STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085041	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delmar Nursing & Rehabilitation Center	101 Delaware Ave., Delmar, De. 19940-1110 Delmar, DE 19940

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview, record review, document review, and facility policy review, the facility failed to protect a resident's right to be free from misappropriation of resident property for 1 (Resident #67) of 8 sampled residents reviewed for abuse. Beginning on 07/05/2025 until 08/14/2025, the facility failed to protect and prevent misappropriation of medication with past non-compliance. Findings include: An undated facility policy titled, Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revealed, d. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.An admission Record revealed the facility admitted Resident #67 on 05/23/2025. According to the admission Record, the resident had a medical history that included a diagnosis of chronic pain syndrome.A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/29/2025, revealed Resident #67 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident received as-needed pain medication.Resident #67's Order Summary Report for active orders as of 07/05/2025, revealed an order dated 05/30/2025, for oxycodone hydrochloride oral tablet 5 milligram, give one tablet by mouth every four hours as needed for pain.Contained within the facility investigation was a handwritten statement from Licensed Practical Nurse (LPN) #17 dated 07/04/2025, which indicated On July 4, 2025 resident [Resident #67] asked for the little white pill. I checked the narcotics lock box and there was no card. I worked the night before [07/03/2025] there was a card and the narcotic sheet. When I checked the computer I was the last person that gave [Resident #67] PRN [pro re nata, as needed] oxycodone at 8:31 pm Thursday night 7/3/25. I checked [his/her] chart and no narcotic sheet was in the chart. Supervisor notified I reordered the medication.The facility five-day report dated 07/09/2025, revealed [LPN #17] noticed that the oxycodone was missing on 7/4 [2025] when she went to give it. She had given it on 7/3/25 and was the last person to give it. Unable to locate medication or narcotic sheet. Per the five-day report, an undetermined amount of Oxycodone could not be found or accounted for at this time.During an interview on 12/04/2025 at 10:47 AM, LPN #17 stated she worked on 07/04/2025 from 7:00 AM to 11:00 PM. LPN #17 stated she could not find Resident #67's oxycodone medication or the narcotic medication sheet and reported it to Registered Nurse (RN) #25. LPN #17 stated the staff searched for the medication and the medication sheet, but the medication and the medication sheet could not be found.During an interview on 12/03/2025 at 8:32 AM, RN #25 stated she was on duty as the charge nurse when it was reported by LPN #17 that Resident #67's medication card of oxycodone could not be located. RN #25 stated she reported the incident to the Administrator and the Director of Nursing (DON). During an interview on 12/04/2025 at 10:10 AM, former DON #10 stated she was not involved in the investigation of Resident #67's oxycodone medication because the Administrator conducted the investigation.As a result of Resident #67's missing oxycodone medication, the facility immediately implemented the following corrective actions:-On 07/05/2025, an audit of all narcotic medication (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cards was conducted to ensure no other medications were unaccounted for. No concerns were identified.-On 07/08/2025, the facility conducted an ad hoc (for this situation) quality assessment performance improvement (QAPI) meeting.-From 07/08/2025 to 07/09/2025, all nurses completed controlled substances competencies. -From 07/09/2025 to 07/18/2025, narcotic sheets were monitored daily for accuracy until narcotic count books were implemented on 07/18/2025.-On 07/14/2025, narcotic books were ordered by way of the pharmacy. -On 07/17/2025, the facility replaced the control drug count verification and narcotic sheet count with controlled substance book on Unit 1.-On 07/18/2025, the facility replaced the control drug count verification and narcotic sheet count with controlled substance book on Units 2, 3, and 4. -On 07/18/2025, the controlled substance policy was changed to include the controlled substance book being utilized for the narcotic count.-On 08/14/2025, the facility conducted an QAPI meeting.After review and verification of the facility's corrective actions, to include staff interviews, resident interviews, and observation of medication administration, the survey team determined the facility implemented the above corrective actions beginning on 07/05/2025 until 08/14/2025, the facility implemented corrective actions to correct the identified deficient practice and prevent recurrence; thus, past noncompliance was cited.