

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Delmar Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 101 Delaware Ave., Delmar, De. 19940-1110 Delmar, DE 19940	
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 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview and record review it was determined that for one (R1) out of three residents reviewed for allergies, the facility failed to ensure a resident with severe food allergy was not served food containing an allergen. The facility's failure placed the residents at risk for a serious adverse outcome including respiratory depression, anaphylaxis or even death from consuming food with a severe allergy. Due to this failure an Immediate Jeopardy (IJ) was called on 7/15/26 at 3:00 PM. The IJ was abated on 7/16/26 at 12:00 AM. Findings include: Cross refer F656; Review of R1's clinical record revealed: 2/12/26 - R1 was admitted to the facility with a diagnosis of Cerebral Palsy. 2/12/26 - An allergy to peanuts was documented as severity severe on the allergy tab in the EMR. 2/12/26 3:00 PM - A physician's order documented epinephrine auto-injector inject 0.3 mL intramuscularly every 24 hours as needed for an allergic reaction. 2/13/26 1:00 PM - A physician's order documented that R1 had a regular diet, pureed texture and honey thick consistency for liquids. The order also noted R1 had an allergy to peanuts and corn. 2/17/26 - An admission MDS documented that R1 required assist of one staff for ADL's including eating and a BIMS score of 15 indicating intact cognition. 3/5/26 - A review of R1's care plan lacked evidence of severe allergy to peanuts. 7/13/26 5:45 PM - A facility reported incident documented that R1 had a peanut allergy and was given peanut butter during dinner time. 7/13/26 5:56 PM - A review of the MAR documented that R1 received a dose of epinephrine. 7/13/26 7:45 PM - A review of the MAR documented that R1 received a dose of Benadryl (antihistamine). 7/13/26 8:06 PM - A provider hospital progress note documented that R1 presented to the emergency room with a history of peanut allergy and experiencing an allergic reaction. The progress note further documented that R1 received epinephrine and nebulizer treatment during transit to the hospital. Additionally, the progress note documented [R1] critical care was necessary to treat or prevent imminent or ill-threatening deterioration for the following conditions: respiratory failure and toxidrome (toxin overdose). 7/13/26 8:55 PM - A nursing progress note (facility) documented that R1 had a peanut allergy and was having difficulty breathing. The note further documented that R1 received a dose of epinephrine and provider was notified. Provider ordered Benadryl 50 mg by mouth and nebulizer treatment. The progress note documented that R1's vital signs were re-assessed, oxygen provided 2L/min via nasal cannula, but oxygen saturation remained low. Provider recommendation to send R1 to emergency room for evaluation. 7/13/26 9:10 PM - A nursing progress note (facility) documented that [R1] had received peanut butter on his dinner tray and E6 (CNA) fed R1 the peanut butter. After [R1] consumed the peanut butter R1 became short of breath and was coughing. At 5:42 PM, [R1] was given epinephrine and Benadryl and [E5 (RN)] advised to monitor [R1] closely for any respiratory changes. At approximately 6:40 PM, [E4 (LPN)] informed [E5] that [R1] had a pulse oxygen reading of 84% on room air and called the on-call provider. On-call provider recommended [R1] be sent to the emergency department for (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0806 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	evaluation. 7/13/26 10:22 PM - A hospital progress note documented R1 was attempted to weaned off oxygen use and pulse oximetry level would decrease. The progress note further documented that there was concern for possible aspiration due to R1 having multiple episodes of emesis post consumption of peanut butter and an antibiotic was ordered. 7/15/26 11:55 AM - A direct observation of kitchen staff serving and plating lunch meals for dining and units. During observation, E13 (Dietary Aide) was adding drinks and desserts for residents to trays. When completed, E12 (Dietary Aide) would read the ticket and tell E7 (Cook) what entree and side was needed for the plate. Once food was plated, E12 would cover the plate and place tray on food cart to send to dining room or unit. 7/15/26 12:10 PM - A direct observation of staff serving trays to residents in dining room. Staff would look at the name on meal ticket and distribute to the residents in the dining room. 7/15/26 12:25 PM - During an interview, E14 (CNA) stated that the expectation is for staff to review dietary ticket when providing tray to resident. The ticket will have preferences, allergies, and any dietary accommodations (utensils, plates, etc.) listed on the ticket and staff is to ensure those are being followed. E14 stated that if a resident received something that they were allergic to or disliked they would notify the supervisor, would remove that item from the tray, and serve the rest of the food to the resident. 