

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Excelcare at Lewes LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599</p> <p>Based on observation, interviews, and record review, the facility failed to ensure that one residents (Resident (R)79) in the sample of 46 received care and services in a manner and environment that maintained dignified dining experience.</p> <p>Findings include:</p> <p>Review of R79's Admission Record located under the Profile tab in the Electronic Medical Record (EMR) revealed R79 was admitted on [DATE] with diagnoses that included generalized osteoarthritis and chronic obstructive pulmonary disease.</p> <p>Review of the quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 11/04/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R79 was cognitively intact.</p> <p>Review of the Care Plan located under the Care Plan tab dated 11/13/24 revealed R79 was to have assistance with activities of daily living (ADL) as needed due to identified self-care deficit.</p> <p>Observation and interview on 02/11/25 at 08:38 AM, R79 was seated in his wheelchair at the foot of his bed. The resident's bed linens were soiled with a large brown stain visible to anyone entering the room and the room was very odorous. The resident's covered breakfast tray was on the overbed table next to the bed. R79 stated, I just want to lay down and look at my bed. They expect me to eat breakfast, and my bed is like that. They said they would change my bed, but they haven't been back.</p> <p>Interview on 02/11/25 at 8:43 AM, Registered Nurse (RN3) stated he would have someone change R79's bed linens. A second request was made at 8:57 AM before the bed was changed. When asked, at 9:15 AM, why the bed was not changed for 14 minutes, RN3 stated, they were passing trays, didn't want them to be sitting.</p> <p>Interview on 02/13/25 at 4:47 PM, the Director of Nurses (DON) and Assistant Director of Nurses (ADON) said the bed linens should have been changed before providing R79 his breakfast.</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46319</p> <p>Based on record review, interviews, and review of facility policy, the facility failed to ensure one of three residents (Resident (R) 21) reviewed for abuse was free from abuse in the sample of 46 residents. This failure had the potential for psychosocial impairment from being verbally abused by a staff member.</p> <p>Findings include:</p> <p>A review of the facility reported incident revealed that on 11/26/24 at approximately 9:00 AM, the Social worker witnessed the involved staff (medical records clerk) having a verbal exchange with the resident in an argumentative tone and when the involved staff was advised to walk away from the altercation, the staff member turned around and confronted the R21 and used profanity.</p> <p>Review of R21's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/26/24 revealed an admitted [DATE] and a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R21 was cognitively intact.</p> <p>On 02/13/25 at 12:10 PM during an interview R21 stated that he had already talked with someone from the state about this incident.</p> <p>Interview on 02/12/25 at 01:04 PM, the Assistant Director of Nurses (ADON) stated that she only remembered the incident occurring.</p> <p>On 02/13/25 at 1:44 PM during an interview the Social Service Director (SSD) stated that she did not actually witness the event but heard raised voices and the accused resident used profanity towards staff. Does not recall if the accused staff used profanity towards the resident.</p> <p>Interview on 02/13/25 at 2:00 PM, the Administrator stated that when the incident happened the medical records staff was immediately removed from the situation, escorted out of the building, and terminated.</p> <p>Review of the facility's policy titled, Freedom from Abuse, Neglect and Reporting of Alleged Violations, reviewed 06/15/2024, indicated, The facility will not use verbal .Verbal/Written Abuse is defined as the use of oral .that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability .The facility will develop and operationalize policies and procedures for screening and training employees. protection of residents and for the prevention, identification, investigation, and reporting of abuse .The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.</p>

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20064</p> <p>Based on document review, record review, interview, and policy review, the facility failed to ensure residents were free from misappropriation for one of one resident (Resident (R) 177) reviewed for misappropriation. Specifically, Licensed Practical Nurse (LPN) 3 took Resident (R)177's Percocet (pain medication) from the medication cart. The facility's failure to safeguard medication placed all residents at risk for their medications to be misappropriated.</p> <p>Findings include:</p> <p>Review of the facility's investigation summary revealed, On 12/4/24, [Licensed Practical Nurse (LPN)5's name] received 2 blister packs of Percocet packs from the pharmacy around 5AM. [LPN5] then handed the 2 packs of Percocet off to [Registered Nurse (RN)5's name] who was responsible for two carts on the unit (referred to as the odd and even carts). Both cards were mistakenly placed on the even cart, causing a discrepancy, the even cart had three cards of Percocet and the odd cart had two cards of Percocet. An adjustment was made and both carts had 2 cards of Percocet. On 12/4/24 at 7PM [LPN3's name] arrived for her shift and the narcotics were counted and recorded as correct. On 12/5/24 at 7AM [LPN3] signed over the even cart to [LPN12's name] with 2 cards of Percocet. The odd cart was signed over to [LPN13] and [LPN3] left the building. [LPN 13] discovered [R177's] blister pack on the odd cart had two tablets remaining. She contacted the pharmacy and confirmed 60 tablets of Percocet were delivered on 12/04/24. The investigation began, one of R177's blister pack of Percocet was found containing 30 tabs and the other was missing. [LPN3] left the building and did not return calls or return to the facility. She was unable to be reached by the facility. The Director of Nursing (DON) notified Regional about the incident and started an investigation. The police department was notified, and the incident was reported to the state. [LPN3] did not respond to the facility calls or the police who went to her house to inquire about the missing medications.