

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085031	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER Encore at Wilmington		STREET ADDRESS, CITY, STATE, ZIP CODE 2723 Shipley Road Wilmington, DE 19810	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, it was determined that for one (R73) out of three residents reviewed for falls, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of Practice by failing to have a registered nurse (RN) complete and document a RN post-fall assessment. Findings include: Delaware State Board of Nursing - RN, LPN . Duties 2024. RN. Post Fall Assessment & Documentation. RN must do initial fall assessment; LPN can do subsequent assessments . updated 10/11/24. Review of R73's record revealed: 10/16/25 - R45 had a physician's order for Eliquis (blood thinner) tablet twice a day for a diagnosis of aFib (irregular heart rhythm). 12/16/25 2:45 PM - The facility's incident report by E29 (LPN) documented that R45 was found on his knees with left arm inside the drawer of the bedside table. Head resting on bedside table. Sent to ER [emergency room]. 12/16/25 2:45 PM - The facility's baseline and subsequent neurological check evaluations were documented by E29. 12/16/25 4:44 PM - A nursing note by E29 documented, S/p [Status post] fall with no injuries. Pulse ox [vital sign that measures oxygen saturation/normal levels 92% to 100%] at 70% on continuous oxygen. Oxygen increased and pulse ox at 88%. Orders given to send resident to hospital for further eval [evaluation]. Review of R45's clinical record lacked evidence that an RN performed the post-fall assessment and documentation on 12/16/25. 6/12/26 10:20 AM - During an interview, E29 recalled R45's 12/16/25 fall after reviewing the documentation. Despite remembering the details of the resident's fall, E29 stated that she could not tell the surveyor if an RN assessed R45 after the unwitnessed fall. E29 confirmed that she performed the baseline and subsequent neurocheck assessments. 6/12/26 10:32 AM - During an interview, finding was reviewed with E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1 (ED), E2 and E3 (ADON) during the exit conference.		

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 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 interview and record review, it was determined that for one (R71) out of four residents reviewed for ADLs, the facility failed to ensure that R71, a dependent resident, was showered/bathed at least two times a week. Findings include: Review of R71's record revealed: 10/16/25 - R71 was admitted to the facility. 1/22/26 - R71 had a physician's order for a shower day every Wednesday and Saturday day shift and to notify the POA of refusal then enter a progress note. 4/24/26 11:54 AM - R71's physician order for a shower on Wednesday and Saturday day shift was discontinued because the resident was discharged to the hospital. 4/24/26 3:35 PM - R71 was readmitted to the facility. Review of the record revealed that R71's physician order for a shower or bathing on Wednesday and Saturday was never re-entered upon re-admission to the facility. The facility failed to ensure that R71 was showered/bathed at least two times a week upon readmission to the facility. 6/15/26 12:45 PM - During an interview, finding was reviewed and discussed with E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1 (ED), E2 and E3 (ADON) during the exit conference.		

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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. Based on interview and record review, it was determined that for one (R68) out of two residents reviewed for hospitalization, the facility failed to ensure R68's physician order for trending weights was followed. Findings include: The facility's policy and procedure for weights, dated 9/2020, revealed, Residents will be weighed to establish baseline weights and identify trends of weight loss or weight gain. 5. Consistent weighing process and technique is used to determine accurate body weight measurement. This includes weighing the resident at approximately the same time of day and using the same scale. Review of R68's record revealed: 3/13/26 - R68 was admitted to the facility with a diagnosis of congestive heart failure. 3/16/26 - R68's care plan created by E4 (RD) for nutrition/hydration listed an intervention that included to monitor weights. 3/23/26 - A cardiology consult note by P4 (Medical Provider) stated, . I will ask nursing to trend weights. 3/23/26 - A physician's order by P4 stated to weigh R68 every Monday and Thursday. Review of the dates and times of R68's documented weights according to the physician's order revealed:-Thursday, 3/26/26 at 11:04 AM;-Monday, 3/30/26, no weight obtained;-Thursday, 4/2/26 at 1:15 PM;-Monday, 4/6/26 at 11:55 AM;-Thursday, 4/9/26 at 1:43 PM;-Monday, 4/13/26 at 10:07 AM;-Thursday, 4/16/26, no weight obtained;-Monday, 4/20/26, no weight obtained; and-Thursday, 4/23/26, no weight obtained. 