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	07/31/2025

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

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review, it was determined that for two (R31 and R10) out of two residents reviewed for PASRR the facility failed to ensure that a new referral for PASRR was completed upon a new mental health diagnosis and start of new psychotropic medications Findings include: The facility policy regarding PASRR undated, indicated The social services director shall be responsible for keeping track of each resident PASRR screening status, and referring to the appropriate authority . any resident who exhibits newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder. 1. Review of R31's clinical record revealed: 12/26/23 - A PASRR level I screening was completed for R31 that documented a diagnosis of dementia/neurocognitive disorder and use of anxiety medication. 1/18/24 - R31 was admitted to the facility with multiple diagnoses including dementia with psychotic disturbance and anxiety. 1/20/24 - An admission MDS assessment documented that R31 had diagnoses of dementia and anxiety. 5/23/24 - A diagnosis of psychotic disorder with delusions was added to R31's diagnosis list. 3/19/25 - A significant change MDS assessment documented that R31 had diagnoses of dementia, anxiety disorder and a psychotic disorder. 4/30/25 - A physician's order was written for R31 to receive an antipsychotic medication every evening at bedtime. 6/11/25 - A quarterly MDS assessment documented that R31 had diagnoses of dementia, anxiety disorder and a psychotic disorder with use anti-anxiety and anti-psychotic medications. 7/23/25 3:11 PM - During an interview E11 (SW) confirmed a referral for a PASRR review was not completed for R31 following a new diagnoses and medications. 7/24/25 2:44 PM - E2 (DON) provided a copy of the new PASRR assessment completed for R31 that day. This PASRR screening was updated to include anxiety disorder, and psychotic disorder with delusions to the diagnoses. Medications added to this PASRR included the use of an antipsychotic. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R10's clinical records revealed: 1/20/25 – R10 was transferred to this long term care facility from another long term care facility. R10's diagnoses included, but were not limited to, unspecified dementia with psychotic disturbance and anxiety disorder. 1/21/25 – A new diagnosis of delusional disorder was added to R10. 7/23/25 – A review of R10's medical record revealed a PASRR Level II screen dated 10/5/23, which documented, Level II - Excluded from PASRR – Primary Neurocognitive Disorder. There was no diagnosis of neurocognitive disorder during R10's stay at the facility and a lack of evidence for resubmitting a PASRR for a new diagnosis of delusional disorder. 7/30/25 10:33 AM – During an interview, E20 (SW) stated that they were unaware if there was a PASRR resubmission for R10 due to the added diagnosis of delusional disorder. 7/30/25 1:00 PM – E20 entered the PASRR resubmission for R10 and the document was dated as 7/30/25. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.

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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 interview and record review it was determined that for one (R3) out of twenty eight residents reviewed the facility failed to develop a care plan to address an identified need. Findings include:Review of R3's clinical record revealed: 5/7/25 - R3 was admitted to hospice. 5/26/25 - A significant change MDS assessment documented that R3 had a poor prognosis and was receiving the specialized service of hospice. 7/23/25 - R3's care plan for ADL's was reviewed. The care plan focus documented that on 5/21/25 a significant change MDS was opened due to R3 signing with hospice. Review of R3's care plans lacked development of a care plan for hospice that included individualized objectives, goals, and timeframes to meet R3's needs. 7/28/25 1:13 PM - During an interview E2 (DON) confirmed the findings. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.