</p> <p>Review of R177's undated Face Sheet located in the resident's electronic medical record (EMR) under the Face Sheet tab indicated that R177's was admitted to the facility on [DATE] and was discharged on [DATE].</p> <p>Review of R177's physician's orders revealed orders for Percocet two tablets 10/325 milligram (mg) every six hours for pain.</p> <p>During an interview on 02/12/25 at 9:51 AM, the Assistant Director of Nursing (ADON) stated the facility's investigation determined LPN3 was responsible for taking R177's Percocet pain medication. The ADON said all nursing staff were interviewed and drug tested . The ADON stated that R177 did not miss any doses of his medication due to the drug diversion.</p> <p>During an interview with the Administrator on 0212/25 at 1:48 PM, she stated LPN3 was arrested for the misappropriation of R177's medications. The Administrator provided an email from the detective investigating the incident indicating that LPN3 was arrested.</p> <p>Interview on 02/12/25 at 10:52 AM, the DON was asked if there was any document the nurses sign that they are to not take residents' medications. The DON stated the nurses sign the facility's Abuse policy.</p> <p>(continued on next page)</p>		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation dated 02/01/23 indicated, .Definitions . Misappropriation of Patient Property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a patient's belongings or money without the patient's consent.		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824</p> <p>Based on interviews, record reviews, and policy review, the facility failed to implement policies and procedures for the reporting of abuse to the State Survey Agency (SSA) for one of five residents (Resident (R) 77) reviewed for abuse out of a total sample of 46 residents. These failures had the potential to contribute to continued abuse in the facility for this resident and other residents.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Reporting of Reasonable Suspicion of a Crime & Alleged Violations provided by the facility and dated 06/15/24 indicated, The facility will develop and operationalize policies and procedures for .reporting of abuse, neglect, mistreatment, and misappropriation of property .Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment .are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency .</p> <p>Review of R77's Admission Record located in the Electronic Medical Record (EMR) under the Profile tab indicated she was admitted to the facility on [DATE].</p> <p>Review of R77's Admission Minimum Data Set (MDS) assessment under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 01/17/25 included a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated she was moderately cognitively impaired.</p> <p>Review of R322's Admission Record located in the EMR under the Profile tab indicated she was admitted to the facility on [DATE].</p> <p>Review of R322's Admission MDS assessment under the MDS tab in the EMR was in progress and incomplete.</p> <p>Review of a facility's investigation dated 02/07/25 of R322's incident indicated R77 reported to the Assistant Director of Nurses (ADON) that she was afraid of a female staff member with a hairband and long, black hair.</p> <p>During an interview on 02/10/25 at 2:38 PM, R77 stated that sometimes staff are rude, but she was not afraid of any staff, and she had no concerns about abuse or neglect.</p> <p>During an interview on 02/13/25 at 5:19 PM, the Director of Nurses (DON), was asked about a witness statement dated 02/07/25 written by the ADON regarding R77's statement about being afraid of a staff with long black hair wearing a headband. The DON stated that R77 was confused, and the allegation was not reported to the SSA or investigated. Additionally, the DON stated that the facility was still working on the five-day report and felt that R77's statement would be investigated during the five-day investigation time period.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/13/25 at 6:10 PM, the ADON provided a revised statement from her interview with R77 which indicated the resident was confused, not consistent with her description of staff members or the time of day/shifts that staff worked. The statement indicated, .Resident recently changed room to move closer to nursing station for closer observation and stated did not feel safe 'because moved here yesterday'. [sic] Revisited resident later at the day [sic], resident did not recall conversation from earlier, no statements of being unsafe. The document was initially unsigned and undated. The ADON then provided documentation indicating that her interview with R77 was on 02/07/25 between 4:00 PM and 5:00 PM. The ADON confirmed that she had not reported the allegation to the Abuse Coordinator due to the resident being confused.</p> <p>During an interview on 02/13/25 at 7:00 PM, the Administrator confirmed that R77's allegation of being fearful of a staff member on 02/07/25 had not been reported to her but should have been. The Administrator confirmed that any resident, regardless of cognition status reporting fear of a staff member should always be reported to the Abuse Coordinator/Administrator to be investigated and reported to the SSA.