STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Delaware Hospital F/T Chronically Ill (Dhci)		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Sunnyside Road Smyrna, DE 19977	

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of the Centers for Disease Control and Prevention (CDC) guidelines, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure three of eight residents (Resident (R) 22, R57, and R11) out of 28 sampled residents had an accurate Minimum Data Set (MDS) assessment. Failure to code the MDS correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the residents. (Cross Reference F883)Findings include:1. Review of R22's electronic medical record (EMR) titled admission Record located under the Profile tab, revealed the facility admitted the resident on 09/21/16.Review of R22's EMR titled quarterly MDS located under the MDS tab with an Assessment Reference Date (ARD) of 12/12/25 indicated the staff could not determine the resident's Brief Interview for Mental Status (BIMS) score. The assessment revealed that the resident was up to date on her pneumococcal vaccine. Review of R22's EMR titled Immunizations located under the Immun (Immunization) tab indicated the resident received the PPSV23 on 12/26/19. There was no evidence that the resident or her representative was offered the PCV13 prior to the age of 55 or the PCV20 or the PCV21 after the age of 55. 2. Review of R57's EMR titled admission Record located under the Profile tab revealed the facility admitted the resident on 01/31/18.Review of R57's EMR titled Immunization located under the Immun tab indicated the resident received the PPSV23 on 09/15/15. There was no evidence that the resident or his representative was offered the PCV13 during his stay at the facility. There was no evidence that the resident or his representative was offered the PCV20 or the PCV21 during his stay when the resident turned [AGE] years of age. Review of R57's EMR titled quarterly MDS located under the MDS with an ARD of 10/31/25 indicated the resident had a BIMS score of 12 out of 15 which revealed the resident was moderately cognitively impaired. The assessment revealed that the section that identifies if the resident was offered a pneumococcal vaccine or was up to date with the pneumococcal vaccine was blank. 3. Review of R11's EMR titled admission Record located under the Profile revealed the facility admitted the resident on 12/30/08.Review of R11's EMR titled Immunization located under the Immun tab indicated the resident received the PPSV23 on 03/03/15. There was no evidence that the resident or his representative was offered the PCV13 during his stay at the facility. There was no evidence that the resident or his representative was offered the PCV20 or the PCV21 during his stay when the resident turned [AGE] years of age. Review of 11's EMR titled quarterly MDS located under the MDS tab with an ARD of 12/05/25 indicated the resident had a BIMS score of nine out of 15 which revealed the resident was moderately cognitively impaired. The assessment revealed that the resident was up to date on his pneumococcal vaccine. During an interview conducted on 01/08/25 at 10:35 AM, the MDS Coordinator (MDSC)1 and MDSC2 were present. MDSC1 stated that she looked into each residents' clinical record to retrieve the information from the EMR. MDSC1 stated that she relied on the accuracy of the clinical record for the status of the pneumococcal vaccine status. MDSC1 stated it was easy to locate accurate information for the influenza vaccine for the residents (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	since that information was in the residents' Medication Administration Records. MDSC1 stated she was not familiar with the CDC recommendations for the pneumococcal vaccine. Review of the Resident Assessment Instrument (RAI) manual, dated 10/2024 and located at Minimum Data Set (MDS) 3.0 RAI Manual | CMS, revealed Pneumococcus is one of the leading causes of community-acquired infections in the United States, with the highest disease burden among the elderly. Adults [AGE] years of age and older and those with chronic medical conditions are at increased risk for invasive pneumococcal disease and have higher case-fatality rates. Pneumococcal vaccines can help reduce the risk of invasive pneumococcal disease and pneumonia. Review of the CDC website: https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, dated 10/26/24 indicated . Based on shared clinical decision- making, adults 65 years or older have the option to get PCV20 [20-valent pneumococcal conjugate vaccine] or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both .PCV13 (but not PCV15, PCV20, or PCV21) at any age and . PPSV23 at or after the age of [AGE] years old.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility policy, and staff interviews, the facility failed to develop a person-centered comprehensive plan of care with measurable goals and plans for four of five residents (Resident (R) 2, R5, R1, and R24) reviewed for care plans, out of a survey sample of 28. The failure to develop a care plan increased the risk for care to be incomplete and/or inconsistent related to the residents taking psychotropic medications.Findings include: 1. Review of R2's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 09/23/25. Review of R2's EMR titled physician Orders located under the Orders tab dated 09/29/25, indicated the resident was ordered an intramuscular injection one time per month for his diagnosis of schizophrenia. Review of R2's EMR titled admission Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 09/29/25 indicated the resident had a Brief Interview of Mental Status (BIMS) score of 0 out of 15, which revealed the resident was severely cognitively impaired. The resident was on an antipsychotic medication on a routine basis. Under the Care Area Assessment (CAA), the resident triggered the use of psychotropic medications and directed the staff to develop a care plan. Review of R2's EMR titled Care Plan located under the Care Plan tab failed to contain evidence that the resident was care planned for the use of the aripiprazole. 2. Review of R5's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 06/13/02. Review of R5's EMR titled physician Orders located under the Orders tab dated 07/17/23, indicated the resident was to be administered an oral medication for the treatment of bi-polar disorders. Review of R5's EMR titled physician Orders located under the Orders tab dated 07/17/23 indicated the resident was to be administered an oral medication for major depressive disorder. Review of R5's EMR titled annual MDS located under the MDS tab with an ARD of 09/12/25 indicated the resident had a BIMS score of 15 out of 15 which revealed the resident was cognitively intact. The resident was on an antipsychotic medication on a routine basis. Under the CAA, the resident triggered for the use of psychotropic medications and directed the staff to develop a care plan. Review of R5's EMR titled Care Plan located under the Care Plan tab failed to contain evidence that the resident was care planned for the use of quetiapine fumarate or the use of escitalopram. 