STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085034	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Excelcare at Lewes LLC	301 Ocean View Blvd Lewes, DE 19958

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Based on interview, record review and review of other documentation as indicated, it was determined that for one (R2) out of seven residents reviewed for abuse the facility failed to ensure residents were free from abuse. R2 was found on the floor of his room, with R1 standing over him, and sent to ER for a head injury. This failure resulted in physical harm (R2) and psychosocial harm as the reasonable person would be adversely affected by being attacked in their home. Findings include:Cross refer F609 and F740.Review of R1's and R2's record revealed:7/1/25 - R2 was admitted to the facility.7/28/25 - R1 was admitted to the facility.8/12/25 - A care plan was initiated for R1 documenting socially inappropriate behavior as evidenced by verbal aggression toward staff and other residents. Interventions included ensuring safety, reminding the resident that behavior was inappropriate, and attempting to redirect with activities or preferred snacks. 10/15/25 - A quarterly MDS assessment documented that R2 had a BIMS score of 7 indicating severe cognitive impairment and required the assistance of one staff for most ADLs.10/21/25 10:45 PM - A progress note documented that R1 was having increased agitation and that redirection was unsuccessful. R1 was described as persistently aggressive, pushing staff, and barricading the door with items while physically holding the door shut. The on-call provider was notified and R1 was sent to the ER.10/22/25 2:18 AM - A progress note documented that R1 returned from the ER with no new orders.10/22/25 8:45 PM - A progress note documented that R1 was extremely agitated and anxious, was pacing hallways, combative with staff, exit seeking, and banging on doors. Staff were advised to call the on-call provider if behaviors continued. 10/23/25 1:00 AM - A provider note documented that R1 was evaluated for follow-up after the ER visit for aggressive behaviors and that no new orders were issued.10/26/25 6:00 AM - A progress note documented that R1 was arguing loudly with roommate R2. Staff reported that behaviors between the two residents had markedly increased within the last week, and that both residents became overly fixated and verbally assertive or aggressive, requiring separation and staff redirection to calm.10/28/25 - A quarterly MDS assessment documented that R1 had a BIMS score of 4 indicating severe cognitive impairment and demonstrated physical aggression toward others, verbal aggression, and other behavioral symptoms during the review period. The MDS documented that R1 was not receiving psychological therapy services.10/29/25 7:45 AM - A progress note documented that R1 was confused and became aggressive with staff, pushing and grabbing, refusing vital signs, and stating he would call 911 because of his roommate. R1 was documented as walking room to room without a shirt until 3:00 AM.10/29/25 at 10:14 AM, a progress note documented that R1 was arguing with the nurse and was frantic, hiding and collecting trash in the room. 10/30/25 11:21 AM - A behavior charting progress note documented that R1 remained out of his room to avoid arguments with R2.10/30/25 6:22 PM - A progress note documented that R1 was verbally aggressive with staff.11/1/25 3:02 PM - A behavior charting progress note documented that R1 was pacing up and down the hallways, asking for a way out, and required redirection to the dining room.Despite repeated documentation from 10/21/25 through 11/1/25 of R1's escalating agitation, aggression, exit-seeking, and continual conflict with his roommate, the facility did not revise R1's care plan, reassess the risk posed by the roommate pairing, increase supervision, obtain behavioral health services, or implement interventions to prevent foreseeable harm.11/2/25 6:58 PM - A facility incident report documented that R2 was found on the floor after an unwitnessed resident-to-resident altercation. R2 was noted to have a contusion to the back of the head and required transport to the hospital for evaluation.11/2/25 7:25 PM - A nursing progress note documented that R1 was heard yelling down the hallway. Staff observed R1 standing over R2, who was on the floor following the altercation.11/2/25 9:01 PM - A hospital progress note documented R2 had a contusion to the back of the head and strain of neck muscle.11/2/25 10:50 PM - R2 was readmitted to the facility post hospital evaluation with diagnosis of head injury and strain of neck muscle.11/3/25 7:00 AM- A