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824</p> <p>Based on interviews, record reviews, and policy review, the facility failed to complete a thorough investigation into an allegation of staff to resident abuse for one of five residents (Resident (R) 77) reviewed for an allegation of abuse out of a total sample of 46 residents. The failure to conduct a thorough investigation had the potential to place other residents at risk for abuse.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Reporting of Reasonable Suspicion of a Crime & Alleged Violations revised 06/15/24 revealed, .In response to allegations of abuse .or mistreatment, the facility will: a. Have evidence that all alleged violations are thoroughly investigated .c. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law . The administrator, Director of Nursing (DON) or Designee will be responsible for obtaining all statements/forms from staff member and will also be responsible for the investigation and documentation of final findings .</p> <p>Review of R77's Admission Record located in the Electronic Medical Record (EMR) under the Profile tab indicated she was admitted to the facility on [DATE].</p> <p>Review of R77's Admission Minimum Data Set (MDS) assessment under the MDS tab in the EMR with an Assessment Reference Date (ARD) of 01/17/25 included a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated she was moderately cognitively impaired.</p> <p>Review of R322's Admission Record located in the EMR under the Profile tab indicated she was admitted to the facility on [DATE]. Review of R322's Admission MDS assessment under the MDS tab in the EMR was in progress and incomplete.</p> <p>Review of a facility's investigation into R322's allegation of abuse revealed that on 02/07/25, R77 reported to the Assistant Director of Nurses (ADON) that she was afraid of a female staff member with a hairband and long, black hair.</p> <p>During an interview on 02/10/25 at 2:38 PM, R77 stated that sometimes staff are rude, but she was not afraid of any staff, and she had no concerns about abuse or neglect.</p> <p>During an interview on 02/13/25 at 5:19 PM, the DON was asked about R77's statement on 02/07/25 to the ADON related to R77 being afraid of a staff with long black hair wearing a headband. The DON stated that R77 was confused, and the allegation was not reported or investigated. Additionally, the DON stated that the facility was still working on the five-day report regarding the other resident in the facility and felt that R77's statement would be investigated during the five-day investigation time period.</p> <p>During an interview on 02/13/25 at 6:10 PM, the ADON confirmed that she had not investigated the allegation due to the resident being confused. The ADON did not confirm or deny that she should have investigated the allegation.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/13/25 at 7:00 PM, the Administrator confirmed that R77's allegation of being fearful of a staff member that she reported to the ADON on 02/07/25 had not been reported to her but should have been. The Administrator confirmed that any resident, regardless of cognition status reporting fear of a staff member should always be reported to her/Abuse Coordinator and that a thorough investigation should have been conducted.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599</p> <p>Based on observation, interviews, and record review, the facility failed to provide treatment to a wound in accordance with the physician's order and revise the care plan to reflect the change of wound treatment for one of six residents reviewed for quality of care (Resident (R) 17) in the sample of 46 residents. The failure created the potential to cause a negative outcome to the healing of R17's wound.</p> <p>Findings include:</p> <p>Review of the Admission Record located in R17's electronic medical record (EMR) under the Profile tab indicated the resident was admitted on [DATE] with diagnoses including acquired absence of right and left legs above the knees, peripheral vascular disease, and type 2 diabetes mellitus with diabetic neuropathy.</p> <p>Review of the quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 11/20/24 revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated the resident was cognitively intact.</p> <p>During an observation and interview on 02/10/25 at 10:53 AM, R17 stated, I have this spot on my stump that I think was caused by the table [overbed table] hitting it. Now I think it's infected. It's supposed to be changed every other day. R17 uncovered his left stump which revealed a bandage dated 2/7 with a B next to the date. R17 stated Yeah, they came in on Friday and changed it, but not over the weekend.</p> <p>During an interview on 02/10/25 at 11:02 AM, Licensed Practical Nurse (LPN9) confirmed that the date on the bandage was 2/7 with a B next to the date. LPN9 reviewed R17's physician orders and stated, It should have been changed yesterday, 02/09/25. It's supposed to be changed every other day. It was changed by the wound care team on Friday.</p> <p>Review of the Physician Orders located under the Orders tab in the EMR revealed the following physician orders:</p> <p>02/07/25, Clean L [left] AKA [above knee amputation] with NSS [normal saline solution], apply Silvasorb Alginate every other day.</p> <p>Review of the Treatment Administration record (TAR) located in the EMR under the Orders tab revealed the treatment was provided on 02/07/25 and not on 02/09/25 as ordered.</p> <p>Review of the Progress Notes, located under the Clinical tab in the EMR revealed a scab on his left stump was identified on 1/28/25. R17 was added to wound rounds. On 01/29/25, the Nurse Practitioner (NP) assessed the new wound/scab on left stump . It is inflamed around the scab with scant amount of drainage noted. Wound care team consulted. R17 was seen by the Wound care team on 01/31/25 with new orders for doxycycline with treatment as bacitracin and dry dressing daily. A Progress Note on 02/07/25 indicated, the Wound Care Physician (WCP) changed the treatment to NSS (normal saline solution), Silvasorb Alginate every other day.