steam table pan was observed on the counter at the left end of the steam table. The steam table pan contained approximately 20 chicken salad sandwiches, stacked one on top of one another. At 12:05 PM the chicken salad sandwiches were being served on the tray line for room trays. A review of the temperature log for the lunch meal revealed the chicken salad sandwiches were within a safe temperature range. At 12:15 PM, the District Dietary Manager (DDM) obtained the temperature of the chicken salad on the chicken salad sandwich. The temperature was 54 degrees Fahrenheit (F). The DDM instructed that the DM stop service. The DDM stated there was another tray of chicken salad sandwiches in the refrigerator. The DDM removed the tray of sandwiches from the refrigerator. The DDM obtained the temperature of the chicken salad sandwiches, and the temperature was 57 degrees F. The DDM told the DM that they would need to stop serving chicken salad sandwiches until he was able to get them to the proper temperature.Review of the Sandwich, Chicken Salad (dice) - 1 Sandwich recipe revealed the chicken salad consisted of Diced, cooked chicken; mayonnaise; and pepper.During an interview on 01/22/26 at 12:42 PM, the Administrator stated all food should be served at the right temperature to avoid any residents getting sick.Review of the facility's policy titled Food: Preparation revised 02/2025 revealed, .All foods will be held at appropriate temperatures, less than 4l degrees F for cold food holding.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure the infection prevention and control program was implemented to prevent the transmission of communicable diseases, including ensuring staff adherence to required personal protective equipment (PPE) and isolation precautions for two residents (Resident (R)2 and R91) who were in Contact/Droplet isolation out of 114 residents.Findings include:During an observation on 01/23/26 at 9:04AM, Licensed Practical Nurse (LPN)6 prepared Resident (R)2's medications then entered R2's room without donning (put on) PPE. Observation of R2's room entrance indicated signage for Contact/Droplet Precautions which indicated that gown, N95 mask, face shield, and gloves to be applied prior to entering the room.During an interview on 01/20/26 at 2:10PM, LPN8 stated that R2 was positive for flu.During an observation on 01/23/26 at 9:20AM LPN6 prepared R91's medications then entered R91's room without donning PPE. Observation of R91's room entrance indicated signage for Contact/Droplet Precautions.During an interview on 01/20/26 at 2:18PM, LPN8 stated that R91 was positive for flu.During an interview on 01/23/26 at 9:20AM, LPN6 stated he only used PPE when he makes contact with the residents and that he does not make contact when giving medications.During an interview on 01/23/26 at 9:53AM the Infection Preventionist (IP) stated that LPN6 should have donned PPE, N95 mask, face shield, gown, and gloves, before entering the room and doffed (take off) the PPE before exiting the residents' rooms.Review of the facility's policy titled Influenza Exposure Control dated 2024 indicated: 6. Infection control: a. Standard Precautions shall be maintained in accordance with facility policy.b. Contact/Droplet Precautions shall be implemented for residents with suspected or confirmedrespiratory virus with the presentation of symptoms. c. Staff shall follow the facility's transmission-based procedures while the Contact/Droplet Precautions are in effect.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and policy review, the facility failed to ensure the kitchen area was free from fruit flies. The facility failed to keep the kitchen clean and ensure bait boxes remained under the three compartments sink to deter pests as recommended by their pest control provider. This created the potential for the harborage of insects and vermin which had the potential to affect 114 out of 114 residents.Findings included:1. During the initial kitchen observation and interview on 01/20/26 from 9:30 AM to 9:54 AM, the following observations were made with the Dietary Manager (DM):a. The smaller three compartment sink in the corner of the kitchen, near the hand-washing sink, had approximately 15-20 fruit flies near the floor on the right side of the sink. On the floor, there were three bait boxes on the right side of the sink and two bait boxes on the left side. There was a one-ounce plastic, empty coffee creamer container on the floor on the right side of the sink and black debris. The Dietary Manager (DM) stated the area needed to be cleaned and confirmed they had a problem with fruit flies currently and in the past. He stated pest control came weekly and sprayed the area.2. During the second kitchen observation and interview on 01/22/26 from 11:54 AM to 12:15 PM, the following observations were made with the Dietary District Manager (DDM):a. The smaller three compartment sink in the corner of the kitchen had approximately 50-75 fruit flies near the floor at each end of the sink. There was one bait box on the floor on the left side of the sink. No other bait boxes were observed. The Dietary District Manager (DDM) stated pest control would treat fruit flies weekly. The DDM stated the area should be clean and food and debris should be removed. The DDM stated the Dietary Manager (DM) added cleaning the area to his weekly cleaning schedule and confirmed it had not been on the schedule until Monday.During an interview on 01/22/26 at 12:42 PM, the Maintenance Director (MD) stated pest control come to the facility weekly, and he encouraged the kitchen to ensure bait boxes are in place. The MD stated they could contact pest control in between weekly visits if they saw an increase in bugs. The MD stated they did not contact pest control this week and they were waiting for the weekly Thursday treatment which occurred on Thursdays.Review of the facility's policy titled, Pest Control Program dated 03/22/26 revealed, It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents.