STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085029	A. Building B. Wing	10/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Bay Rehabilitation and Healthcare Center	110 W. North Street Georgetown, DE 19947

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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 0686 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review, it was determined that for one (R1) out of three (3) residents reviewed for pressure ulcer (PU), the facility failed to ensure that R1 received the necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers (PU's) from developing. R1 had an avoidable unstageable PU develop on bilateral buttocks at the facility causing harm to the resident. Findings include: Cross refer F692 Review of R1's clinical record revealed: 8/25/25 - A progress note from the hospital documented that R1 had a stage II pressure ulcer to the sacrum measuring 4.5 cm L x 0.5 cm W. A wound photograph provided from hospital revealed R1's sacrum open, pink in color, matching the measurements. Additionally, a smaller open area noted approximately 2 cm L and 0.5 cm W, location distally, pink in color, and intact edges. 9/2/25 - R1 was admitted to the facility. 9/2/25 8:07 PM - A Braden scale assessment was completed for R1 with a score of 18 indicating moderate risk of skin breakdown. 9/2/25 8:13 PM - An admission skin check documented that R1 had a wound noted to the sacrum upon admission. The admission skin check lacked evidence of assessment, measurement, or staging related to the wound. 9/2/25 - A baseline care plan documented that R1 had a potential for pressure ulcers related to impaired mobility, decreased activity, potential for alteration in nutrition and potential for friction with the following interventions: barrier cream to buttocks, coccyx, sacrum and perineum every shift after each incontinent episode, monitor for adequate nutrition and hydration, offload heels while in bed, pressure reducing mattress to bed, pressure reducing cushion to wheelchair, turn and reposition every two hours, and weekly skin checks. 9/3/25 - A physician's order documented to wash sacral wound with Vashe, apply Medi-honey, and cover with boarder foam dressing daily on night shift. This treatment is consistent with a Stage II pressure ulcer treatment guidelines per standard practice. 9/3/25 - A review of R1's new wound alert assessment documented an open area noted to sacrum. The assessment lacked evidence of measurement, staging, and description of the wound. On the bottom of the form in the lower right-hand corner was an unsigned note dated 9/4/25 that documented, buttocks/coccyx 12 cm L x 15 cm W x UTD (unable to determine) D. 100% necrotic, continue same treatment and LLAM (low air loss mattress) to bed. The added note does not appear to be written in the same handwriting as the original form was documented and lacked signature. The facility lacked evidence that a consultation with the physician on 9/4/25 about the change in the wound and no new treatment was ordered for the wound. 9/6/25 - An admission MDS documented that R1 had a stage II pressure ulcer on admission with the following interventions: pressure relieving device to chair, pressure ulcer/injury care, and applications of medications or ointments. The MDS also documented that R1 was dependent for all ADL's including turning, repositioning, and incontinence care. 9/9/25 - The facility lacked evidence of a weekly pressure ulcer assessment including staging, measurement, and assessment of the wound. 9/11/25 - The admission MDS was signed off by E11 (MDS coordinator) as complete and the accuracy of the data that R1 had a stage II pressure ulcer noted. 9/11/25 - A review of R1's new wound alert assessment documented an area noted to coccyx measuring 15 cm L x 18 cm W x UTD D. Black in color and necrotic. Continues on LLAM. The note documented coccyx which is inconsistent to the previous note with handwritten assessment that documented buttocks/coccyx. The facility lacked evidence of an order for the use of the LLAM in the clinical record. 9/16/25 - A progress note from WCN documented that R1 had an 'unstageable bilateral sacrum: measuring 17 cm L x 20 cm W. The wound was 100% necrotic. A new order for Silvadene cover with ABD pad twice a day. The note is inconsistent with documentation from previous WCN progress notes as the documentation uses sacrum and coccyx. The note is unclear regarding location of wound. 9/17/25 - A physician's order documented unstageable to sacrum: apply Silvadene cream and cover with ABD pads twice a day. The physician's order mentions sacrum and lacks evidence of treatment to bilateral buttocks. 9/17/25 - A physician's order was added for a low air loss mattress (LLAM) for wound care healing. 9/23/25 - A progress note from WCN documented [R1] was seen by WC physician (WCMD) for unstageable wound bilateral sacrum measuring 23 cm L x 22 cm W and 100% necrotic, odiferous, with purulent drainage noted. [R1] to continue on Silvadene BID. Verbal consent from wife to debride next week. The note does not mention area noted to buttocks or evidence of treatment to buttocks. 9/25/25 11:13 AM - A progress note documented that R1 was sent to the emergency room due to altered mental status, abnormal labs, and strong foul odor to sacral wound. 9/25/25 - R1 was admitted to the hospital with a diagnosis of sepsis, AKI (kidney injury), and a large sacral ulcer with suspicion of gangrene. A photograph provided from the hospital revealing R1 with bilateral

