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	02/18/2026

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

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview it was determined that the facility failed to ensure a homelike environment when the facility repeatedly utilized an overhead paging system to communicate with other staff. Findings include:During random observations overhead paging for non-emergent communication was heard the following times: 2/12/26 10:45 AM.2/12/26 10:47 AM.2/12/26 11:01 AM.2/13/26 11:58 AM.2/13/26 1:12 PM.2/16/26 1:24 PM.2/16/26 1:59 PM.2/16/26 2:59 PM.2/13/26 9:58 AM - During the facility resident council meeting an anonymous resident confirmed the overhead paging by facility staff was unpleasant. 2/17/26 3:21 PM - During an interview E1 (NHA) confirmed the facility utilized overhead paging to communicate with other staff members. E1 stated We use it during the day, but we stop at 7:00 PM. 2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON).

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on interviews, record review and review of other facility documentation it was determined that for one (R174) out of three residents sampled for discharge, the facility failed to ensure a referral for home health care services was completed prior to discharge. R174 was discharged to home on 8/12/25. R174's home health services did not begin until 8/20/25 eight days after discharge from the facility. Findings include:A facility policy titled Notice Requirements before Transfer/Discharge dated 5/1/25 documented The facility will provide sufficient preparation and orientation to residents to ensure an orderly transfer or discharge from the facility.A review of R174's clinical record revealed:7/28/25 - R174 was admitted to the facility with the following diagnoses: aortic valve replacement, aortic regurgitation, and congestive heart failure.8/11/25 - A review of R174's discharge summary documented, Discharge summary and post-discharge plan for home health aide, home health RN/LPN, occupational and physical therapy.8/12/25 - R174 was discharged to home with a family member.9/30/25 9:40 AM - A review of a complaint to the Division documented, [R174] was discharged to a family member's home without a home health care agency referral. Further review of the complaint documented that R174 had been in the home for one week and had not received any physical or occupational therapy and had not received a wellness check from a nurse.2/16/26 11:00 AM - During an interview, E15 (SW) reported, I would need to check if a referral was made for [R174].2/16/26 12:17 PM - During an interview, E15 confirmed R174's referral for home health and therapy services was not requested until 8/15/25. E15 then stated, [R174's] referral for home health care was opened for recommended services on 8/20/25.2/16/26 1:48 PM - During an interview, E35 (DT) reported, [R174] already had therapy equipment at home. E35 confirmed and stated, Physical therapy and occupational therapy were recommended for [R174]. E35 then reported, Typically, recommendations are communicated to social services to set up home care.2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, it was determined that for four (R2, R9, R22, R41 and R46) out of forty-nine sampled residents the facility failed to revise the residents care plans to reflect their individualized needs. Additionally, it was determined that for R2 the facility failed to ensure that the resident and the resident representative were involved in developing the care plan. Findings include:1. Review of R2's clinical record revealed: 11/15/24 – R2 was admitted to the facility. 11/4/25 – A Brief Interview for Mental Status (BIMS) evaluation documented R2 with a score of 15 out of 15, showing an intact cognitive status. 2/9/26 9:27 AM – During an interview, R2 stated that he did not recall having quarterly care plan meetings since his admission. 2/10/26 – A review of R2's electronic chart documented a care conference meeting on 11/29/24, where R2 was present and no further meetings afterwards. Furthermore, the electronic chart for R2 documented a care plan completed on 3/10/25, 5/21/25 and 12/2/25. 