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947</p> <p>Based on observations, record review and interviews, the facility failed to ensure one (Resident (R) R46) of two residents reviewed for pressure sores in the sample of 46 residents was provided with all planned interventions related to an existing pressure sore. This failure created the potential for the resident to experience further unnecessary skin breakdown.</p> <p>Findings include:</p> <p>Review of R46's undated Admission Record dated 02/13/25 in the Electronic Medical Record (EMR) under the Summary tab indicated admitted to the facility on [DATE] with diagnoses including dementia and type 2 diabetes.</p> <p>Review of R46's significant change Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/13/24 in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident was at risk for developing pressure ulcers but did not have any current pressure ulcers at the time of the assessment. The assessment indicated a pressure reducing mattress was being used on the resident's bed.</p> <p>Review of R46's comprehensive physicians orders dated 02/13/25 in the EMR under the Orders tab indicated orders, order dated 02/08/25 that indicated, cleanse left heel wound with normal saline solution. Apply calcium alginate and bordered gauze daily. An order dated 02/08/25, that indicated the resident was to receive the following treatment: cleanse left buttock with normal saline solution, apply zinc, cover with bordered gauze, change daily and as needed. The order did not indicate the application of a low air loss mattress to the resident's bed.</p> <p>Review of R46's Skin Integrity Care Plan, dated 02/07/25 in the EMR under the Care Plan tab revealed the resident had a stage 2 pressure sore to her left buttock and a deep tissue injury to her right heel. The care plan indicated the resident was at risk for further skin breakdown and indicated preventative skin measures, including a pressure reducing mattress on the resident's bed, were to be implement as ordered. The care plan did not indicate the application of a low air loss mattress to the resident's bed.</p> <p>Review of R46's Health Status Note dated 02/07/25 in the EMR under the Notes tab revealed, Resident seen by [Facility's Wound Care Physician (WCP)] for wound rounds . Air Mattress order placed in TELLIS (the facility's maintenance request system).</p> <p>Observations of R46 lying in bed in her room on 02/10/25 at 4:34 PM, on 02/11/25 at 9:01 AM 1:09 PM, 3:10 PM, and 3:46 PM, and on 02/12/25 at 8:30 AM and 9:45 AM revealed no low air loss mattress applied to the resident's bed. R46 was lying on a regular pressure reducing mattress.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation of the resident along with Unit Manager (UM1) on 02/12/25 at 1:16 PM, UM1 confirmed a low air loss mattress was not applied to R46's bed. UM1 stated the WCP had ordered a low air loss mattress for the resident during wound rounds conducted the previous week to prevent potential worsening of the resident's wounds and stated she had placed the order for the mattress into the facility's TELS system that day (02/07/25).</p> <p>During an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 02/13/25 at 4:30 PM, the ADON confirmed the resident's low air loss mattress was expected to have been ordered timely and would typically have been expected to have been placed on the resident's bed on the same day.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40824</p> <p>Based on interviews and record reviews, the facility failed to prevent an injury during incontinence care for two of eight residents (Resident (R) 171 and R170) reviewed for accidents out of a total sample of 46 residents. Specifically, the facility failed to utilize a mechanical lift for assistance out of bed for R170 and failed to properly assist R171 with bed mobility during incontinence care which according to the care plan required the assistance of two staff members. This failure resulted R171 sustaining a laceration to her forehead when she rolled off the bed during incontinence care. Additionally, R170 sustained a skin tear to the abdomen during incontinence care related to improper transfer.</p> <p>Findings include:</p> <p>1. Review of R171's Admission Record located in the Electronic Medical Record (EMR) under the Resident tab indicated she was admitted to the facility on [DATE] with diagnosis of cerebral infarction.</p> <p>Review of R171's Care Plan located in the EMR under the Care Plan tab initiated 09/01/20 included two-person assistance with bed mobility and was incontinent of bowel and bladder.</p> <p>Review of R171's quarterly Minimum Data Set (MDS) located in the EMR under the MDS tab did not include a Brief Interview for Mental Status (BIMS) score due to the resident not being able to participate. R171 was noted to have impairment to all extremities and was dependent with all activities of daily living (ADL) including incontinent care and bed mobility.</p> <p>Review of R171's fall investigation provided by the facility revealed the resident sustained a fall on 06/06/24 at 9:40 PM while being provided incontinence care by Certified Nursing Assistant (CNA1). The resident was noted to have rolled off the bed and sustained a laceration to the left forehead with active bleeding. R171 was transported to the Emergency Department (ED) for evaluation and treatment. No sutures were required. A computed tomography (CT) scan was performed of the head and was negative. The resident returned to the facility on [DATE] with no new orders. The facility investigation confirmed that CNA1 was immediately suspended pending investigation and was terminated on 06/07/24 for failing to follow the resident's plan of care which indicated that two staff were to be present during bed mobility.