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Surveyor: Latoya GordonBased on interview, record review, document review, and facility policy review, the facility failed to ensure staff reported allegations of abuse immediately to the Administrator/designee and the administrative staff timely reported allegations of abuse to the state survey agency for 4 (Residents #19, #42, #88, and #93) of 8 sampled residents reviewed for abuse. Findings include: An undated facility policy titled, Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revealed, It is the policy of [facility name] that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, or not later than 24 hours if the events that caused the allegations do not involve abuse and do not result in seriously bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures. 1. An admission Record indicated the facility admitted Resident #42 on 03/28/2025. According to the admission Record, the resident had a medical history that included a diagnosis of major depressive disorder and anxiety disorder.The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/04/2025, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident did not have any behaviors.Contained within the facility investigation file was a handwritten statement from Occupational Therapist (OT) #31 dated 06/12/2025, which indicated On Wednesday, 6/11 [2025] prior to [Resident #52] doctor appointment, the nsg [nursing] aides were attempting to place L [left] shoulder brace. Pt [Patient (Resident #42)] accused the aide of trying to break my arm, I was in a room close by & assisted with placing brace. The brace was already halfway secured & I finished & tightened the straps. The Incident Tracking indicated on 06/11/2025 at 9:00 AM, Resident #42 reported that a certified nurse aide (CNA) intentionally pulled their arm. Per the Incident Tracking, the facility notified the state survey agency of the resident's allegation of physical abuse on 06/12/2025 at 4:14 PM. During an interview on 12/04/2025 at 1:30 PM, OT #31 stated she did not report the allegation because the aides and the nurse were in the resident's room. OT #31 stated she would consider what the resident alleged as an allegation of abuse because the resident stated staff hurt their arm. During an interview on 12/04/2025 at 12:55 PM, the Director of Nursing (DON) confirmed the incident reported by Resident #42 occurred on 06/11/2025.The DON stated staff were supposed to report allegations of abuse immediately. The DON stated the allegation should have been reported on 06/11/2025. During an interview on 12/04/2025 at 2:00 PM, the Administrator stated Resident #42 reported CNA #1 accidently hurt their arm, but it pissed them off. The Administrator stated she expected the incident to be reported as an allegation of abuse on the day that the incident happened.2. An admission Record revealed the facility admitted Resident #93 on 02/21/2025. According to the admission Record, the resident had a medical history that included a diagnosis of metabolic encephalopathy. Contained within the facility investigation file was a document titled Staff Coaching Form for Licensed Practical Nurse (LPN) #7 dated 03/21/2025, which indicated Description of Incident: On 3/21/25 Resident [Resident #93] made statement that CNA [certified nurse aide] had smacked hand while providing care. Residents [spouse] denied that the incident happened. Nurse did not report potential allegation of abuse. Action Steps: Nurse to report any allegation of Abuse or potential allegation of abuse (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to Nursing Supervisor, DON/ADON [Director of Nursing/Assistant Director of Nursing. During an interview on 12/02/2025 at 6:46 PM, LPN #7 stated she would have notified the DON of the allegation, but the DON was handling another incident at the time and was on the phone with another staff member. LPN #7 stated she was not sure if the resident's allegation was abuse; therefore, she did not report what the resident reported to her immediately. According to LPN #7, the former DON informed her that the incident should have been reported immediately. During an interview on 12/03/2025 at 2:52 PM, the DON stated if there was an allegation of abuse reported to staff, the staff should report the allegation immediately to the manager on duty. The DON stated the allegation involving Resident #93 was not reported to the manager on duty immediately and the staff was educated related to the reporting requirements. During an interview on 12/04/2025 at 10:50 AM, the Administrator stated that as soon as an allegation of abuse was made or occurred, it should be reported. The Administrator stated LPN #7 should have reported the resident's allegation of abuse immediately.3. An admission Record indicated the facility admitted Resident #63 on 05/24/2024. According to the admission Record, the resident had a medical history to include a diagnosis of hypertensive heart disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/30/2024, revealed Resident #63 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. An admission Record indicated the facility admitted Resident #77 on 09/30/2023. According to the admission Record, the resident had a medical history to include a diagnosis of senile degeneration of the brain. A quarterly MDS, with an ARD of 11/23/2024, revealed Resident #77 had a BIMS score of 4, which indicated the resident had severe cognitive impairment. An admission Record indicated the facility admitted Resident #88 on 03/03/2021. According to the admission Record, the resident had a medical history to include a