2/16/26 8:50 AM – During an interview, E15 (SW) confirmed that R2's last care conference meeting was 11/29/24 and that there were no care conference meetings in 2025. There was a lack of evidence that R2 was involved in developing a care plan for 3/10/25, 5/21/25 and 12/2/25. 2. Review of R9's clinical record revealed: 3/17/23 - A physician's order was written for R9 to wear a right palm protector at all times, as tolerated, may use rolled gauze [wash cloth] if replacement unavailable. 12/8/25 - Reviews to R9's care plan for potential for further contractures related to impaired mobility and existing contractures was completed, the palm guard/replacement was listed as an intervention. The care plan lacked evidence of any potential refusals from R9 to wear the palm guard or a replacement such as a rolled washcloth or gauze. 2/9/26 10:00 AM - R9 was observed without a palm guard or replacement. R9 answered no when offered a palm guard/replacement. E19 (LPN) stated he usually refuses. 2/11/26 12:10 PM - R9 was observed without a palm guard or replacement. 2/16/26 1:13 PM - R9 was observed without a palm guard or replacement. R9 answered no when offered a palm guard/replacement. 2/16/26 1:17 PM - During an interview E18(CNA) confirmed that R9's palm guard/replacement was not in place and stated, I haven't seen the palm guard recently, but we use a washcloth then, he takes it out or sometimes says no. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/16/26 1:25 PM - During an interview E23 (LPN) stated he gets the washcloth I have not seen the palm guard he takes them out. E22(RN) then immediately confirmed that R9's care plan for a palm guard should have been updated to reflect the residents' potential refusals. 3. Review of R22's clinical record revealed: 9/16/25 - A quarterly MDS assessment documented that R22 was cognitively impaired and dependent for bathing. 12/15/25 Annual MDS assessment documented that R22 was cognitively impaired and dependent for bathing. 12/29/25 - A review of R22's care plan for self-care deficit was completed. The care plan documented that R22 required set up assistance for bathing. 12/15/25 Annual MDS assessment documented that R22 was cognitively impaired and dependent for bathing. 2/12/26 2:28 PM - During an interview E24(CNA) confirmed that R22 was dependent for bathing and occasionally refuses care. E24 stated, She needs me to pretty much do everything now for her now. She hasn't been able to without help in a while. 2/12/26 2:28 PM - During an interview E3 (DON) confirmed the finding and stated she would revise R22's care plan to include the R22's dependence for bathing. 4. Review of R41's clinical record revealed: 11/3/25 - A quarterly MDS assessment documented that R41 was cognitively impaired and dependent for bathing. 11/17/25 - R41's care plan for self-care deficit was reviewed by the facility and indicated that R41 required one person to assist them with bathing. The care plan lacked documentation of R41's dependance for bathing. 2/18/26 12:19 PM - During an interview E4 (ADON) confirmed the facility failed to ensure that R41's self-care deficit care plan was revised to reflect residents' dependence for bathing. 5. Review of R46's clinical record revealed: 10/27/25 R46's behavior care plan for safety hazard to others as evidenced by resident is combative during care, attempts to hit staff with bed remote and call bell was created. 1/13/26 - A quarterly MDS assessment documented that R46 was cognitively impaired and had physical behaviors four to six times in a seven-day period. 1/13/26 - An incident report was submitted to the State Agency that alleged R46 aggressed another resident during an altercation when R46 swung a television remote and hit another resident. 1/19/26 - A five day follow up to the previous incident report was submitted that documented, care (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plans were reviewed. 2/12/26 - Review of R46's behavior care plans lacked evidence of revision to include R46's new behavior of an attempt to hit residents. 2/12/26 1:37 PM - During an interview E3 (DON) confirmed that the facility failed to revise R46's behavioral care plan to include the new potential for resident-to-resident altercations. 2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD), and E3 (DON).