</p> <p>Review of CNA1's Witness Statement dated 06/06/24 and provided by the facility indicated, I walked into the room with [CNA2], [R171] had a bm [bowel movement] and was very sweaty. [CNA2] left to get a sheet. I continued to clean R171, her feet rolled out of the bed and her head followed. I tried my best to hold her up. She fell, I stepped into the hall and called for CNA2 because she was the only person I seen (sic). When she came to the room I asked her to get [Licensed Practical Nurse (LPN)1].</p> <p>Review of CNA2's Witness Statement dated 06/06/24 and provided by the facility stated, I [CNA2] was @ [at] the nurse station talking to [LPN1] when [CNA1] called my name to come to room .when I walked in I saw [R171] on the floor bleeding from the left side of her face. I [CNA2] immediately called [LPN1] to come fast and that [R171] was on the floor</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of LPN1's Witness Statement provided by the facility stated, This writer was sitting at the desk when [CNA1] rushed out of [R171's room] and asked to call [CNA2] the other aid. Writer did so. [CNA2] went to rm [room] and came out calling for writer. As writer came to rm, [R171] was observed lying down on the floor, face down, bleeding from the side of the left side of the head.</p> <p>During an interview on 02/13/25 at 2:25 PM, LPN1 stated that CNA1 came out of R171's room and called for CNA2 to come to the room to assist her. CNA2 then saw R171 on the floor bleeding from the head and called for LPN1. LPN1 immediately assessed R171, notified her supervisor and called 911 (Emergency Services). R171 was to have two-person assistance with all ADL care due to contractures. R171 went to the ED and returned with a bandage wrapped around her head. LPN1 confirmed that R171 should have had two CNAs providing care to her and she did not know why CNA1 gave care by herself.</p> <p>During an interview on 02/13/25 at 10:18 AM, the Assistant Director of Nurses (ADON) confirmed that R171 was dependent on staff for all ADL care. It was determined that CNA1 didn't follow the protocol for two-person assistance and should have.</p> <p>18947</p> <p>2. Review of R170's Admission Record, dated 02/13/25 in the EMR under the Admissions tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia, morbid obesity, and congestive heart failure.</p> <p>Review of R170's significant change MDS with an ARD of 08/29/24 in the EMR under the MDS tab revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident did not transfer/move from a sitting to standing position from her bed or any other surface due to her medical condition or safety concerns. The assessment indicated the resident was totally dependent on staff to transfer in and out of her bed to a wheelchair and required extensive assistance from staff to move about in her bed.</p> <p>Review of R170's comprehensive care plan dated 09/17/24 in the EMR under the Care Plan tab indicated the resident's mobility status as assistance of two staff with use of Hoyer lift for transfers to and from bed and assistance of two staff for movement within bed. The care plan indicated the resident was non-ambulatory.</p> <p>Review of R170's Fall Risk Evaluation dated 09/24/24 and found under the Assessment tab in the EMR, revealed a score of 18, which indicated the resident was at risk for falls. The assessment indicated the resident's ambulation/elimination status as bedbound/incontinent. The assessment indicated the resident's gait/balance as Not able to perform function.</p> <p>Review of R170's Health Status Note dated 09/25/24 in the EMR under the Notes tab revealed, Resident was lowered to the floor during transfer from her bed, acquired small skin tear to the L [left] lateral abdomen, was assisted back to bed via Hoyer lift and x [time] 4 staff assist, resident recently readmitted to facility and therapy to evaluate and confirm transfer status.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's investigation related to R170's 09/25/25 fall revealed R170 was lowered to the floor when she became weak and was unable to stand while Certified Nursing Assistant (CNA6) and CNA7 assisted the resident to stand next to her bed to provide ADL/Peri-care. The investigation revealed four unidentified staff members, and the use of a Hoyer lift were required to transfer the resident back to her bed and indicated the resident received a skin tear to her abdomen during the incident.</p> <p>Interview with the Director of Nursing (DON) on 02/13/25 at 4:33 PM, she stated her expectation was the resident's plan of care was to be followed by staff related to any resident care.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947</p> <p>Based on record review and interviews, the facility failed to ensure two Residents (R) R28 and R65) out of three residents reviewed for urinary function/catheters had appropriate orders in place related to the use of their indwelling urinary catheters in the sample of 46 residents. This failure created the potential for the residents to go without appropriate catheter related care.</p> <p>Findings include:</p> <p>Review of R65's Admission Record, dated 02/13/25 in the Electronic Medical Record (EMR) under the Admissions tab indicated the resident was admitted to the facility on [DATE] with diagnoses included quadriplegia following a spinal cord injury and urinary retention.</p> <p>Review of R65's admission Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 11/05/24 and in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident had an indwelling urinary catheter in place in his bladder.