progress note documented that one-to-one (1:1) supervision was initiated for R1.11/3/25 8:09 AM - A hospital x-ray report documented that R2 had a scapholunate ligament (ligament in wrist) injury suspected to left wrist.11/3/25 2:09 PM - A progress note documented that the IDT team discussed the 11/2/25 incident and confirmed that R1 was placed on 1:1 supervision starting at 7:00 AM.11/3/25 4:00 PM - A room change form documented that R1 was moved to another room due to the 11/2/25 incident.11/3/25 4:14 PM - A progress note documented that the ADON (E3) consulted with the NP (psych) regarding R1's behavioral changes. The facility lacked evidence that a psych consult actually occurred.11/4/25 5:09 PM - An electronic training text message documented: Staff must promptly recognize and report roommate conflict for resident

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, it was determined that for two (R1 and R6) out of seven residents reviewed for abuse, the facility failed to report resident to resident abuse to the State Agency within two hours. Findings include:1.Review of R1's clinical record revealed:7/28/25 - R1 was admitted to the facility. 11/4/25 - A review of facility reported incident documented that R1 experienced a psychotic episode and made contact with three residents (R3, R4, and R5) which occurred on 11/3/25 at 9:00 PM. The incident report documented that the report was submitted to the state agency on 11/4/25 at 2:39 PM.11/7/25 9:30 AM - During an interview, E6 (CNA) confirmed the incident occurred on 11/3/25 at approximately 9:00 PM. 11/13/25 12:10 PM - During an interview, E3 (ADON) confirmed that she was made aware an incident occurred on 11/3/25 around approximately 9:00 PM and stated that when obtaining staff interviews on 11/4/25 was then informed of R1 having resident to resident physical contact with other residents. E3 stated the report was submitted late due to facility wanting to submit accurate data regarding the incident. E3 confirmed the incident report was not submitted within the two hour time frame to the state agency.2. Review of R6's clinical record revealed:10/27/25 - R6 was admitted to the facility.11/3/25 - A progress note documented an IDT meeting was held regarding R6 making fabricated statements and discussion of R6 being moved to a different unit due to R7 being in the room, not allowing for privacy to the roommate. 11/14/25 12:50 PM - During an interview, E7 (CNA) revealed that R6 stated that her husband R7 choked her. E7 confirmed that this allegation of abuse was reported to the nurse, but E7 could not give recall the exact date of the allegation. 11/14/25 1:05 PM - During an interview, E11 (LPN) revealed that E7 reported the allegation of abuse between R6 and R7. E11 stated the allegation was reported to the nursing supervisor working that day and confirmed the process was to report allegations to supervisor and they would report to management. 11/14/25 2:10 PM - During an interview, E4 (SW) confirmed that an IDT meeting occurred and discussed R6 making false statements in regards to R7 and the family mentioned the history of the allegations during the meeting. E4 confirmed that statements were discussed during the IDT but unsure of the occurrence of them.11/14/25 2:32 PM - During an interview, E3 (ADON) confirmed she was present in the IDT meeting and stated that the family mentioned that R6 had a history of making allegations about R7. E3 stated she was not aware that R6 alleged that R7 choked her and staff did not report the allegation of abuse to her.11/14/25 3:15 PM - Findings were reviewed with E1 (Corporate NHA), E2 (DON) and E3 (ADON) during the exit conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, it was determined that for one (R2) out of seven (7) residents in the investigative sample, the facility failed to ensure the clinical record contained accurate documentation. Findings include:Review of R2's clinical record:7/1/25 - R2 was admitted to the facility.11/7/25 - A review of R1's clinical record lacked evidence of a progress note, consult, medication review, or visit summary after the incident on 11/2/25. 11/13/25 1:25 PM - The facility provided electronic communication from E16 (NP) documenting R2 was seen on 11/6/25 for a wellness check. 11/14/25 9:16 AM - During an interview, E12 (LPN) stated that R2 had not been seen by psychiatrist on 11/6/25 and confirmed no progress notes were not in the electronic medical record for the aforementioned date. The facility failed to ensure the clinical record contained accurate documentation. 11/14/25 - Findings were reviewed with E1 (Corporate NHA), E2 (DON) and E3 (ADON) during the exit conference.