7/15/26 12:35 PM - During an interview, E7 stated the expectation is for the dietary aide who is plating the food should verify that all the items on the tray match the dietary ticket. E7 also stated that allergies are noted on tickets and will be highlighter for staff to see. 7/15/26 12:45 PM - During an interview, E9 (Dietary Manager) stated that the menu on 7/13/26 called for snickerdoodle cookie and confirmed that snickerdoodle cookie was pureed that day for the dinner meal. E9 stated the expectation is for staff to ensure all food on the tray matches the ticket before leaving the kitchen. E9 stated the facility does not place peanut butter in cups for any reason and confirmed the menu does not have peanut butter mentioned for any meal on the four-week rotation. 7/15/26 2:24 PM - During an interview, E8 stated that a nurse came down to the kitchen to notify them that R1 had received peanut butter on his tray at dinner. E8 stated he was unsure how peanut butter had made it on R1's tray as the kitchen staff does not place peanut butter in cups for the residents. 7/15/26 2:36 PM - During an interview, E10 (Dietary Aide) stated he was working on 7/13/26 and was responsible for placing dessert and drinks on R1's tray that evening. E10 stated that the ticket stated R1 was to receive a magic cup and recalls providing the magic cup to the tray. E10 stated that peanut butter was not placed on R1's tray and did not see a cup of peanut butter during prepping. 7/15/26 2:44 PM - During an interview, E11 (Dietary Aide) stated that R1 received pureed fruit on 7/13/26 and did not recall seeing a container of peanut butter in the kitchen during the shift. E11 stated that the kitchen does not serve peanut butter in cups to the resident's and has never seen peanut butter in a cup while working. E11 stated that when the staff serves peanut butter it comes right from the jar and used to make sandwiches. 7/15/26 3:20 PM - During an interview, E6 (CNA) stated that R1 had received a brown colored substance in a cup on the tray and stated the ticket documented dessert was pureed snickerdoodle cookie. E6 stated she did not realize the cup had peanut butter in it and fed it to R1. E6 stated that R1 started coughing after eating the peanut butter and E6 notified the nurse. 7/15/26 3:00 PM - Am Immediate Jeopardy was called and reviewed with the facility leadership E1 (NHA). 7/16/26 12:01 AM - The facility determined Immediate Jeopardy was abated at this time. The abatement plan included providing in person and electronic education of all staff, facility management present and completing audits in real-time during meals. updating of facility procedures with plating and traying in the kitchen, and a facility wide audit and update of allergies in EMR. 7/17/26 2:00 PM - The facility's abatement was reviewed with E1 (NHA). It was determined through observation, interview and record review that the facility completed the abatement plan on 7/16/26 12:00 AM. 7/17/26 3:00 PM - Findings reviewed with E1 (NHA) and E2 (DON) during the exit conference.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, it was determined that for one (R1) out of three residents in the investigative sample, the facility failed to develop a comprehensive resident centered care plan for an identified care area. Findings include: Cross refer F806 Review of R1's clinical record revealed: 2/12/26 - R1 was admitted to the facility with a diagnosis of Cerebral Palsy. 2/12/26 - An allergy to peanuts was documented as severity severe on the allergy tab in the EMR (electronic medical record). 2/13/26 1:00 PM - A physician's order documented that R1 had a regular diet, pureed texture and honey thick consistency. The order also noted R1 had an allergy to peanuts and corn. 3/5/26 - A review of R1's care plan lacked evidence of severe allergy to peanuts. 7/13/26 - A facility reported investigative packet documented that R1's care plan will be updated to reflect the severe peanut allergy. 7/14/26 - A review of R1's care plan documented that R1 had allergies to peanuts, corn and peanut butter with the following interventions: allergies listed on dietary ticket and in EMR (electronic medical record) and follow physician's orders as indicated. 7/15/26 3:15 - During an interview, E1 (NHA) confirmed that the care plan was updated for R1 related to aforementioned incident. 7/17/26 3:00 PM - Findings reviewed with E1 (NHA) during the exit conference.		