</p> <p>Review of R65's Order Summary Report, dated 02/13/25 in the EMR under the Orders tab indicated no orders for the resident's use of his urinary catheter or related to routine care of the catheter.</p> <p>Review of R65's Medication Administration Record (MAR) and Treatment Administration Record (TAR) dated 02/01/25 through 02/13/25 and found in the EMR under the Orders Tab, indicated nothing to show the provision of routine catheter related care had been provided for the resident during that time period.</p> <p>Review of R65's comprehensive care plan, most recently dated 01/10/25 and found in the EMR under the Care Plan Tab, indicated the resident had a suprapubic catheter in place in his bladder and indicated the catheter was to be changed every four weeks at the resident's urology office.</p> <p>During an interview with the Director of Nursing (DON) and the Assistant DON (ADON) on 02/13/25 at 4:27 PM, both stated their expectation was there would be physician's orders for the use and routine care of any resident's indwelling urinary catheter.</p> <p>2. Review of the Admission Record located under the Profile tab in the EMR revealed R28 was admitted on [DATE] with diagnoses acute kidney failure, and neuromuscular dysfunction of bladder.</p> <p>Review of the quarterly MDS located under the MDS tab in the with an ARD of 01/07/25 revealed a BIMS score of 15 out of 15 which indicated R28 was cognitively intact.</p> <p>During an interview on 02/11/25 at 8:44 AM, R28 stated, They're overdue by a month, at least, for changing my catheter. Probably six weeks.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the December 2024, January 2025, and February 2025 Physician Orders located under the Orders tab in the EMR revealed an order for Urinary Catheter - 18F30 cc bulb dated 11/28/24. There were no orders for catheter care.</p> <p>Review of the December 2024, January 2025, and February 2025 MAR and TAR revealed no orders for catheter care.</p> <p>During an interview on 02/12/25 at 4:43 PM, the ADON stated, I'll have to check on the catheter care, why it's not on the orders.</p> <p>During an interview on 02/12/25 at 5:39 PM, the ADON stated, (R28's) catheter was last changed 11/24 when sent to the hospital for a UTI (urinary tract infection). We (facility) have a policy that it (catheter) is not to be changed every month, only when symptomatic. The orders didn't transfer over from 11/24, I don't know why.</p> <p>11599</p> <p>2. Review of the Admission Record located under the Profile tab in the EMR revealed R28 was admitted on [DATE] with diagnoses acute kidney failure, and neuromuscular dysfunction of bladder.</p> <p>Review of the quarterly MDS located under the MDS tab in the with an ARD of 01/07/25 revealed a BIMS score of 15 out of 15 which indicated R28 was cognitively intact.</p> <p>During an interview on 02/11/25 at 8:44 AM, R28 stated, They're overdue by a month, at least, for changing my catheter. Probably six weeks.</p> <p>Review of the December 2024, January 2025, and February 2025 Physician Orders located under the Orders tab in the EMR revealed an order for Urinary Catheter - 18F30 cc bulb dated 11/28/24. There were no orders for catheter care.</p> <p>Review of the December 2024, January 2025, and February 2025 MAR and TAR revealed no orders for catheter care.</p> <p>During an interview on 02/12/25 at 4:43 PM, the ADON stated, I'll have to check on the catheter care, why it's not on the orders.</p> <p>During an interview on 02/12/25 at 5:39 PM, the ADON stated, (R28's) catheter was last changed 11/24 when sent to the hospital for a UTI (urinary tract infection). We (facility) have a policy that it (catheter) is not to be changed every month, only when symptomatic. The orders didn't transfer over from 11/24, I don't know why.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18947</p> <p>Based on policy review, record review, observation, and interviews, the facility failed to ensure one (Resident (R) R65) out of seven residents reviewed for accidents in the sample of 46 resident was appropriate for the use of side rails on his bed. This failure created the potential for the resident to be injured related to potentially unnecessary side rails installed and in use on his beds.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Bed Rails/Grab Rails dated 05/03/24 indicated, The facility will attempt to use appropriate alternatives prior to installing a side or bed rail .The use of side rails will require a physicians order; .The use of bed rails will be included in the residents' plan of care .The nursing department will evaluate the resident for the use of bed/side rails upon admission, readmission, quarterly and as needed.</p> <p>Review of R65's Admission Record, dated 02/13/25 and found in the Electronic Medical Record (EMR) under the Admissions tab, indicated the resident was admitted to the facility on [DATE] with diagnoses including quadriplegia following a spinal cord injury.</p> <p>Review of R65's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/05/24 in the EMR under the MDS tab revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated that the resident was totally dependent upon staff to move about in his bed and to transfer in and out of his bed. The assessment did not indicate side rails were in use for R65.</p> <p>Review of R65's Order Summary Report dated 02/13/25 in the EMR under the Orders tab, indicated no orders for the resident's use of side rails on his bed.</p> <p>Review of R65's comprehensive care plan, most recently dated 11/06/24 in the EMR under the Care Plan tab indicated the resident was quadriplegic and was unable to move any of his extremities independently. The care plan indicated the resident was completely dependent upon staff to complete all of his Activities of Daily Living (ADLs), including moving about in his bed. The care plan revealed nothing to indicate the resident's use of side rails.