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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. Number of residents sampled: Number of residents cited: Based on observation, interview and record review, it was determined that for one (R74) out of one resident reviewed for positioning, the facility failed to turn and reposition the resident and promote the healing of a pressure ulcer in accordance with professional standards of practice to prevent skin breakdown. Findings include: Review of R74's record revealed: 7/7/23 - R74 Was admitted to facility with diagnoses including cerebral Infarct, hemiplegia, muscle wasting, and contractures8/27/24 - R74's Braden Scale for pressure ulcer risk documented a score of 14 (moderate risk). 5/28/25 - An annual MDS documented R74 as dependent for turning and repositioning. 7/09/25 - R74's A care plan documented that R74 received turning and repositioning at least every two hours and as needed.7/23/25 - An observation of R74 position in the bed on right side at 9:09 AM, 10:00 AM, 11:00 AM, 12:30 PM, and 1:07 PM.7/23/25 1:19 PM - During an interview with E8 (CNA), she stated that when she does total care for a dependent resident, she will turn and reposition them 2-3 times a shift, depending on their needs, such as wound care.7/23/25 1:45 PM - An interview with E4 (LPN) confirmed that R74 had not been repositioned and would have E8 complete the task. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, it was determined that for two (R98 and R18) out of four residents reviewed for respiratory care, the facility failed to ensure the oxygen tubing and humidifier bottle were changed weekly for R18. Also, R98's BiPAP equipment was not stored in a protective plastic bag. Findings include: Review of the facility's policy and procedure titled Oxygen Administration, dated 10/1/24, documented .Keep delivery devices covered in plastic bag when not in use. 1. Review of R98's clinical record revealed: 12/19/24 – R98 was readmitted to the facility. 7/23/25 – A care plan documented R98 as receiving oxygen therapy related to COPD, respiratory failure, obesity and hypoventilation. R98 has a BiPAP for OSA (obstructive sleep apnea). 7/14/25 – An annual MDS documented R98 as using oxygen and a non-invasive mechanical ventilator such as a BiPAP. 7/16/25 - A physician order for R98 documented to encourage and apply BiPAP every night at bedtime. The resident needs encouragement to use BiPAP. Ensure that the humidifier chamber is filled with sterile water. BiPAP settings at: IPAP 20/EPAP 8. 7/21/25 8:50 AM – An observation noted R98's BiPAP mask sitting on top of the bedside table. There was no bag for the BiPAP to be placed into. 7/21/25 8:57 AM – An observation of E13 (RN Educator) entering R98's room with clear bags. E13 proceeded to take out a clear plastic bag and label it with R98's name. E13 then put R98's BiPAP mask into the clear plastic bag and set it back down on the bedside table. During an interview, E13 stated that the BiPAP should probably be in a bag. 2. Review of R18's record revealed: 3/14/25 - R18 was admitted to the facility with a diagnosis including but not limited to COPD and interstitial lung disease. 7/25/25 - A physician's order for R18 documented change mask, nasal cannula tubing, and humidifier bottle every night shift on Fridays. 7/21/25 9:23 AM - An observation of R18's nasal cannula oxygen tubing and the humidifier bottle undated. 7/21/25 9:26 AM - During an observation and interview with E4 (LPN), it was confirmed there were no dates on R18's oxygen tubing and the humidifier bottle, and she replaced and dated them immediately. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on record review and interview, it was determined that for two (R129 and R123) out of two residents reviewed for a change in condition, the facility failed to ensure residents were free from experiencing a significant medication error. For R129, staff administered another resident's medication resulting in the need for emergency medical intervention of Narcan for opioid overdose and transport to hospital for further medical intervention. The facility's failure placed R129 at risk for a serious adverse outcome including anaphylaxis, depressed respiratory status, and even death related to administration of a significant medication in error. Due to this failure an Immediate Jeopardy was called on 7/19/25 at 9:55 AM. Based on the facility's evidence at the time of the survey, the deficiency as determined to be past non-compliance as of 7/20/25 at 11:59 PM. For R123, staff administered insulin for a blood glucose outside of parameters, resulting in interventions related to critically low blood sugar. The facility's error caused hypoglycemia and placed R123 at risk for a serious adverse outcome including diabetic coma or even death from a critically low blood sugar. Due to this failure an Immediate Jeopardy was called on 12/13/24 at 12:08 PM. Based on the facility's evidence to correct at the time of the survey, the deficiency was determined to be past non-compliance as of 12/14/24 at 11:00 PM. Findings include: 1. Review of R129's clinical record revealed: 7/17/25 - R129 was admitted to the facility with diagnoses including diabetes, metabolic encephalopathy, and unspecified congestive heart failure. 7/18/25 - A physician's order documented that R129 was prescribed the following medication: sodium chloride (supplement), sodium bicarbonate (supplement), rosuvastatin calcium (reduces cholesterol), latanoprost eye drops (treat glaucoma), dorzolamide eye drops (treat glaucoma), and Lasix (diuretic). The EMR also documented R129 had an allergy to aspirin. 7/19/25 - An admission MDS documented that R129 was dependent for ADLs and documented a 99 in the BIMs section indicating R129 did not complete the interview. 7/19/25 9:55 AM - A facility incident report documented that R129 was administered another resident's medication. R129 received the following medications: ms contin 60 mg (narcotic for pain), xanax 0.5mg (narcotic for anti-anxiety), tizanidine 2mg (muscle relaxer) and aspirin 81 mg. Additionally, the report documented that R129 was administered a one-time dose of Narcan and supplemental oxygen. R129 was then sent to the hospital for further medical intervention and admitted . 7/19/25 12:59 PM - A nursing progress note documented that R129 received another resident's medication at 9:55 AM and vital signs were as follows: BP 139/84, P 73, T 97.0, R 20, and SPO2 80% (oxygen level) on room air. The progress note also documented that oxygen was applied at 4L/min and SPO2 (oxygen level) was 94% on 4L. Additionally, the note documented a new order for Narcan one dose and to send R129 to the emergency department via 911 for further treatment. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	7/19/25 6:42 PM - A hospital progress note documented that [R129] presented to the emergency department with lethargy due to administration or wrong medications including sedative medications and medications that can cause respiratory depression including ms contin, Xanax, duloxetine (anti-depressant), tizanidine, and citalopram. [R129] will be closely monitored overnight with telemetry, continuous pulse oximetry, capnography until drug effects wear off. If [R129] continues to worsen, intubation will be needed. 7/25/25 1:45 PM - During an interview, E5 (RN) confirmed that R129 received the wrong medication and E17 reported the error immediately. E5 confirmed that R129 received a dose of Narcan, supplemental oxygen, and was sent to the emergency department for further treatment. E5 also confirmed the facility provided education regarding the medication error and the importance of utilizing the rights of medication administration. 725/25 2:02 PM - During an interview, E17 (LPN) confirmed that R129 received the wrong medication and the error was reported immediately. E17 stated that R129 was a new admission and the EMR did not have a picture uploaded E17 thought R129 was a different resident. E17 stated that the physician was notified immediately after realizing the wrong medication was administered and R129 was provided medical care per orders. 7/25/25 2:30 PM - An Immediate Jeopardy was called and reviewed with the facility leadership including E1 (NHA) and E2 (DON). 7/25/25 – 4:30 PM – Based on a review of the facility's corrective actions, it was verified that past noncompliance was abated as of 7/20/25 at 11:59 PM. The incident was promptly identified, and Resident R129 was immediately sent to the hospital for evaluation and treatment. The root cause was determined to be the absence of a photo ID in R129's electronic medical record (EMR), which contributed to a medication error. The facility updated its admission process to ensure photo identification is captured, expanding staff access to the EMR system to facilitate timely uploading of resident photos. Additional staff were trained to take photographs at the time of admission, further supporting timely and accurate photo ID capture. A facility-wide audit was conducted to confirm that all current residents had a photo ID included in their EMRs. All nursing staff received re-education and training on the 7 Rights of medication administration. Staff interviews and medication administration observations conducted by surveyors verified the facility had returned to and maintained compliance. 2. 8/1/24 – R123 was admitted to facility with diagnoses including type 2 diabetes. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12/5/24 – The EMR documented a physician's order, Accu check before meals and HS [bedtime]. 12/11/24 – The EMR documented a physician's order, Aspart (fast acting insulin) flex pen subcutaneous solution pen-injector 100 unit/ml. Inject 5 units subcutaneously with meals for diabetes. Hold for FSG (finger stick glucose) <180 (less than 180) or if not eating. 12/13/24 12:06 PM – The EMR documented, R123 did not eat any breakfast and their lunch time finger stick glucose as 124 mg/dl. 12/13/24 12:08 PM – The EMR documented, Aspart insulin 5 units was administered to R123's left arm subcutaneously. 12/13/24 - The EMR documented, R123 did not eat any lunch. 12/13/24 – A nursing progress note in the EMR written by E12 (RN - Agency) documented, . approximately 1230 daughter reported that resident was not acting right.resident is laying supine (on back) in bed, leaned to the right, eyes closed, mouth open. Resident presents as disoriented, able to follow commands, A&Ox1, pallor skin color, diaphoretic. FSBS 46. Administered glucose gel 1 tube, called 911 at 1321, EMS arrived 1325 rechecked fingerstick [and it was] 65. 12/13/24 – The EMR documented that EMS transported R123 to the hospital, hypoglycemia resolved. 7/24/25 9:55 AM – During an interview, E2 (DON) confirmed that E12 administered Aspart insulin 5 units subcutaneously to R123 when the medication should have been held. Additionally, E2 stated that education was provided to all nursing staff regarding medication administration with medication parameters. 7/25/25 1:45 PM - 2:00 PM – During interviews with multiple nursing staff including LPN's and RN's it was verified that nursing staff received education and training on the facility's process when administering medications that have parameters. 7/25/25 - 2:50 PM - An Immediate Jeopardy was called and reviewed with the facility leadership including E1 (NHA) and E2 (DON). 7/30/25 10:10 AM – During an interview E13 (Staff Educator) stated when there is an incident that occurs in the facility that requires education she is notified by the DON or ADON and E13 is then responsible for providing the education specific to the incident. Additionally, E13 stated that education began promptly at 4:00 PM on 12/13/24 and was completed at 11:00 PM on 12/14/24. 7/25/25 1:45 PM - 2:00 PM – During interviews with multiple nursing staff consisting of LPN's and RN's all nursing staff were able to correctly state the facility's process when administering medications that have parameters. Based on a review of the facility's investigation, documented response, completion of in-service training, and staff interviews, it was determined that past noncompliance occurred but was corrected prior to the survey. The plan of correction was initiated on 12/13/24 and completed on 12/14/24. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The incident was promptly identified and R123 was immediately sent to the hospital for evaluation and treatment. The root cause was determined to be a failure to recognize or adhere to medication parameters outlined in the order. Nursing staff received targeted in-service training on following physician orders, with a focus on understanding and applying medication parameters. Staff interviews confirmed that nursing staff understood the expectations regarding physician order compliance. Medication administration observations (med pass) were conducted by surveyors to ensure staff were accurately following physician orders, including parameter-based instructions. Surveyor review of documentation and staff practices verified that the facility had returned to and maintained compliance. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON).