3.Review of R1's admission Record located under the Profile tab of the EMR, revealed R1 was admitted on [DATE] with a diagnosis that included major depressive disorder. Review of R1's Order Summary Report located under the Orders tab of the EMR revealed a physicians order for an oral medication for a diagnosis of major depressive disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R1's annual MDS located under the MDS tab in the EMR with an ARD of 09/26/25, a BIMS score of 10 out 15 which indicates he was moderately intact. The MDS indicated that R1 takes antipsychotic medication. Review of R1's CAA located under the MDS tab in the EMR dated 12/19/25, revealed the resident was administered antipsychotic medication for seven days prior to the assessment. Review of R1's Care Plan located under the Care Plan tab of the EMR dated 12/29/25 did not address the resident's use of the antipsychotic medication. Review of R1's Medication Administration Record (MAR) located under the Orders tab of the EMR dated January 2026 revealed the resident had been administered the medication twice daily. 4. Review of R24's annual MDS with an ARD date of 05/09/25 and located in the MDS tab of the EMR, revealed R24 was admitted on [DATE]. The resident had a BIMS score of 15 out of 15 indicating R24's cognition was intact. The resident received an antipsychotic medication and had a diagnosis of schizophrenia. The CAA Summary revealed Psychotropic Drug Use triggered for care planning. Review of R24's orders, located in the EMR under the Order tab revealed the resident was ordered oral medications for her diagnoses of schizoaffective disorder and depression related to the schizoaffective disorder. Review of R24's care plan, revised 11/04/25, located in the EMR under the Care Plan tab revealed Neurobehavioral Health but there was no care plan for antipsychotic medications.During an interview conducted on 01/08/2026 at 10:35 AM MDS Coordinator (MDSC) 1 and MDSC2 were present. MDSC1 stated the MDSCs complete the CAA and then decide on whether or not they develop a care plan or not. MDSC1 stated the EMR for the development of the care plan does not have the capacity to specifically address the use of psychotropic medications. MDSC1 stated the care plans were individualized for each resident's needs. MDSC1 stated if there was an associated black box warning with the medication the care plan does not have the ability to add this information for a resident. During an interview conducted on 01/09/25 at 12:29 PM, the Director of Nursing (DON) stated the care plans for residents were individualized for their specific needs and the information about the use of psychotropic medications were in the residents' consents. Review of the MDS 3.0 Resident Assessment Instrument (RAI) Manual, dated 10/24 indicated .The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA (Care Area Assessment) process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based trigger conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers. After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT (Interdisciplinary Team) must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs.

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Some

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on document review, interviews, observations, and facility policy review, the facility failed to ensure that four of 10 residents (Residents (R) 5, R4, R71, and R6) reviewed for unsupervised smoking, smoked safely. In addition, all residents refused to don (put on) a smoking apron for protection and would hold onto their cigarettes and/or lighters instead of nursing staff securing the smoking paraphernalia safely. In addition, R34 was identified as a resident who smoked and had a lighter in her room. R34 used an oxygen concentrator, while in her room and while her lighter was kept in her room. This placed all residents who smoke of an increased opportunity for burns.The facility's Administrator and Director of Nursing (DON) were notified on 01/07/26 at 6:40 PM that Immediate Jeopardy existed related to the failure to assess and monitor three residents R5, R71, and R6 who smoked. The Immediate Jeopardy began on 01/07/26 at 6:40 PM when the three residents were identified with upper extremity impairments In addition, the facility failed to supervise these three residents while they smoked. The facility provided an Immediate Jeopardy Removal Plan that was accepted on 01/08/26 at 3:01 PM. The survey team validated implementation of the removal plan through observations, interviews, and review of training records. Immediate Jeopardy was removed on 01/09/26 at 11:30 AM. After removal of the Immediate Jeopardy, the deficiency remained at a ''E'' scope and potential for more than minimal harm.Findings include:1. Review of R5's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 06/13/02 with a diagnosis of quadriplegia.

Review of R5's EMR titled Care Plan located under the Care Plan tab dated 11/07/23 indicated the resident voiced that it was important for him to be independent to do things on my own and to practice safe smoking habits. The care plan identified that the resident was paralyzed and required assistance, at times, for retrieving and/or lighting his cigarettes. The interventions for R5's care plan revealed that the nurses were to provide the resident with his cigarettes upon his request and preferred to keep his lighter with him. Also, the care plan indicated the resident preferred to smoke at his leisure and he declined to don a smoking apron.

Review of R5's EMR titled Smoking Safety Assessments located under the Assmts (Assessments) tab dated 11/26/24 indicated that the resident had total or limited range of motion in hands or arms.

Review of R5's EMR titled quarterly Minimum Data Set (MDS) located under the MDS tab with an Assessment Reference Date (ARD) of 12/05/25 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed the resident was cognitively intact. The resident was identified with bi-lateral impairment of both upper extremities. Review of R5's EMR titled Smoking Safety Assessment located under the Assmts tab dated 01/06/26 indicated that the resident had total or limited range of motion in hands and arms.

During an interview on 01/07/2026 at 8:42 AM, Certified Nurse Aide (CNA) 2 confirmed R5 kept his cigarettes and lighter with him.

During an interview on 01/07/2026 at 8:43 AM, Office Associate (OA)1, who worked on the same unit where R5 lived, stated the resident kept his own cigarettes and lighter with him. OA1 stated the staff will take R5 to the front smoking area and will then leave the resident so he can smoke on his own.

During an interview on 01/07/2026 at 8:47 AM, Registered Nurse (RN) 8 stated that R5 kept his

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	cigarettes and lighter with him. During an interview on 01/07/2026 at 9:03 AM, Licensed Practical Nurse (LPN) 5 confirmed R5 kept his cigarettes on him but not the lighter. During an interview on 01/07/2026 at 10:14 AM with RN6, who was the current nurse supervisor on the same unit where R5 lived, confirmed the staff would take R5 out to the front smoking area and allow the resident to smoke on his own. During an interview on 01/07/2026 at 11:10 AM with CNA5, who was the receptionist for the front lobby, confirmed R5 does smoke on his own., but she keeps an eye on him. During an interview on 01/07/2026 at 11:35 AM, the Activity Aide (AA)1 confirmed that R5 liked to keep his cigarettes and lighter with him. AA1 stated the resident wore a cross-body bag and that was where the resident kept his cigarettes and lighter. AA1 stated at times he would bring the resident out to the front smoking area but that the receptionist kept an eye on the resident from inside the building. During an observation on 01/07/26 at 11:41 AM, the front smoking area had multiple areas to sit. There were two black plastic buckets which contained sand and cigarette butts. There was a large metal ashtray next to one of the columns. Upon entrance back into the lobby from the front smoking area were two desks. One desk was positioned next to the large window which faced the smoking area. The second desk was closer to the main hallway entrance. During an observation at 12:23 PM, staff brought R5 to the outside front smoking area. The resident was positioned next to the large metal ashtray, and he faced the window which faced the front lobby. The resident retrieved a packet of cigarettes and pulled one cigarette with his right hand. The resident placed the cigarette in his mouth and then retrieved his lighter and lit his cigarette. These items were retrieved from the resident's green cross body bag. The resident's fingers on his right hand were severely contracted but he had slight movement in his arm to move the cigarette to and from his mouth. CNA5 was present during this observation and was reading a magazine. CNA5 pointed to a fire extinguisher which was hanging on a wall directly in front of CNA5 and stated she was not aware of a smoking blanket in case of a fire. The observation ended at 12:30 PM. 2.Review of R6's admission Record located under the Profile tab in the EMR revealed the resident was admitted on [DATE] with a diagnosis of tobacco use, cataract, and vascular Dementia. Review of R6's Annual MDS located under the MDS tab in the EMR with an ARD of 01/24/26 revealed R6had a BIMS score of 15 out of 15 indicating cognitive intact. Review of R6's Care plan located under the Care Plan tab in the EMR with a revision date of 01/05/26 revealed the resident had the potential to harm himself while smoking, declines to use a smoking apron, and has burned holes in his clothes and gloves, and to report changes in mood and demeanor that may cause him harm. Review of R6's Smoking Safety Evaluation located under the Assessment tab in the EMR, dated 01/24/25 revealed R6 utilizes tobacco; has poor vision or blindness; balance problems while sitting or standing; drops ashes on self; unable to light a cigarette safely; unable to hold a cigarette safely; unable to extinguish a cigarette; unable to use ashtray to extinguish a cigarette. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 01/05/26 at 11:28 AM, R6 confirmed he was a smoker, held his own cigarettes and lighter and that he smoked in the smoking section. During an observation on 01/07/26 at 11:01 AM, R6 came out of his room and confirmed he had his cigarettes. R6's cigarettes were observed in a cup holder on the side of his wheelchair in a green plastic holder. During an observation on 01/07/26 at 11:03 AM, LPN2 wheeled resident out to the smoking area. The resident did not have an apron on and was not offered one. The staff member went back into building and left the resident outside the 500 unit in the smoking area. The resident had his own cigarettes and lighter, and he lit his own cigarette. During an observation on 01/07/26 at 11:03 AM, no fire extinguisher or fire blanket was present on the 500-unit smoking area. No fire safe ash trays were present, just large metal cans. During an interview on 01/07/26 at 11:14 AM, R6 confirmed staff do not come outside to supervise him when he smokes. During an observation on 01/07/26 at 11:24 AM, R6 put his cigarette butt on the ground and went into building. During an interview with on 01/07/26 at 11:27 AM, LPN2 revealed she did not supervise the resident during smoke break because he did not require supervision. She also stated the resident was permitted to have his smoking materials. 3.Review of R71's admission Record located under the Profile tab in the EMR revealed the resident was admitted on [DATE] with a diagnosis of epilepsy, hereditary and idiopathic neuropathy, neurosyphilis, hemiplegia and hemiparesis affecting non-dominate side, traumatic subarachnoid hemorrhage. Review of the Smoking Safety Evaluation located under the Assessments tab located in the EMR dated 03/07/25, revealed R6 utilizes tobacco; had balance problems while sitting or standing; total or limited ROM in arms or hands. Review of R71's quarterly MDS located under the MDS tab in the EMR with an ARD of 11/07/25, revealed R71 had impairment of upper extremity on one side. R71 had a BIMS score of 15 out of 15 indicating cognitively intact. Review of Care plan located under the Care Plan' tab in the EMR with a revision date of 11/07/25 revealed the resident had the Potential to have skin injuries because he smokes cigarettes and declines to wear a smoking apron. The care plan also revealed for aides to report any injury, changes, or abnormalities to the nurse. During an observation on 01/07/26 at 8:43 AM, R71 wheeled himself down the 500-unit hallway with a cigarette in his mouth and lighter in his right hand. The resident did not have on smoking apron. Activity Director (AD) offered him smoking apron and resident refused. R71 and AD went out in smoking area, with staff assisting resident outside. R71 smoking a cigarette without a smoking apron. During an observation on 01/07/2026 at 8:45 AM, the AD left the smoking area where R71 was smoking, went to the farthest side of the facility van approximately 50 feet away from smoking area. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an observation on 01/07/26 at 8:47 AM, the AD went back into the facility and left R71 outside smoking alone. During an observation on 01/07/26 at 8:48 AM, no fire extinguisher or fire blanket was present on the 500-unit smoking area. No fire safe ash trays present just large metal cans. During an observation on 01/07/26 at 8:49 AM, R71 wheeled himself back into the facility and to his room. No staff accompanied him. R71 confirmed he kept his cigarettes and lighter. There were metal non fireproof cans for cigarette butts and R71 placed his cigarette butt in one of the cans. During an interview on 01/07/26 at 12:12 PM, the AD revealed that R71 did not require supervision during smoking and had a right to decline to wear the smoking apron. AD also revealed R71 was permitted to keep his cigarettes and lighter in his possession. 4.Review of R4's Smoking Safety Evaluation located under the Assessments tab in the EMR dated 12/05/25 revealed R4 utilizes tobacco; has balance problems while sitting or standing; burns skin, clothing, furniture or other; drops ashes on self; does not follow the facility's policy on location and time of smoking; unable to extinguish a cigarette safely; unable to use ashtray to extinguish a cigarette. Review of R4's annual MDS located under the MDS tab in the EMR with an ARD of 12/05/25 revealed the resident had impairment of upper extremity on one side. R4 had a BIMS score of 13 out of 15 indicating cognitively intact. Review of R4's Care Plan located under the Care Plan tab of the EMR dated 12/16/25 revealed R4 had the Potential to injure himself when because he had a stroke, smoke cigarettes, and has seizure disorder, declines to wear a smoking apron and drops ashes on clothing. The care plan revealed that R4 often Declines to wear a smoking apron, is to keep cigarettes at the nurse's station, does not always follow the smoking schedule and needs reminders to smoke in the designated smoking area, and sometimes needs assistance by one person to push him to the smoking area. During an observation on 01/05/26 at 11:03 AM, R4 was in his room sitting in a wheelchair with a pack of cigarettes in a red plastic holder and a cigarette on the outside of the pack. The resident confirmed he had a lighter that was located under a white washcloth on the arm rest of the wheelchair. During an interview on 01/07/26 at 12:12 PM, the AD stated residents are permitted to have their cigarettes and lighter in their possession as long as they are care planned and that R4 and R6 are care planned to keep them. She revealed staff are only present during smoke break if the resident is care planned for supervision. The AD revealed she was not familiar with the results of the residents smoking assessments. The AD confirmed there were no fire extinguisher or smoking blanket near the 500-unit smoking area. During an observation on 01/08/26 at 11:15 AM, R4 was sitting outside of the 500 unit in the smoking area smoking a cigarette. There was no staff present for supervision. R4 confirmed he kept his cigarettes and lighter. 5. Review of R34's quarterly MDS with an ARD date of 12/10/25 and located in the MDS tab of the EMR, revealed R34 was admitted on [DATE]. The resident had a BIMS score of 14 out of 15 indicating (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	R34's cognition was intact. The MDS also indicated that the resident received oxygen therapy, and had diagnoses of chronic obstructive pulmonary disease, unspecified, personal history of nicotine dependence, and Wernicke's encephalopathy. Review of R34's care plan, revised 09/08/25, located in the EMR under the Care Plan tab revealed Safety: Smoking, I need: to practice safe smoking habits by following my smoking schedule and smoke in authorized areas. An intervention included I need my aides to assure proper storage of my smoking materials. (Cigarettes and lighter. I keep them at the nurse's station and also have some cigarettes kept in my room and can have whenever I want to go outside to smoke. I need everyone to report changes in my abilities to my nurse. Review of R34's Smoking Safety Evaluation, dated 12/02/25, located in the EMR under the Assessment tab revealed R34 utilized tobacco and Note: Supervision will be required for all Residents during designated smoking times. This evaluation will be utilized for the Resident's smoking care plan on admission and as indicated. The evaluation determined that R34 was able to light a cigarette safely, was able to hold a cigarette safely, was able to extinguish a cigarette safely, and was able to use ashtray to extinguish a cigarette. During an interview on 01/07/26 at 9:03 AM, Certified Nurse Aide (CNA)4 stated, Yes, R34 smokes and CNA4 then picked up the sign-out sheet on a clip board at the nurse station with R34's signature when she went outside to smoke. CNA4 stated R34's cigarettes are kept in a drawer at the nurse station but R34 keeps her lighter. On 01/07/26 at 9:05 AM, R34 was in her bed with covers over her head and unwilling to talk. The oxygen concentrator was observed at R34's bedside. During an interview on 01/07/26 at 10:23 AM, Unit manager RN4 stated R34 was a smoker and occasionally needed assistance with wheeling in her wheelchair. RN4 stated R34 signed herself out to smoke and refused to wear a smoking apron. RN4 stated staff always supervised her and could be seen through the window and there are outside cameras. RN4 stated R34's cigarettes were kept at the nurse station and R34 kept her lighter as R34 had a private room. On 01/07/26 at 12:25 PM, R34 was sitting in a wheelchair at the lunch table in the dining room feeding herself with no difficulty. R34 confirmed she kept her lighter, but the pack of cigarettes are returned to the nurse station. R34 had oxygen in use via nasal cannula and an oxygen concentrator plugged into the wall. During an interview on 01/08/26 at 3:37 PM, RN2 was asked if a resident used oxygen in their room should they keep a cigarette lighter in their room. RN stated, No. During an interview on 01/08/26 at 4:07 PM, CNA8 and CNA9 stated R34 was a smoker. They stated the residents' cigarettes and lighter are stored in the nursing station. The CNAs stated R34 had her own lighter, but it was not okay to have a lighter in her room because she used oxygen in her room. During an interview on 01/08/26 at 6:10 PM, CNA10 stated the facility's new policy was that R34 had to be supervised. CNA10 stated cigarettes were kept at the nurse station. CNA10 then opened a drawer in the nurse station and a pack of cigarettes with R34's name was in the drawer but there was no lighter observed. During an interview on 01/09/26 at 9:23 AM, RN9 stated R34, should not keep a cigarette lighter in her room since she uses oxygen. During an interview on 01/07/26 at 1:33 PM, the Administrator, DON , the Medical Director, Quality Assurance, Social Services Chief Administrator, and RN 4, who was responsible for the development of resident care plans, were in attendance. The Administrator stated all residents who smoked were supervised. RN4 stated R5 was a resident who lived in the facility for a long time and if he needed assistance with smoking, he would request this from the staff to help him. The