</p> <p>Review of R65's Device/Restraint Assessment and Consent Form dated 01/29/25 in the EMR under the Assessment tab, indicated, 1/4 side rails to the resident's bed, however there was nothing on the assessment to indicate the rationale for the use of side rails, what alternatives were attempted prior to the implementation of the side rails, or that risks related to the use of the rails had been addressed with the resident prior to implementation of the side rails.</p> <p>R65 was observed laying in his bed with 1/4 side rails raised on both sides of his bed on 02/10/25 at 3:30 PM, on 02/11/25 at 10:06 AM, 1:15 PM, 3:07 PM, and 3:48 PM, and on 02/12/25 at 8:32 AM, 9:52 AM, and 11:53 AM. R 65 was not able to move anything below his neck independently.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 02/12/25 at 11:55 AM, R65 confirmed he was not able to move independently and was not able to use the rails on his bed.</p> <p>During an observation of R65 along with the Assistant Director of Nursing (ADON) on 02/12/25 at 2:46 PM, the ADON confirmed the resident's side rails were raised on both sides of his bed and confirmed the resident was not able to use the side rails at all due to his quadriplegia. She stated the side rails should not have been on the resident's bed.</p> <p>During an interview with the Director of Nursing (DON) and the ADON on 02/13/25 at 4:27 PM, both stated their expectation was that side rails were to be used only when necessary and physician's orders, a care plan, and a thorough assessment were required related to the use of rails prior to use.</p>

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20064</p> <p>Based on interview, record review, and policy review, the facility failed to ensure one of six sampled residents (Resident (R) 176) whose medications were reviewed was free from significant medication error in the sample of 46 residents. Specifically, R176 was administered Ativan, an anxiolytic medication, and morphine, a narcotic pain medication, without a physician order for the medications. This medication error had the potential to cause the resident to become over sedated and experience respiratory depression.</p> <p>Findings include:</p> <p>Review of the summary provided by the facility revealed on 07/26/24 at approximately 9:35 PM, Registered Nurse (RN)4 started the medication pass for the hall she was assigned to on the evening shift. She took out medications for a hospice resident including 0.5 milligrams (mg) of Ativan and 15 mg of Morphine and proceeded to the room. RN4 did not check R176's armband or ask her name before administering the medications. After R176 swallowed the medication she realized she had given the medication to the wrong resident. She immediately called the supervisor and Director of Nursing (DON) and reported the medication error. RN4 was instructed to stay with R176 and administer Narcan and take vital signs every ten minutes. R176 did not have any adverse effects from the medication error. RN4 was counseled immediately and completed a medication pass competency. She was then allowed to administer medications.</p> <p>Review of R176's undated Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included heart failure, anemia, and chronic obstructive pulmonary disease (COPD).</p> <p>Review of R176's Medication Administration Record (MAR) dated 07/2024revealed R176 did not have orders for Ativan or Morphine.</p> <p>Review of RN4's personnel file revealed RN4 received counseling on 07/26/24 regarding the medication error. She received education on the five rights of medication administration.</p> <p>During an interview on 02/12/25 at 4:32 PM the Assistant Director of Nursing (ADON) stated R176 was given the wrong medications and the physician was notified immediately. The ADON stated the physician ordered Narcan which was given, and there were no adverse reactions.</p> <p>During an interview on 02/13/25 at 1:49 PM, the Director of Nursing (DON) stated RN4 called her immediately after she realized she gave the wrong medication to the wrong resident. The DON stated she went to the facility and counseled RN4. She ensured R176 was not having any adverse effects from the medications.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Geriatric Pharmacy LLC, Policy and Procedure [NAME], revised March 2022, revealed, . Prepare the medications for one customer at a time only . Confirm the medication and dose are correct . Verify each medication preparation to ensure the medication is the right drug at the right dose, the right route at the right time, for the right customer . Verify the Medication Administration (MAR) reflects the most recent medication order. Facility staff observe the resident for possible medication-related adverse consequences . when the following conditions occur . Medication error . In the event of a significant medication-related error or adverse consequence, immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant is defined as . Life threatening . The physician's orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed .</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER Excelcare at Lewes LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599</p> <p>Based on observation, interview, record review, and policy review, the facility failed to implement an effective infection control program to ensure personal protective equipment (PPE) was used for one resident of one resident (Resident (R) 320) who was on contact isolation, and failed to identify COVID from the weekend to weekday for R80 who was not placed on contact isolation in a timely manner to prevent the potential spread of an infection.