6/15/26 11:43 AM - During an interview, finding was reviewed and confirmed with E4. The facility failed to follow a physician's order to trend R68's weights. 6/15/26 4:15 PM - Findings were reviewed with E1 (ED), E2 (DON) and E3 (ADON) during the exit conference.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and interview, it was determined that for one (R74) out of two residents reviewed for accidents, the facility failed to ensure R74 received adequate assistance and supervision to prevent accidents. R74, who required moderate assistance, sustained a facial injury after falling on the floor while receiving care from a staff member. Based review of the facility's evidence to correct the deficient practice and substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 1/6/26. Findings include: Review of R74's clinical record revealed: 10/20/25 - R74 was admitted to the facility with diagnoses including congestive heart failure and cognitive communication deficit. 10/20/25 - R74's care plan documented that he was at risk for falls due to chronic pain and weakness. 12/24/25 - R74's medications included Apixaban 5 mg (anticoagulant) twice daily for deep vein thrombosis. 12/30/25 - R74's readmission MDS assessment documented a BIMS score of 5, indicating severely impaired cognition. The assessment also documented that R74 had right and left upper extremity impairments and required partial/maximal assistance to roll left and right. 1/3/26 - A facility incident report documented, .found [R74] on the floor beside his bed on the window side. [R74] was lying prone [face down] with blood noted to flow from his face. [E27, CNA] and [E28, LPN] were in the room and stated that [R74] fell from the bed to the floor while [E27] was providing care. Skin tear noted to left cheek with bleeding, skin tears also noted on right elbow and bilateral knee. [R74] was sent to ER for evaluation. 1/3/26 - A general note entered in R74's clinical record documented, [R74] returned from [hospital]. had 5 stitches on his cheek to be removed in 5 days. 1/5/26 4:11 PM - An IDT (interdisciplinary) Note entered in R74's clinical record documented, .RCA [root cause analysis]: Positioning near bed edge; bed not wide enough; insufficient guarding; absent floor mat use during care; update care plan and audit compliance. 1/5/26 - R47's fall care plan was updated to include bilateral fall mats while in bed, resident bed in low position, wide bed replacement, and resident safe bed positioning. 1/6/26 - A document entitled Investigation Report Interview, signed by E27 and E3 (DON), documented, I [E27] walked in around 9 am [9:00 AM] to do morning care to [R47]. The task was changing his brief, I pulled [R47] close to me and assisted [R47] on the right side, [R47] was on the right side. I [E27] was cleaning his brief and the task was done. I told [R47] to roll back and he began to roll the opposite way instead. 1/6/26 2:00 PM - A document entitled Investigation Report Interview documented, Name of Person Interviewed: [E28, LPN]. At around 1000 [10:00 AM] [E27] called and stated [R47] rolled off the bed while being changed. [R47] was found laying on the floor beside his bed on the window side. Blood was flowing from [R47]'s face. 1/6/26 - A facility document entitled, Educational Opportunity Notice signed by E27 and E2 documented, .[E27] will be conscious of resident positioning when providing care to minimize risk of fall or injury. Verbal education provided. [E27] provide demonstration of what she would do differently and verbalized understanding of education provided. 1/6/26 11:00 AM - A facility document entitled, Staff Development Program Attendance Record. Providing Safe Care in Bed documented a staff training was held and contained the signatures of nursing and CNA staff. A document entitled, Providing Safe Care While Patient In Bed dated 1/6/26 stated the contents of the education provided during the training. 6/11/26 12:30 PM - E27 gave the surveyor a documented audit completed for 6 residents monitored for 3 shifts daily for 4 weeks from 1/5/26 to 1/26/26. 6/11/26 1:32 PM - During an interview, E28 stated, [E27] told the [R47] to roll on his side and he rolled too much. I was not in the room when it happened. There was blood on [R47] and the floor. [R47] was sent out to the hospital. The surveyor asked E27 if had received training after the incident. E27 stated that he received training the next day or so and verbalized the training received. 6/11/26 2:00 PM - Based on the surveyor's review of the facility's investigation, documented response, audit completion, staff interview, and no further resident falls while provided care, the deficiency was considered past non-compliance with a compliance date of (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	1/6/26.6/15/26 1:15 PM - Findings reviewed with E1 and E2.6/15/26 4:15 PM - Findings were reviewed with E1, E2 and E3 (ADON) during the Exit Conference.