Administrator confirmed there were no smoking blankets for the front smoking area or the smoking area in the back of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Delaware Hospital F/T Chronically Ill (Dhci)		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Sunnyside Road Smyrna, DE 19977	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	facility. The Administrator also stated the residents from the 500 unit who utilized the back smoking area did not require supervision. During an interview on 01/09/26 at 9:00, the Maintenance Director stated the necks to the ash tray bottoms were located behind the facility and verified that they were not attached to the safety ash trays in the front and back smoking areas. Review of the facility's policy titled, Smoking Policy dated 05/31/24, noted Procedures/ Responsibilities: .In the case of residents who are excluded/ grandfathered by this policy, they will be monitored and assessed as needed for unsafe smoking behaviors. Notwithstanding this policy, other residents may be excluded from this policy once they have been deemed in need of a special non-pharmacological approach to behavior modification management. Upon admission, each resident will be assessed for tobacco use and any safety concerns regarding tobacco use. The assessment for tobacco use will be utilized to determine a resident's plan of care for tobacco cessation. Individuals are responsible for ensuring that they clean up any and all tobacco product waste, such as cigarette butts, after use. Review of the NFPA (National Fire Protection Association) 99(12), Sec. 11.5.1.1.1 requires that smoking materials (e.g., matches, cigarettes, lighters, lighter fluid, and tobacco in any form) be removed from patients receiving respiratory therapy. Review of the NFPA 99(12), Sec. 11.5.3.2.1 requires that smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read No Smoking or shall be posted with the international symbol for no smoking.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on record review, interview, and facility policy review, the facility failed to ensure that one resident (R) 8 out of a survey sample of two, had a complete tracheostomy (trach) change. This has the potential for residents to have their airway compromised and potentially develop severe infection that could be life-threatening.Findings include:Review of R8's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 04/28/21, with a diagnosis of anoxic brain injury. The resident required the use of a tracheostomy (a device that was placed in the opening of the windpipe [trachea] to provide an airway for breathing). Review of R8's EMR titled physician Orders located under the Orders tab dated 07/17/23 indicated the physician or the respiratory therapist (RT) was to change the tracheostomy every three months, each April, July, October, and January. The tracheostomy change included a size six trach, with an extra-long Shiley, with a cuffed trach tube with a disposable inner cannula.Review of R8's EMR titled TAR located under the Orders tab dated 01/06/25 was blank. Review of R8's titled respiratory Progress Notes located under the Prog (Progress) Notes tab dated 01/15/25 revealed the RT completed tracheostomy care. Review of R8's EMR titled Treatment Administration Record (TAR) located under the Orders dated 04/06/25 indicated Registered Nurse (RN) 6 changed R8's tracheostomy. Review of R8's EMR titled respiratory Progress Notes located under the Prog Notes tab dated 04/15/25 revealed that the RT completed trach care only. Review of R8's EMR titled respiratory Progress Notes located under the Prog Notes tab dated 05/05/25 revealed the RT completed the resident's tracheostomy change. Review of R8's EMR titled TAR located under the Orders tab dated 07/06/25 indicated RN8 changed the resident's tracheostomy.Review of R8's EMR titled respiratory Progress Notes located under the Prog Notes tab dated 07/08/25 revealed the RT completed trach care only. Review of R8's EMR titled respiratory Progress Notes located under the Prog Notes tab dated 07/24/25 revealed the RT completed trach care only. Review of R8's EMR titled respiratory Progress Notes located under the Prog Notes tab dated 09/05/25 revealed the RT completed the resident's tracheostomy change. Review of R8's EMR titled TAR located under the Orders tab dated 10/06/25 was blank.There were no corresponding RT progress notes which would address when the resident's tracheostomy change was completed per physician order.Review of R8's EMR titled Medical Professional Note [written by the RT] located under the Prog Notes dated 12/24/25 revealed the RT completed the resident's tracheostomy change. Two months later the physician orders specifically indicated the resident was to have a complete tracheostomy change in October. There was no documentation in the clinical record that the physician was notified of the late tracheostomy change. During an interview on 01/06/26 at 2:20 PM, RT stated she tries to come to the facility each week and it has not happened recently due to medical issues. RT stated the last time she was in the facility was during the month 12/25 and she changed R8's tracheostomy. RT stated nursing was not to change the tracheostomy only the RT. RT stated nursing can change the Velcro ties, clean the trach site, and suction the resident's trach. RT stated she was not aware of the physician orders to change R8's tracheostomy for the specific months identified in the orders for the resident. During an interview on 01/06/26 at 3:06 PM, RT stated that a tracheostomy change was the removal of the tracheostomy and only the RT can do this. During an interview on 01/06/26 at 3:16 PM, RN 6 reviewed the entry he made on 04/06/25 documenting that he had completed R8's tracheostomy change. RN6 stated that there was an error in his documentation and only the physician or the RT could complete the tracheostomy change. During an interview on 01/07/26 at 8:47 AM, RN 8 reviewed the entry she made on 07/06/25 and stated that she never would remove a resident's inter cannula and this was the responsibility of the RT. RN8 stated the entry was a mistake. During an interview on 01/07/26 at 10:43 AM, the Director of Nursing (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DON) stated her expectation was the TAR was to reflect the care for R8, but that nursing needed to ensure that the documentation was correct and that care was provided to the resident. During an interview on 01/07/26 at 1:33 PM, the Medical Director stated the clinical staff were to follow his orders and to notify him if the orders could not be implemented. In addition, the Medical Director stated the reason that a complete tracheostomy change was required for R8 was to maintain patency, to prevent infections, and to provide cleanliness.