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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. Based on interview and record review for one (R56) out of two residents reviewed for catheter use, the facility failed to refer R56 to urology timely while having an ongoing urinary catheter issue. Findings include: Review of R56's clinical record revealed:10/24/23 - R56 was admitted to the facility.11/6/23 - A care plan documented R56 had a foley catheter related to neurogenic bladder with the following interventions: resident had a 18F with a 30 mL balloon, position catheter bag and tubing below level of the bladder; monitor intake and output per facility policy; monitor for signs and symptoms of discomfort on urination and frequency; monitor for signs and symptoms of UTI and report to physician; monitor and document for pain or discomfort related to catheter. 2/25/25 - A progress note documented R56 returned from an appointment and foley catheter was found to be out, with balloon intact. The progress note documented that foley catheter insertion was attempted and unsuccessful at this time, due to resistance. The provider was notified and recommendation to leave foley catheter out and bladder scan every 8 hours for residual urine. 2/26/25 - A progress note documented that foley catheter re-insertion was successful.3/1/25 - A progress note documented that R56 had large amount of bleeding and blood clots noted from penis. The on-call provider was notified and labs and urine culture ordered. 3/2/25 6:03 AM - A progress note documented that R56 presented with excessive bleeding and clots around urinary catheter and was sent to hospital for evaluation. 3/2/25 9:51 AM - A diagnostic report for CT results documented the tip of the catheter is seen in the penile urethra with distended balloon just proximal to the tip. 3/2/25 3:54 PM - A progress note documented that R56 returned from hospital. 3/5/25 12:00 AM - A physician's progress documented that R56 was recently seen and examined by urology with foley catheter change. The diagnoses, assessment, and plan section documented that R56 will follow up with urology.11/3/25 10:31 AM - A visit summary report documented that R56 was seen by urology. 2/18/2026 9:35 AM - During an interview, E30 (LPN) stated that R56 was difficult to replace the urinary catheter and recalls staff having ongoing difficulty changing. E30 stated that R56 was recommended to follow up with urology and have catheter changes done with them due to the increased difficulty. 2/18/2026 10:03 AM - During an interview, E31 (LPN) stated that R56 had multiple catheters dislodged in the year 2025 and stated that R56 was difficult catheter to change. E31 stated that R56's catheter would leak often and would require staff to change it. E31 stated the expectation would be for staff nurses to attempt to change the catheter and if unsuccessful they would be referred out.2/18/2026 12:11 PM - During an interview, E14 (LPN) stated the expectation is to get residents scheduled with outside providers as soon as possible. E14 confirmed that R56 did not see urology until 11/3/25.The facility failed to refer R56 to an outside provider timely. 2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON).

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, it was determined that for one (R173) out of two residents reviewed for hydration, the facility failed to ensure that R173 maintained proper hydration which resulted in harm, requiring hospitalization on 6/1/25 and 6/19/25 with diagnosis of acute kidney injury (AKI) and dehydration. Findings include:The BUN (blood urea nitrogen) lab test 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 R173's clinical record revealed: 4/25/25 - R173 was admitted to the facility with a diagnosis of acute lithium toxicity, AKI (acute kidney injury), acute metabolic encephalopathy and congestive heart failure (CHF).4/28/25 - A care plan documented that R173 had potential for alteration in nutrition due to dementia and Parkinson's disease with the following interventions: assist at meals as needed, encourage oral fluids to promote adequate hydration, and monitor for the need of other nutrition interventions. 4/28/25 - A nutrition progress note documented a nutrition assessment which recommended R173's fluid intake should be 1943-2098 mL/day. The assessment further identified R173 was at risk for dehydration and malnutrition. The progress note further mentions lab tests obtained on 4/26/25 which documented the following lab values: Sodium 140; BUN 29; creatinine 1.4; eGFR 53. 4/30/25 - An admission MDS documented that R173 required set up assistance of one staff for feeding and hydration and also documented that R173 was a BIMS of 1, indicating severely cognitively impaired. The daily totals obtained from CNA Task flow sheet and MAR for R173's fluid intake:5/1/25 - 1080 mL.5/2/25 - 840 mL.5/3/25 - 620 mL.5/4/25 - 1080 mL.5/5/25 - 1080 mL.5/6/25 - 720 mL.5/7/25 - 1680 mL.5/7/25 - A Malnutrition Risk Assessment documented that R173 was at risk for malnutrition related to severe dementia and hand shake (tremors). 