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Based on record review and interview, it was determined that for one (R1) out of one resident reviewed for hydration, the facility failed to ensure that R1 was offered sufficient fluids to maintain proper hydration. This failure resulted in harm when R1 was transferred to the hospital on 9/25/25 with a diagnosis of metabolic acidosis, hypokalemia and AKI (acute kidney injury) and elevated lab values indicative of dehydration. Findings include:Cross refer F686The BUN (blood urea nitrogen) lab measures the amount of urea nitrogen in the blood. The BUN is directly related to the metabolic function of the liver and the excretory function of the kidney . BUN levels also may vary according to the state of hydration, with increased levels seen in dehydration and decreased levels seen in overhydration. Mosby's Diagnostic and Laboratory Test Reference 2023.Review of R1's clinical record revealed:9/2/25 - R1 was admitted to the facility.9/2/25 - A physician's order was written for lisinopril hydrochlorothiazide 20 mg - 12.5 mg one tablet by mouth twice a day for hypertension. The aforementioned medication is an antihypertensive as well as a diuretic.9/3/25 - A review of R1's labs (CMP) revealed a sodium level (NA) of 135 mmol/L (normal value is 137 - 145 mmol/L.) The blood urea nitrogen level (BUN) was 17.0 mg/dL (normal value is 9.0 - 20.0 mg/dL). As of 10/21/25 there was no evidence that these labs were reviewed by the provider. 9/3/25 - An admission nutritional assessment documented that R1's recommended fluid intake was 1724 - 2155 mL/day. 9/3/25 - A baseline care plan documented that R1 was as risk for alteration in hydration related to impaired mobility, medications and diagnosis of recent AKI (acute kidney injury), UTI, and course of antibiotic and the following interventions: encourage adequate fluid intake and monitor for signs and symptoms of dehydration such as poor skin turgor, dry mucous membranes, concentrated foul smelling urine, decreased urine output, change in mental status, notify nursing and MD as appropriate. The daily totals obtained from CNA flow sheets for R1's fluid intake were:-9/3/25 - Intake: 600 mLs. Output: 2050 mLs.-9/4/25 - Intake: 600 mLs. Output: 800 mLs.-9/5/25 - Intake: 480 mLs. Output: 1125 mLs.-9/6/25 - Intake: 600 mLs. Output: 1070 mLs. 9/6/25 - An admission MDS documented that R1 was dependent on staff for all ADL's including eating and hydration. The daily totals obtained from CNA flow sheets for R1's fluid intake were:-9/7/25 - Intake: 360 mLs. Output: 2650 mLs. -9/8/25 - Intake: 600 mLs. Output: 1400 mLs. -9/9/25 - Intake: 720 mLs. Output: 1050 mLs.-9/10/25 - Intake: 360 mLs. Output: 1550 mLs.-9/11/25 - Intake: 720 mLs. Output: 1250 mLs.-9/12/25 - Intake: 640 mLs. Output: 1500 mLs. -9/13/25 - Intake: 840 mLs. Output: 950 mLs. -9/14/25 - Intake: 720 mLs. Output: 850 mLs.-9/15/25 - Intake: 360 mLs. Output: 670 mLs.-9/16/25 - Intake: 600 mLs. Output: 300 mLs.-9/17/25 - Intake: 600 mLs. Output: 240 mLs. -9/18/25 - Intake: 360 mLs. Output: 0 mLs.-9/19/25 - Intake: 600 mLs. Output: 50 mLs. -9/20/25 - Intake: 480 mLs. Output: 110 mLs.-9/21/25 - Intake: 600 mLs. Output: 300 mLs. -9/22/25 - Intake: 600 mLs. Output: 460 mLs.-9/23/25 - Intake: 600 mLs. Output: 500 mLs.-9/24/25 - Intake: 360 mLs. Output: 750 mLs. -9/25/25 - Intake: 100 mLs. Output: 100 mLs (went to hospital) The facility failed to meet R1's recommended daily hydration goal on all the above dates. 9/25/25 - A hospital progress note documented that R1 presented to the emergency department with an acute kidney injury (AKI) with creatinine value of 9.1 mg/dL (high) and a BUN (blood urea nitrogen) level of 155 mg/dL (high). [R1] with severe metabolic acidosis. 10/20/25 2:50 PM - During an interview, E6 (CNA) and E7 (CNA) confirmed that R1 required total care with ADL's including feeding and drinking. E6 stated that R1 had a poor appetite and would pocket food and confirmed that staff would try to feed and encourage R1's intake. E6 confirmed that the staff nurses were aware of R1's decreased intake. 10/21/25 10:30 AM - During an interview, E4 (LPN) confirmed R1 had decreased intake and notified the UM (unit manager) and provider of these concerns. E4 stated that staff encouraged fluid intake for R1 and requested R1 be sent to the hospital related to decreased intake. 10/21/25 11:05 AM - Review of R1's EMR progress notes lacked evidence of efforts to address R1's decreased oral fluid intake including approaches to increase hydration and consultation with the doctor. 10/21/25 1:45 PM - During an interview, E2 (DON) confirmed that the provider was not consulted regarding R1's decreased intake and no interventions were ordered to increase hydration. 10/22/25 12:34 PM - During an interview, E9 (LPN UM) stated that staff did not report decreased intake for R1 during the aforementioned dates. E9 stated that the dietician usually follows resident's closely regarding intake and hydration status. 10/22/25 2:57 PM - During an interview, E10 (Dietician) confirmed that she reviewed R1's nutritional status on 9/3/25 and again on 9/24/25. E10 confirmed that she reviewed R1's intake and addressed nutritional needs based on low oral intake (food) and the presence of the wound. E10 confirmed that a liquid protein supplement and nutritional supplement were added to R1's regimen. E10 confirmed that she did not address