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess the need for side rails and obtain informed consent for two (Resident (R)9 and R27) of two residents reviewed for side rails. This had the potential to place residents at risk of injury or death.Findings include:1. Review of R9's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 12/10/25 and located in the MDS tab of the electronic medical record (EMR), revealed R9 was admitted on [DATE]. R9's cognition was severely impaired, and had diagnoses of epilepsy, traumatic brain injury, and tracheostomy status.Review of R9's orders located in the EMR under the Order tab revealed no order for side rails.Review of R9's care plan, revised 09/08/25, located in the EMR under the Care Plan tab revealed Basic Care Needs: I can't complete my cares on my own; I am totally dependent for all care. Because I have had a subdural hematoma, post-traumatic brain injury, seizures, and encephalopathy. I am nonverbal, nonambulatory and have the potential to have skin impairment and weight gain or loss. I show this by: not participating in myADLs [activities of daily living] total dependent and not being able to tell you what I want or need and being incontinent. Interventions included I use a wide low air loss mattress, bilateral side rails. I reposition in bed: with the help of 2 staff and use my wedge for effective turning off my back Review of R9's Bed Rail Assessment, dated 03/14/25, located in the EMR under the Assessment tab revealed 3a. Side Rail Placement: a. Side Rails/Assist Bar are indicated and serve as an enabler to promote independence. The assessment included the resident representative's signature and date but no documentation about if the risks versus benefits were explained, no risk for entrapment was assessed or if alternatives were tried before using the bed rails.On 01/05/26 at 10:38 AM, R9 was observed asleep in bed with a tracheostomy in place, the head of the bed was up, and side rails in use. R9's bed was in a low position with fall mats in place. On 01/08/26 at 9:24 AM, Certified Nurse Aide (CNA)4 was observed bringing in a shower bed into R9's room. CNA3 was standing at R9's bedside. CNA3 stated regarding the use of side rails, To keep her in bed so she doesn't fall. CNA3 stated the resident had not fallen from the bed and could not grab or used the side rails. 2. Review of R27's quarterly MDS with an ARD date of 01/07/26 and located in the MDS tab of the EMR, revealed R27 was admitted on [DATE]. R27's cognition was severely impaired. The resident was coded for functional limitation in range of motion in her upper and lower extremity, had a feeding tube, and had diagnoses of Alzheimer's disease, epilepsy, unspecified, and cerebral vascular accident.Review of R27's order, dated 11/18/24, located in the EMR under the Order tab revealed Bilateral upper side rails for safety. No directions specified. Review of R27's care plan, revised 07/16/25, located in the EMR under the Care Plan tab revealed Safety: Falls. I: have the potential to fall and injure myself. Because I: have dementia/Alzheimer's disease. In the past: I have fallen; I have fractured my right hip. An intervention included have bilateral side rails to ensure my safety.Review of R27's Bed Rail Assessment, dated 12/15/25, located in the EMR under the Assessment tab revealed 12. Reason(s) for Side Rail Use: a. Used to keep resident in bed. The assessment included the resident representative's signature and date but no documentation about if the risks versus benefits were explained, no risk for entrapment was assessed or if alternatives were tried before using the bed rails.On 01/05/26 at 10:39 AM, R27 was observed asleep in a low bed with the head of bed up, a fall mat in place, and both hands contracted with cloth rolls in place. On 01/08/26 at 9:15 AM, R27 was observed being transported back to her room from the shower room on a shower bed by CNA3 and CNA4. R27's hands were contracted and (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	positioned on her chest. During an interview on 01/08/26 at 9:20 AM, CNA3 stated the resident had side rails For falling. CNA 3 stated the resident could not grab or use the side rails. During an interview on 01/09/26 at 10:27 AM, Registered Nurse (RN)4 stated she or another RN completes the side rail assessments. RN4 stated she will be discontinuing the side rails for both residents (R9 and R27). RN4 stated, The only reason they should have side rails is if the residents use them to reposition. RN4 stated the residents' responsible parties signed the assessments, but it didn't include risks versus benefits. RN4 stated when she started her employment, the side rails were already in place for both residents. RN4 stated she thought maybe at one time the residents could use them as enablers. RN4 stated R9 and R27 had not been assessed for the risk of entrapment. She also acknowledged the assessments didn't include it. RN4 stated she was not sure what alternatives were tried before the installation of the side rails. She also stated, both residents have low beds with fall mats and R9 had a wide mattress. RN4 stated she wasn't sure if they should have a physician's order for the use of side rails. RN4 stated they don't have a policy for side rails.A facility policy for side rails was requested and not provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication was administered to one (Resident (R)35) of one resident observed for pharmacy services. This failure had the potential to compromise patient safety, efficacy of the prescribed treatment, and fulfill the legal and ethical responsibilities.Findings include:Review of R35's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) date of 11/26/25 and located in the MDS tab of the electronic medical record (EMR), revealed R35 was admitted on [DATE], and had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating R35's cognition was intact. The resident had diagnoses of vitamin deficiency, unspecified, anemia, unspecified, and vitamin D deficiency, unspecified.Review of R35's orders, located in the EMR under the Order tab revealed orders for Ferrous Sulfate Tablet 325 (65 Fe [iron]) MG [milligram] Give 1 tablet by mouth one time a day for Anemia, Give before breakfast with orange juice, start date 12/23/25; Multiple Vitamin Oral Tablet (Multiple Vitamin) Give 1 tablet orally one time a day for Vit [vitamin] supplementation, start date 10/18/25, and Cholecalciferol Oral Tablet 25 MCG [microgram] (1000 UT [unit]) (Cholecalciferol) Give 2 tablet by mouth one time a day for Vit D, start date-10/18/25.Review of R35's care plan, located in the EMR under the Care Plan tab revealed Basic Care Needs: I need some assistance with my ADLs [activities of daily living] because I have arthritis and physical challenges.On 01/05/26 at 9:47 AM, R35 was observed awake in bed wearing a hospital gown and three (3) pills [a small white tablet, a medium off-white tablet, and