</p> <p>Findings include:</p> <p>Review of the facility's policy titled, Enteral Feeding Medication Administration dated 05/01/24 and provided by the facility stated, .Universal precautions and clean technique will be utilized when stopping, starting, flushing, and giving medications through the feeding tube. PPE [personal protective equipment] will be used as needed .The personal protective equipment worn will vary by task being performed and likelihood of exposure to body fluid .Enhanced Barrier Precautions will be used in the facility as extra level of protection for some residents in order to prevent the transmission of MDROs [multidrug resistant organisms] infections. Enhanced barrier precautions will be used when providing direct contact or during high-contact care with certain residents .Resident with feeding tubes .</p> <p>Review of the facility's policy titled, Enhanced Barrier Precautions Policy dated 05/01/24 stated, . Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs .Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: .device care or use: . feeding tube .</p> <p>1.Review of R320's Admission Record located in the EMR under the Profile tab indicated an original admitted [DATE] with diagnosis of dysphagia following cerebral infarction.</p> <p>Review of R320's Baseline Care Plan located in the EMR under the Care Plan and dated 02/11/25 indicated, NPO (nothing by mouth) intake status and PEG tube (percutaneous endoscopic gastrostomy- a tube inserted through the wall of the abdomen directly into the stomach).</p> <p>Review of R320's Order Summary Report located in the EMR under the Orders tab included amlodipine (anti-hypertensive medication) via PEG tube, chewable aspirin (medication used to stop blood clots) via PEG tube, apixaban via PEG tube and metoprolol via PEG tube.</p> <p>Review of R320's Review of R320's Order Summary Report located in the EMR under the Orders tab included Enhanced Barrier Precautions r/t [related to] Peg tube every shift for Enhanced Barrier Precaution, don gloves and gown before high contact resident care. Remove gown and gloves and handwash/sanitize hands, before exiting the room or before providing care to another resident in the room starting 02/10/25.</p> <p>Review of R320's Progress Notes located in the EMR under the Progress Notes tab indicated R320 had episodes of emesis and loose stool on 02/11/25.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Excelcare at Lewes LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Ocean View Blvd Lewes, DE 19958	
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 02/12/25 at 9:36 AM, R320 had a sign on her door indicating that she was on Contact Precautions to include, cleaning hands before entering the room and when leaving the room, put on gloves before room entry, discard gloves before room exit, and put on gown before room entry. Discard gown before room exit.</p> <p>During an observation and interview on 02/12/25 at 9:36 AM Licensed Practical Nurse (LPN)2 performed hand sanitizing, donned gloves, and a surgical mask, then prepared and administered medications via PEG tube. LPN2 did not don a gown prior to administering medications via R320's PEG tube. LPN2 was asked what the facility's policy regarding what PPE to wear when administering medications via PEG tube. LPN2 said that she only needed to wear a mask and gloves. Review of the signage on the door and the orders in the EMR for Enhanced Barrier Precautions LPN2stated that it was her understanding that only the nurse aides needed to wear a gown during close contact activities. LPN2 stated that she did not consider PEG tube medication administration a close contact activity. Additionally, LPN2 confirmed that R320 had three loose stools on 02/11/25 during the 3:00 PM -11:00 PM shift along with intermittent emesis.</p> <p>During an interview on 02/12/25 at 1:50 PM, the Director of Nursing (DON) confirmed that it was her expectation for nurses to wear a gown, mask, gloves, and eye protection during PEG tube medication administration.</p> <p>2. Review of the Admission Record found in R80's electronic medical record (EMR) under the Profile tab noted the resident was admitted on [DATE] with diagnoses that included rheumatoid arthritis, chronic pain syndrome, and idiopathic peripheral autonomic neuropathy.</p> <p>Review of the quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR with an assessment reference date (ARD) of 12/09/24 revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 which indicated R80 was cognitively intact.</p> <p>During an observation and interview on 02/10/25 at 11:17 AM, R80 stated, I'm not feeling well. I was very sick yesterday. I vomited so many times they had to change my entire bed three times. R80 denied having the flu, norovirus, or COVID. There was no signage on the outside of the resident's room to indicate she was in isolation of any kind or proper trash receptacles in the room if on isolation.</p> <p>During an interview on 02/10/25 at 11:46 AM, the Director of Nurses (DON) and Assistant Director of Nurses (ADON) said they were not informed of R80's vomiting on 02/09/25. The DON stated, We need to know what happened, why that was not communicated.</p> <p>During an interview on 02/10/25 at 1:07 PM, Certified Nursing Assistant (CNA)5 stated, They (nurses) knew she was sick. She was sick like seven times. Her whole bed and everything changed so many times. No signs went up until you started asking about it.</p> <p>Review of the Progress Notes located in the EMR under the Clinical tab revealed on 02/08/25, R80 was noted to have received medication for a cough. There was no documentation on 02/09/25 that R80 was vomiting. On 02/10/25, the Progress Note identified R80 received medication for loose stool.</p> <p>Review of the Clinical Physician Orders located in the EMR under the Orders tab, dated 02/10/25, revealed R80 was placed on contact isolation precaution for 10 days, tested positive for COVID.</p>		