diagnosis of schizophrenia. A quarterly MDS, with an ARD of 12/11/2024, revealed Resident #88 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired in cognitive skills for daily decision making. Contained within the facility investigation file was a handwritten statement from the Activities Director (AD) dated 12/12/2024, which indicated I was in my office getting ready to leave and I heard residents screaming. As I walk out [Resident #77] was on the left of [Resident #88]. [Resident #63] was yelling saying [Resident #77] had hit [Resident #88] in the face. [Resident #88's] lip was busted and bleeding. Contained within the facility investigation file was email correspondence from Licensed Practical Nurse (LPN) #17 to former Director of Nursing (DON) #8 dated 12/12/2024, that indicated On December 11, 2024 I went to the kitchen to get ice cream and pudding for the nurse coming in at 7 pm. As I was coming back from the kitchen on station 2 I heard [the AD] hollering for me. When I got there [the AD] was standing beside [Resident #88]. [The AD] stated she was in her office and heard [Resident #88] and [Resident #63] yelling. [The AD] said that [Resident #63] told her that [Resident #77] had punched [Resident #88] in the face. The facility Investigation Summary indicated on 12/11/2024, Resident #63 reported that Resident #77 hit Resident #88. Per the Investigation Summary, the Administrator was notified of the incident on 12/13/2024. During an interview on 12/05/2025 at 11:32 AM, the Director of Nursing stated she did not know why the allegation was not reported in a timely manner. During an interview on 12/05/2025 at 12:39 PM the Administrator stated staff were expected to report any and all allegations of abuse and neglect to their direct supervisor immediately. The Administrator stated the allegation should have been reported immediately.4. An admission Record revealed the facility admitted Resident #19 on 08/10/2029. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and senile degeneration of the brain. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/22/2025, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed Resident #19 had a Staff Assessment for Mental Status (SAMS), that indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated the resident was dependent on staff for activities of daily living. The Incident Reporting System indicated on 03/30/2025 at 10:45 AM, Resident #19 was found to have a yellow fading bruise on their right upper arm and left thigh. Per the Incident Report System, the resident was not able to vocalize how the bruising occurred. The Incident Report System indicated the facility notified the state survey agency of the injury of unknown origin on 04/02/2025 at 11:02 AM. During an interview on 12/05/2025 at 3:15 PM, the Administrator stated she expected an injury of unknown origin to be reported to the state survey agency within two hours, and the incident with Resident #19 was not timely reported.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, record review, document review, and facility policy review, the facility failed to implement their abuse policy when they failed to obtain witness statements from involved staff for 3 (Residents #19, #77, and #80) of 8 sampled residents reviewed for abuse. Findings include: An undated facility policy titled, Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, revealed E. Investigation Abuse Policy Requirements: It is the policy of [facility name] that reports of 'abuse' are promptly and thoroughly investigated. Procedure: The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. a. Investigation of abuse: When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: * Who was involved * Residents' statements - For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction and document findings. * Resident's roommate statements (if applicable) * Involved staff and witness statements of events. 1. An admission Record revealed the facility admitted Resident #19 on 08/10/2029. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and senile degeneration of the brain. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/22/2025, revealed Resident #19 had a Staff Assessment for Mental Status (SAMS), that indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated the resident was dependent on staff for activities of daily living. The facility five-day report dated 04/07/2025 indicated on 03/30/2025, Resident #19 was found to have a bruise on their right upper arm and left thigh. Per the five-day report, the resident was unable to state how the bruise occurred. The five-day report indicated the skin assessment completed revealed the resident had a purple/yellow fading bruise on the right upper bicep and skin discoloration on the left thigh. Contained within the facility investigation file was a document titled Accident/Incident Statement Form RN [registered nurse] Supervisor completed by RN #15 and dated 03/30/2025, which indicated 3. List all nursing staff caring for the resident during the time of incident and one shift prior: [Licensed Practical Nurse [LPN) #12 [Certified Nurse Aide (CNA) #11] [CNA #29] [CNA #28]. However, the facility investigation file did not contain evidence of statement from CNA #28 or CNA #29. During an interview on 12/05/2025 at 3:15 PM, the Administrator stated staff from the previous shifts since the last resident's skin check should have been interviewed. 