a medium black tablet] were on her chest. R35 stated she was given her medication in a cup but must have missed her mouth. R35 then picked up a small medicine cup that was on her overbed table positioned over her lap. Licensed Practical Nurse (LPN)2 was in the hallway and was asked about the three pills. LPN2 entered the room and confirmed she gave the medication to R35 in a medicine cup but didn't notice she didn't take them. LPN2 stated the pills were a multivitamin, iron, and one to reduce fat. During an interview on 01/07/26 at 10:11 AM, Registered Nurse (RN)4 stated she was the Unit Manager. RN4 explained their procedure prior and during the administering of medications to a resident. RN4 was denied there were any residents who self-administered their medications. RN4 confirmed LPN2 should have stayed with R35 to ensure she took her medications. She stated, Yes absolutely, never leave the medication with the resident. During an interview on 01/07/26 at 4:21 PM, the Director of Nurse (DON) stated she was unaware of R35 spilling three of her medications on 01/05/26 during the morning medication pass and the nurse wasn't in the room but was in the hallway when it was discovered. DON stated there were no residents who self-administered their medications. DON stated, it was her expectation for the nurse to stay with the resident until the medications were taken. Review of the facility's policy titled Medication Administration, dated 12/04/23 provided by the facility revealed It shall be the policy of the Long-Term Care Section of the Division of Services for Aging and Adults withPhysical Disabilities (DSAAPD) that nursing services, in collaboration with pharmaceutical services, will administer medications in accordance with acceptable standards of practice. d. Medications should never be left at the bedside to be taken later. The policy did not include staff ensuring the residents take the medication.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to utilize menus with portion sizes for regular, mechanical soft, and puree diets for two of two meals. This failure could potentially cause residents to become malnourished or experience weight loss or weight gain.Findings include:Review of the week-two menus for Spring 2025 did not include portion sizes for the regular, mechanical soft and pureed diets.Review of the individual resident's pre-selected menu sheets for lunch on 01/06/26 and 01/07/26 did not include portion sizes.Review of the facility diet type report, dated 01/09/26, provided by the facility, revealed 35 regular diets, 18 mechanical soft diets, and nine pureed diets.On 01/06/26 at 12:10 PM, the tray line on the 200 unit was observed in progress. Food Service Worker (FSW)1 read each resident's pre-selected menu and plated the food accordingly with no portion sizes to follow. FSW1 confirmed he followed the resident's pre-selected menu items. No portion sizes were listed on the food items, and no other menus were being used to determine portion sizes. The food items that were served included a cold turkey submarine sandwich, salmon square, chips, roasted potatoes, mixed vegetables, mashed potatoes with gravy, pureed mixed vegetables, and puree salmon. On 01/07/26 at 12:07 PM, the tray line on the 200 unit was observed in progress. FSW1 read each resident's pre-selected menu and plated the food accordingly with no portion sizes to follow. FSW1 confirmed he followed the resident's pre-selected menu items. No portion sizes were listed on the food items, and no other menus were being used to determine portion sizes. The food items included roast beef slices, stuffed pasta shells, gravy, pureed soup, pureed stuff pasta shells, pureed asparagus, mechanical soft roast beef, rice, pureed beef, pureed mix vegetables, regular mix vegetables, baked potato halves, asparagus, regular soup, mashed potatoes, French fries, and garlic bread. FSW1 was asked how he knew what serving utensils to use since the menus did not have portion sizes. FSW1 stated they have a list of portion sizes in the main kitchen they go by for proteins, mashed potatoes, etc.During an interview on 01/07/26 at 12:08 PM, the Dietary Manager (DM) confirmed the portion sizes were not included on the facility's week-two Spring 2025 menus or pre-selected menus. DM stated the dietary staff used a list of portion sizes available in the main kitchen that included general food groups and items. DM then provided the list titled Standard Serving Sizes, the dietary staff used when determining serving utensils or amounts to serve. The list only included generalized food groups such as protein, starches, vegetables, and breakfast foods. The list did not include mechanical soft or pureed foods. During a follow up interview on 01/09/26 at 12:40 pm, the DM stated they had menus with serving sizes that could have been used. The week-two menus for Spring 2025 with portion sizes were provided.During an interview on 01/09/26 at 12:42 pm, the Registered Dietitian (RD) stated she was not aware menus without portion sizes were being utilized. The RD stated, she was aware of the requirement for menu portion sizes, So to ensure the menus were balanced. When comparing lunch on 01/06/26 according to the week-two Spring 2025 menus with portion sizes it was revealed: The portion size for the regular roasted potatoes was 4 ounces (oz) but 3.25oz was served, andThe portion size for the puree salmon was 4 oz but 3.25oz was servedWhen comparing lunch on 01/07/26 according to the week-two Spring 2025 menus with portions sizes it was revealed: The portion size for the pureed soup was 6 oz, but 3 oz was served, The portion size for the pureed stuff pasta shells was 4 oz but 3oz was served, The portion size for the pureed asparagus was 4 oz, but 3 oz was served, The portion size for the mechanical soft roast beef was 4 oz, but 3.25 oz was served,The portion size for the rice was 4 oz, but 3.25 oz was served,The portion size for the pureed roast beef was 4 oz, but 3 oz was served,The portion size for the baked potatoes was one potato, but one half was served,The portion size for the (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	asparagus was 4 oz, but it was served with tongs, andThe portion size for the regular soup was 6 oz, but 3 oz was servedA policy for menus was requested and the facility stated they did not have one.