5/8/25 - 1920 mL.5/9/25 - 1410 mL.5/10/25 - A physician's order documented encourage increased fluid intake of 240 mL per shift. 5/10/25 - 720 mL.5/11/25 - 840 mL.5/12/25 - A nutrition progress note documented R173's average fluid intake was 330 mL/day and recommended to discontinue prescribed hydration pass related to R173's diagnosis of CHF. The assessment documented to encourage oral fluid intake and determined a new fluid goal was 1635 - 1766 mL/day.The daily totals obtained from CNA Task flow sheet and MAR for R173's fluid intake:5/12/25 - 960 mL.5/13/25 - 1200 mL. 5/14/25 - 940 mL.5/15/25 - 1800 mL.5/16/25 - 1200 mL.5/17/25 - 720 mL.5/18/25 - 1320 mL.5/19/25 - 720 mL.5/20/25 - 840 mL.5/21/25 - 1000 mL.5/22/25 - 1320 mL.5/23/25 - 1200 mL.5/24/25 - 1080 mL.5/25/25 - 1080 mL.5/26/25 - 1200 mL.5/27/25 - 1080 mL.5/28/25 - 960 mL.5/29/25 - 930 mL.5/30/25 - 1080 mL.5/31/25 - 1080 mL.6/1/25 - 360 mL.6/1/25 11:00 AM - A transfer form documented that R173 was being sent to hospital post fall for evaluation. 6/1/25 - A hospital progress note documented that R173 presented to the emergency department related to frequent falls, hypotension, and confusion. R173 was admitted with diagnosis of AKI and dehydration, requiring further work up.6/4/25 - R173 was readmitted to the facility.6/10/25 - A nursing progress note documented R173 had low oral intake and will discuss adding R173 to the assist to feeding list.The facility lacked evidence of resident being added to the feeding list or the assessment regarding the need. The daily totals obtained from CNA Task flow sheet and MAR for R173's fluid intake:6/11/25 - 1320 mL.6/12/25 - 1040 mL.6/13/25 1:00 AM - A physician's progress note documented that R173 was seen following two unwitnessed falls. The progress note lacked evidence of assessment of hydration status, fluid intake, or interventions to encourage hydration. 6/13/25 - 840 mL.6/14/25 - 1200 mL.6/15/25 - 720 mL.6/16/25 - 780 mL. 6/16/25 - A progress note documented R173 was having lethargy.6/17/25 - 1160 mL.6/18/25 - 1140 mL.6/18/25 - A progress note documented R173 was having increased confusion, agitation, (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	restlessness, and continues with poor intake.6/19/25 - 720 mL.6/19/25 1:48 PM - A laboratory results report documented that R173 had the following lab values: BUN level of 62 mg/dL, creatinine 1.70 mg/dL, hemoglobin 7.6 g/dL and hematocrit 23.3.6/19/25 2:35 PM - A progress note documented that lab results were called to provider and documented R173 would be seen by MD. The progress note documented R173 was noted to have increased shortness of breath, increased falls, and increased confusion/agitation/anxiety.6/19/25 4:21 PM - A nursing progress note documented that R173 was sent to the hospital for further evaluation.6/19/25 4:24 PM - A hospital progress note documented that R173 had lab values of BUN of 62 mg/dL and creatinine 1.7 mg/dL upon arrival to emergency department. The progress note further documented R173 was being admitted with diagnosis of AKI, hypotension, and anemia with a plan to fluid resuscitation via IV fluids and avoid nephrotoxic medications.2/17/26 11:15 AM - During an interview, E16 (Dietician) stated resident's will have a nutrition evaluation at admission and quarterly thereafter and the dietician is expected to review intake, weights, labs and hydration status. E16 stated that additional fluids or supplements can be ordered if fluid goals are not being met and if resident is not consistently meeting goals the expectation is to discuss with the provider. E16 also stated that a resident having a diagnosis of AKI would be someone that would be closely monitored to prevent from reoccurring. 2/18/26 11:45 AM - During an interview, E13 (CNA) stated that if a resident is not drinking well the staff is expected to encourage fluids, monitor intake and notify the nurse if the resident is not meeting fluids goals during their shift. 2/18/26 12:00 PM - During an interview, E14 (LPN) stated that R173 was not a good drinker and staff would encourage him to drink. E14 stated that R173 would drink if staff would sit and encourage him to drink, but did say at times he would refuse to drink and push the cup away. E14 stated that R173 having poor intake was reported to the Nurse Manager and the process is for the Nurse Manager to report goals not met to the provider. E14 could not verify if the Nurse Manager reported R173 not meeting fluid goals was reported at that time and stated she did not see any progress notes documenting that. 2/18/26 12:15 PM - During an interview, E17 (Unit Manager) stated the expectation is for the provider to be notified if a resident is not meeting fluid goals and to be evaluated by the provider and dietician for interventions related to hydration. Despite nursing documenting R173's decreased intake and change in mentation, the facility failed to increase monitoring, implement approaches to increase hydration and consult with the physician about decreased intake.2/18/26 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (ROD) and E3 (DON).