2. An admission Record revealed the facility admitted Resident #77 on 09/30/2023. According to the admission Record, the resident had a medical history that included a diagnosis of senile degeneration of the brain. A quarterly Minimum Data Set (MDS), with an Assessment Reference Data (ARD) of 05/24/2025, revealed Resident #77 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. An admission Record revealed the facility admitted Resident #80 on 11/14/2024. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and vascular dementia. A quarterly MDS, with an ARD of 05/20/2025, revealed Resident #80 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. The facility five-day report dated 08/19/2025 indicated on 08/14/2025, Resident #77 wheeled over to Resident #80 and started to pull Resident #80's hair. Per the five-day report, Resident #80 yelled and staff separated the residents immediately. The five-day report indicated Resident #80's scalp was red but there were no break in the skin noted. During an interview on (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/05/2025 at 11:01 AM, Licensed Practical Nurse (LPN) #17 stated she witnessed the incident between Resident #77 and Resident #80. LPN #17 stated the facility usually requested witness statements from the staff, but she was unaware if facility management asked for her statement, because the incident occurred at the end of her shift and she went home. The facility investigation file did not contain a witness statement from LPN #17. During an interview on 12/05/2025 at 11:23 AM, the Director of Nursing (DON) stated LPN #17 was the nurse on the unit at the time and witnessed the incident between Resident #77 and Resident #80. The DON stated she was unaware if LPN #17 was asked for a witness statement. During an interview on 12/05/2025 at 11:29 AM, the Administrator stated there should have been witness statements from any staff that was in the area at the time of the incident.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Surveyor: Rachele KempBased on interview, record review, and facility policy review, the facility failed to ensure a pharmacy recommendation was implemented for 1 (Resident #37) of 5 sampled residents reviewed for unnecessary medications. Findings include: An undated facility policy titled, Medication Regimen Review and Reporting, indicated, Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. The policy specified, 2. The Consultant's Pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated. Per the policy, 8. The facility follows up on the recommendations to verify that appropriate action has been taken. Recommendations shall be acted upon in a timely manner. a. For those issues that require Physician intervention, the attending Physician either accepts and acts upon the report and recommends or rejects all or some of the report and should document his or her rationale of whey the recommendation is rejected in the resident's medical record. An admission Record revealed the facility admitted Resident #37 on 08/29/2025. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and cerebral atherosclerosis. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/29/2025, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Resident #37's Order Summary Report for active orders as of 12/05/2025, revealed an order dated 08/29/2025, for lactobacillus capsule, give two capsules by mouth one time a day related to cerebral atherosclerosis. Resident #37's pharmacy MRR for 09/02/2025, revealed a recommendation from the Consultant Pharmacist to Add a strength to the resident's order for lactobacillus capsule. Per the pharmacy MRR, the resident's order for lactobacillus only indicated to give two capsules by mouth one time a day. During an interview on 12/05/2025 at 8:10 PM, Licensed Practical Nurse Unit Manager #9 stated he was unable to locate Resident #37's MRR that contained the physician's signature to indicate the physician reviewed the Consultant Pharmacist's recommendation. During an interview on 12/05/2025 at 9:31 AM, the Consultant Pharmacist stated the recommendation for Resident #37's order for lactobacillus had not been corrected. The Consultant Pharmacist stated every medication needed to include a strength. During an interview on 12/05/2025 at 1:18 PM, Resident #37's primary physician stated if he would have seen the Consultant Pharmacist's recommendation for Resident #37's order for lactobacillus, he would have signed the recommendation to indicate agreement. Resident #37's primary physician stated lactobacillus was available in different strengths and he expected the order to include the dosage (strength). During an interview on 12/05/2025 at 1:45 PM, the Director of Nursing (DON) stated she expected staff to maintain a copy of the signed MRR for each resident. Per the DON, the physician should respond to the pharmacist's recommendations within a day or two. The DON stated the pharmacist's recommendation for Resident #37's lactobacillus should have been follow-up on. During an interview on 12/05/2025 at 2:16 PM, the Administrator stated MRRs should be completed in a timely fashion and followed up on by the physician.