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, it was determined that for one (R38) out of two residents reviewed for accidents, the facility failed to timely notify the provider when R38's ankle pain was reported to staff. Findings include: Review of R38's clinical record revealed: 3/25/24 - R38 was admitted to the facility with diagnoses including age-related osteoporosis and left lower leg amputation. 4/5/24 - R38's care plan documented dependence on two staff persons with mechanical lift for sit to stand transfers. 10/2/25 - A quarterly assessment documented R38 had a BIMS of 10, indicating moderately impaired cognition. The assessment also documented that R38 had right and left lower extremity impairments and was dependent for assistance to stand and to transfer from bed to chair. 10/24/25 - A Physical therapy Treatment Encounter Note signed by E30 (PT) documented, .Transfer: bed to chair via sit pivot in small increments and max A [assist] of 2. R [right ankle] appeared to have slightly more eversion [pointing outward]. No swelling or redness noted. Nurse made aware and came to [R38]'s room. 10/24/25 - An Occupational Encounter Note documented, [R38] required max A [assistance] x2 for squat pivot transfer from bed to wheelchair and reported no pain with transfer. [R38] reported 5/10 pain in R [right] ankle upon attempted PROM [passive range of motion]. mobility stopped immediately d/t reported pain. [R38] further reported small cut on middle R [right] toe. Nursing notified of both cut and pain immediately. 10/24/25 1:27 PM - An Administration Note entered by E29 (LPN) documented that Tylenol was given to R38 for a complaint of right ankle pain. 10/25/26 8:27 AM - An Administration Note documented entered by E31 (LPN) documented, .[R38] c/o [complained of] right ankle pain. Supervisor and MD notified .The provider was notified of R38's change in condition 8 hours after it was reported to staff. 10/25/25 12:46 PM - A General Note entered documented, [R38] reported pain on right ankle. [P1, NP] made aware. New order received for STAT right ankle x-ray two view x-ray. 10/25/25 10:53 PM - A facility incident report documented, [R38] reported pain on right ankle. [R38] stated pain increases with movement, right ankle noted with swelling. [P1, NP] made aware. New order received for STAT right ankle x-ray. At 2151 [9:51 PM] x-ray results received. acute fracture in distal shaft of the right fibula. [R38] left facility at 2252 [10:52 PM] for ER. 10/26/25 1:05 AM - A hospital radiology report documented that [R38] had an acute distal fibular fracture. 10/29/25 - A facility document entitled, Investigation Report Interview, documented, Name of Person Interviewed: [E29]. Alerted by therapy that [R38]'s ankle appeared to be turned outward. PRN [as needed] Tylenol given. Cause unknown. [R38] stated she doesn't remember hitting her leg on anything. This was during 10/24/25 day shift. 6/10/26 - During an interview R38 stated, I did not have PT on that Thursday. That Friday when PT came, my leg looked funny. I don't know how it happened. 6/11/26 10:53 AM - During a joint interview with E30 (PT) and E33 (OT), E33 stated, [R38] always had right ankle eversion, but it was more everted than baseline. We did a squat pivot from the chair to the wheelchair. When I started the PROM, [R38] complained of pain. I stopped and we immediately let [E29] know. The surveyor asked what time this occurred. E30 stated, [R38]'s session was between 1:00 PM and 3:00 PM. We continued to work on upper body strength exercises. I did not notice any redness or swelling. E30 stated, [R38] has been transferred by stand pivot on the right leg previously with no issues. 6/11/26 2:16 PM - During an interview, E29 stated that she was informed by PT and OT that R38 had ankle pain and gave her Tylenol. The surveyor asked E29, Did you assess R38's ankle pain or notify the provider? E29 stated, No, I didn't. 6/15/26 1:15 PM - Findings reviewed with E1 (NHA) and E2 (DON). 6/15/26 4:15 PM - Findings were reviewed with E1, E2 and E3 (ADON) during the Exit Conference.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, review of facility documentation and staff interviews, it was determined that the facility failed to post the required federal staffing information. Findings include: 6/11/26 12:00 PM - An observation in the healthcare's nursing station revealed that the staffing posting did not contain the total worked hours per shift for each discipline, Registered Nurse (RN), Licensed Practical Nurse (LPN) and Certified Nursing Assistants (CNA). 6/11/26 12:16 PM - In an interview, E23 (Scheduler) stated that ever since she joined the company under the previous ownership, the staffing postings did not contain the hours worked by the nurses and the nursing aides (CNAs). 6/15/26 2:00 PM - Finding was discussed with E1 (ED) and E2 (DON). 6/15/26 4:15 PM - Finding was reviewed with E1, E2 and E3 (ADON) during the Exit Conference.		