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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 and interview it was determined that for two (R109 and R97) out of twenty eight residents reviewed the facility failed to ensure practices to prevent infection were followed. Findings include:Review of the CDC's Clinical Safety: Hand Hygiene for Healthcare Workers indicated, Protect yourself and your patients from deadly germs by cleaning your hands. https://www.cdc.gov/clean-hands/hcp/clinical-safety. Review of the Nursing Skills checklist for oral medication administration indicated, Multi-dose containers: When removing tablets or capsules from a multi-dose bottle, pour the necessary number into the bottle cap and then place the tablets or capsules in a medication cup. Cut scored tablets, if necessary, to obtain the proper dosage. If it is necessary to touch the tablets, wear gloves. https://wtcs.pressbooks.pub/nursingskills/chapter/15-4-checklist-for-oral-medication-administration. 1. 7/22/25 9:06 AM - During an observation of medication administration E18 (LPN) was observed giving medications to R111, then exiting the room without performing hand hygiene. 7/22/25 9:10 AM - E18 (LPN) was observed preparing medications to administer to R109. E18 grabbed a bottle of Tylenol and poured a tablet into the palm of her bare hand, then tilted her hand until the tablet landed in a medicine cup. Next, E18 grabbed a bottle of supplements and poured two capsules into the palm of her bare hand, then tilted her hand until the tablet landed into the medicine cup containing the Tylenol. E18 then turned to the medications in the cup to R109. Upon surveyor intervention E18 immediately confirmed that medications should not be touched with bare hands to prevent infection and that hand hygiene should have been performed between medication administrations. 2. Review of R97's clinical record revealed: 6/11/25 - R97 was admitted to the facility. 6/11/25 7:00 PM - A physician's order for R97 documented to flush PICC line (IV line) with 10 mL normal saline before and after each use. 6/12/25 6:00 AM - A physician's order for R97 documented to administer cefazolin sodium (antibiotic) every eight hours for left groin seroma. 7/21/2025 2:12 PM - During an interview, R97 stated that staff does not wear a gown when administering antibiotics through the PICC line or when flushing the tubing. 7/21/2025 2:20 PM - During an observation, E19 (Agency LPN) disconnected R97's tubing from antibiotic administration. E19 did not have on a gown while accessing R97's PICC line. 7/21/2025 2:23 PM - During an observation, E19 administered a saline flush to R97's PICC line and did not have a gown on. 7/21/2025 2:25 PM - During an interview, E19 confirmed that she did not have a gown on and did not follow transmission based precautions while accessing R97's PICC line. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation and interview it was determined that the facility failed to ensure that essential kitchen equipment is maintained in safe operating condition. 1. 7/22/25 10:25 AM - During a tour of the kitchen, the sanitizing solution in 2 out of 2 red sanitizer buckets was tested for chemical concentration by E16 (Dietary Supervisor). The chemical concentration level was too low and did not register at the appropriate sanitizing level (400 ppm) on the test strip.The ineffective level of sanitizer in the bucket was confirmed by E16.7/22/25 - 10:32 AM - The sanitizing solution was tested by E16 at the source where it leaves the container, mixes with water, and flows into the three compartment sink. The chemical concentration level tested below 200ppm on the test strip, which is too low to provide appropriate sanitization for food safety.The ineffective level of sanitizer at the three compartment sink was confirmed by E16.7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.