STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. Building B. Wing	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ocean Grove Post Acute	231 South Washington Street Millsboro, DE 19966

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that for one out of four resident units the facility failed to provide a clean and homelike environment. Findings include: 7/2/25 9:27 AM - During an observation on the Ocean Gardens unit, room [ROOM NUMBER] was noted to have two areas approximately 6 in length, brown in color by the air conditioning unit. 7/2/25 9:33 AM - During an interview, E4 (Maintenance) confirmed the air conditioning unit in room [ROOM NUMBER] was leaking and recently just replaced. E4 confirmed the two large areas, brown in color next to the air conditioning unit. 7/2/25 9:37 AM - During an observation on the Ocean Gardens unit, room [ROOM NUMBER] was noted to have approximately six circular areas, brown in color, linear pattern noted on the ceiling. room [ROOM NUMBER] also noted to have a large area, approximately 12 long, brown in color noted in the closet. 7/2/25 9:50 AM - During an observation on the Ocean Gardens unit, room [ROOM NUMBER] was noted to have a leaking shower head in the bathroom. While observing the leaking shower head, it was noted that the tiles in the shower were covered with a pink and gray substance, slippery in consistency. Also noted that multiple tiles and the baseboard lining was missing from the bathroom wall and floor. 7/2/25 10:28 AM - During an interview, E5 (Maintenance Director) and E6 (Maintenance Corporate) confirmed the aforementioned areas in room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] were in disrepair and would put in a work order to complete. 7/2/25 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), and E7 (IP) during the exit conference.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on record review and interview it was determined that for one (R163) out of two residents reviewed for wound care, the facility failed to ensure that wound care was performed in accordance with the physician's ordered frequency. Findings include: 1. The facility policy on wound treatment and management last updated 3/25 indicated, Wound treatments will be provided in accordance with physicians orders .treatments will be documented in the electronic health record. Review of R163's clinical record revealed: 5/22/25 - R163 was admitted to the facility with multiple wounds including on the right hip, leg and foot related to diabetes, and poor circulation resulting in some areas of dead tissue. 5/22/25 - A care plan for skin impairment was created for R163 with the intervention to administer treatment per physician's order. 5/26/25 - An admission MDS assessment documented R163 was cognitively intact and having multiple wounds that required care. May 2025 - R163's TAR lacked evidence that daily wound care treatments were completed on 5/30/25. R163's progress notes lacked documentation regarding resident absence or refusal for that date. 6/18/25 - A Physician's order was written for R163 to receive daily wound care treatments and dressing changes to the right hip, right lower leg, right ankle and right heel. June 2025 - R163's TAR lacked evidence that daily wound care treatments were completed on 6/12, 6/13, 6/19, and 6/20. R163's progress notes lacked documentation regarding resident absence or refusal on those dates. 6/23/25 11:16 AM - During an interview R163 stated, They don't always have enough staff, so my dressing is not changed every day like it's supposed to be. 6/26/25 10:00 AM - During an interview E28 (LPN) wound care nurse stated I told [R163] before if someone doesn't do it during the day then ask them to do it at night or tell me because sometimes, I am assigned to do other things. E28 then reported that R163 was compliant and wants to heal. E28 then confirmed the blank areas on R163's TAR to indicated missed treatments. 6/26/25 11:58 AM - During an interview E20 (RN) unit manager confirmed the findings and stated, I was unaware it wasn't always being done.

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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. Based on record review and interview it was determined that for one (R27) out of six residents reviewed for medication review the facility failed to provide medications and/or biologicals, as ordered by the prescribe, to meet the needs of the resident. Findings include: The facility policy on ordering medication updated June 2024, indicated, medications and related products are received from the pharmacy on a timely basis. Review of R27's clinical record revealed: 6/4/25 - R27 was admitted to the facility with multiple diagnoses including diabetes. 6/4/25 - A physicians order was written for R27 to receive Ozempic injections for diabetes every Tuesday. The same day the order was then changed to every Friday. 6/13/25 - A physicians order was written to discontinue R27's Ozempic injection. 6/13/25 - A physicians order was written for R27 to receive Bydureon (a once weekly injection similar to Ozempic) for diabetes every Friday. 6/20/25 12:48 PM - An orders administration note in R27's clinical record written by E20 (RN) unit manager documented Bydureon . medication not available. NP aware may hold until arrival from pharmacy no alterative medication. 6/20/25 - A physicians order was written to discontinue R27's Bydureon injections. 6/21/25 - A physicians order was written for R27 to receive Exenatide injections twice a day for diabetes. June 2025 - Review of R27's MAR revealed Ozempic was not received on 6/6, and 6/13. Bydureon was not received on 6/20. 6/23/25 1:12 PM - During an interview R27 stated, They are not getting my Ozempic 6/26/25 11:27 AM - E2 (DON) confirmed the facility lacked evidence of delivery of R27's Ozempic from the pharmacy. 6/26/25 12:03 PM - During an interview - E20 (RN) unit manager stated, [R27] comes in has order for Ozempic. The pharmacy ask it to be changed to Bydureon, then they say it's not available so they change again to Exenatide. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/26/25 1:45 PM - During an interview C1 (QAPharmD) confirmed the findings and stated, We did get an order for the Ozempic then the facility submitted another order with a change. We did not dispense either order. We should have sent the second and that was a miss on the pharmacy part. It was miss-assessed. On 6/13 they discontinued the Ozempic and submitted a new order for the Bydureon and that had been discontinued by the manufacturer. We pharmacist spoke to the facility and we told them we could provide Exenatide. 7/2/25 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), the exit conference.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review it was determined that for one (R164) out of three residents reviewed for nutrition the facility failed to ensure the resident received food that accommodated intolerance's. Findings include: Review of R164's clinical record revealed: 5/28/25 - R164 was admitted to the facility with multiple diagnoses including gastroesohageal reflux disease (GERD a severe and uncomfortable heart burn) and a feeding tube. 5/28/25 - A physicians order was written for R164 to receive a medication to treat GERD daily. 5/30/25 - A care plan for GERD was created for R164 that included an intervention to avoid foods or beverages that tend to irritate esophageal lining, i.e. alcohol, chocolate, caffeine, acidic or spicy foods, fried or fatty foods. Encourage resident to avoid alcohol, smoking, coffee (even decaffeinated), fatty foods, chocolate, citrus juices, [NAME], tomato products, garlic and onions. Encourage a bland diet. 6/3/25 - An admission MDS assessment documented that R164 was severely cognitively impaired. 6/25/25 12:15 PM - During a dining observation R164 was observed being fed a lunch meal of tomato sauce over pasta and softened garlic bread and tomato juice by E31 (CNA). E31 reported that the only dietary restrictions for R164 were related to texture. 6/26/25 12:09 PM - During a dining observation R164 was observed being fed a lunch meal of E32 sliced steak with onions and peppers over rice by E32 (CNA). The lunch ticket that accompanied R164's meal lacked documentaion regarding avoidance of dietary intolerance's related the the diagnosis of GERD such as tomato, and onions. 6/26/25 12:17 PM - During an interview E34 (FSD) reported the facility has always available options by request such as sandwiches and salads. E34 confirmed the dietary department was unaware of dietary intolerance's related to R164's diagnosis of GERD. 6/26/25 12:32 PM - E33 (RN) assigned to R164 reviewed the GERD care plan with the surveyor and confirmed the lunch that day did not avoid the residents dietary intolerance's related to GERD. 7/2/25 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), the exit conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, it was determined that for three (R127, R164 and R319) out of thirty-two (32) residents in the investigative sample, the facility failed to ensure the clinical record contained accurate documentation. Findings include: A review of R127's clinical record revealed: 12/3/24 - R127 was admitted to the facility. 12/30/24 - A physician's order for R127 documented morphine sulfate ER (extended release) 15 mg tablet, give 1 tablet by mouth every 12 hours for pain. 1/3/25 9:00 PM - The medication administration record for R127 documented a blank, unsigned value for the morphine sulfate medication to be administered. 1/4/25 9:00 AM - The medication administration record for R127 documented a blank, unsigned value for the morphine sulfate medication to be administered. 7/2/25 - A review of the controlled drug administration record for R127 for the morphine sulfate medication documented that the medication was administered on 1/3/25 at 9:00 PM and on 1/4/25 at 9:00 AM. 7/2/25 11:02 AM - During an interview with E2 (DON), it was determined that E9 (RN) had forgotten to sign off the administration of the morphine sulfate medication in the electronic medication administration record and R127 did not miss any scheduled doses. 2. A review of R319's clinical record revealed: 11/25/24 - R319 was admitted to the facility. 11/25/24 - A physician's order for R319 documented morphine sulfate ER (extended release) 15 mg tablet, give 1 tablet by mouth every 12 hours for pain. 1/3/25 9:00 PM - The medication administration record for R319 documented a blank, unsigned value for the morphine sulfate medication to be administered. 1/4/25 9:00 AM - The medication administration record for R319 documented a blank, unsigned value for the morphine sulfate medication to be administered. 7/2/25 - A review of the backup pharmacy dispensary log documented that 1 tablet of morphine sulfate 15 mg tab was dispensed on 1/3/25 and 1/4/25. 7/2/25 11:02 AM - During an interview with E2 (DON), it was determined that a new blister pack of morphine sulfate 15 mg had been sent to the facility from the pharmacy for R319. Therefore, E9 (RN) had to use the backup pharmacy medication to give to R319. It was confirmed that R319 did not miss any scheduled doses. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of R164's clinical record revealed: 5/28/25 - R164 was admitted to the facility with a feeding tube. 5/28/25 - A physicians order was written for R164 to receive liquid nutrition for malnutrition if the resident consumes >50 % of a meal. 6/9/25 - A nutritional assessment completed by E30 (RD) documented that R164 was to receive nutrition through the feeding tube when <50% of a meal was consumed. Less than 50% meal consumption was not consistent with the current physicians order. 6/25/25 2:12 PM - During an interview E20 (RN) unit manager confirmed the findings and stated that R164's nutritional assessment had a less than [<] sign documented in error instead of a greater than sign [>] consistent with R164's physicians orders related to nutrition through the feeding tube based on meal intake. E20 provided a copy of R164's hospital discharge records that also indicated the resident was to receive nutrition through the feeding tube with >50% consumption of a meal. 7/2/25 2:30 PM - Findings were reviewed with E1 (NHA), E2, E3 (ADON) during the exit conference.