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff wore appropriate Personal Protective Equipment (PPE), specifically disposable gowns, and gloves, during the administration of medication through a percutaneous endoscopic gastrostomy (PEG) tube for one (Resident (R)27) of 10 residents who had PEG tubes. This deficient practice resulted in a risk of contamination and the potential spread of infection to the patient and other residents. Findings include:Review of R27's admission Record located under the Profile tab of the Electronic Medical Record (EMR), revealed R27 was admitted on [DATE] with a diagnosis of gastrostomy status.Review of R27's Minimum Data Set (MDS) located under the MDS tab of the EMR, with an Assessment Reference Date (ARD) of 12/19/25 revealed R27 received nutrition through feeding tube.During an observation on 01/08/26 at 9:20 AM, Licensed Practical Nurse (LPN)1 administered medication to R27 through her PEG tube, and LPN1 did not wear PPE. There was no signage located on R27's door that indicated the resident was on Enhanced Barrier Precautions (EBP).During an interview on 01/08/26 at 9:20 AM, LPN1 revealed she thought the use of PPE was only for providing treatments to the resident such as cleaning the PEG tube area. LPN1 confirmed she should have worn PPE during the PEG tube medication administration.During an interview on 01/09/26 at 12:29 PM, with the Infection Preventionist (IP)2 and the Director of Nursing (DON), IP2 confirmed staff are to wear PPE during medication administration with a PEG tube resident. DON confirmed staff were trained to wear PPE and recently had a skills fair that addressed wearing PPE with residents who had PEG tubes.Review of the facility policy titled, Enhanced Barrier Precautions and Isolation Procedures (Contact Precautions) dated 12/31/25 revealed Policy/ Position Statement: . The facility shall utilize Standard Precautions, Enhanced Barrier Precautions (EBP), and Transmission Based Precautions, (e.g., Contact Precautions) as clinically indicated to prevent, identify, contain, and control infectious disease, including multi-drug-resistant organisms (MDROs). Precautions will be implemented using the least restrictive approach necessary to protect residents, staff, visitors, and others, while maintaining residents' rights, dignity, psychosocial well-being, and quality of life.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Hospital F/T Chronically Ill (Dhci)	100 Sunnyside Road Smyrna, DE 19977

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer five of eight residents (Residents (R) 20, R21, R22, R11, and R57) reviewed for flu/pneumonia vaccinations and/or their representatives, the opportunity for the residents to be vaccinated in accordance with nationally recognized standards of 28 sample residents. This practice had the potential to increase the risk for this resident to contract pneumonia. In addition, the facility policy did not reflect current CDC recommendations. Findings include:1. Review of R20's electronic medical record (EMR) titled admission Record located under the profile tab indicated the facility admitted the resident on 01/24/25. The resident was over the age of 55 at the time of his admission. Review of R20's EMR titled Immunization located under the Immun (Immunization) tab failed to indicate that the resident received a pneumococcal vaccine. There was no evidence in the clinical record that the resident and/or his representative were given the opportunity to receive the PCV20 or the PCV21. 2. Review of R21's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 02/21/24. The resident was over the age of 65 at the time of his admission.Review of R21's EMR titled Immunization located under the Immun tab failed to indicate that the resident received a pneumococcal vaccine. There was no evidence in the clinical record that the resident and/or his representative were given the opportunity to receive the PCV20 or the PCV21.3. Review of R22's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 09/21/16. The resident was [AGE] years of age at the time of her admission.Review of R22's EMR titled Immunization located under the Immun tab indicated the resident received (Pneumovax23) PPSV23 on 12/26/16. There was no evidence in the clinical record that the resident and/or her representative were given the opportunity to receive the PCV20 or the PCV21.4. Review of R11's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 12/30/08. The resident turned [AGE] years of age during his stay at the facility. Review of R11's EMR titled Immunization located under the Immun tab indicated the resident received the PPSV23 on 03/13/15. There was no evidence in the clinical record that the resident and/or her representative were given the opportunity to receive the PCV20 or the PCV21.5. Review of R57's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 04/16/08. The resident turned [AGE] years of age during his stay.Review of R57's EMR titled Immunization located in the Immun tab indicated the resident received the PPSV23 on 09/10/15. There was no evidence in the clinical record that the resident and/or his representative were given the opportunity to receive the PCV20 or the PCV21.Review of a document provided by the facility and referred to as a pharmacy report indicated that in 2023 four residents received the PCV20 vaccination. In 2024, two residents were identified who received the PCV20 vaccination. Finally, in 2025 two residents were identified who received the PCV20 vaccination. During an interview on 01/06/2026 at 11:49 AM, the Pharmacist stated the facility ordered the PCV20 in 2025 and would need to run a report which identified how often the PCV20 was ordered. During an interview on 01/06/26 at 1:02 PM, the Director of Nursing (DON), who was also the facility's Infection Preventionist (IP)1, confirmed the facility failed to offer the PCV20 vaccine to the following residents: R20, R21, R22, R11, and R57. During an interview on 01/07/2026 at 1:56 PM, the Medical Director stated there had been no communication regarding the pneumococcal vaccines for the residents for at least six months. The Medical Director stated that he has not updated the facility's policy on the current CDC recommendations. Review of the CDC website titled PneumoRecs VaxAdvisor App (Application) for Vaccine Providers dated 01/15/25 indicated . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Delaware Hospital F/T Chronically Ill (Dhci)		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Sunnyside Road Smyrna, DE 19977	

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer PCV15, PCV20, or PCV21 for all adults 50 years or older.Who have never received any pneumococcal conjugate vaccine.Whose previous vaccination history is unknown. Based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both.PCV13 (but not PCV15, PCV20, or PCV21) at any age and . PPSV23 at or after the age of [AGE] years old.Review of a facility policy titled Protocols for Influenza and Pneumococcal Vaccinations dated 02/08/23 indicated . It shall be the policy for the Long-Term Care Sector of the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)to have a standardized procedure/protocol for administering vaccinations. Pneumococcal Conjugate Vaccine (PCV13} is recommended for all adults 65 years or older.Pneumococcal Polysaccharide Vaccine (PPSV23) is recommended for all adults 65 years or older.