STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. Building B. Wing	05/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Eden Hill, LLC	300 Banning Street Dover, DE 19904

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, it was determined that for three (R38, R76, and R234) out of four residents reviewed for Advance Directives, the facility failed to offer an opportunity to formulate an advance directive. Findings include: 1. Review of R38's clinical record revealed: 4/30/25 - R38 was admitted to the facility. 5/1/25 - A BIM's assessment was completed for R38 with a score of 15 indicating R38 was cognitively intact. 5/1/25 11:05 AM - A social history assessment was completed for R38 and documented that R38 was a full code and had a general POA. The assessment did not determine if R38 had an advanced directive or wanted to formulate one. 5/14/25 10:38 AM - During an interview, E18 (Clinical Liaison) confirmed that the admitting nurse is responsible to review admission documents with the residents upon admission. 5/14/25 10:42 AM - During an interview, E13 (LPN) confirmed that the admitting nurse is responsible to complete the resident assessments. 5/14/25 12:17 PM - During an interview, E1 (NHA) and E2 (DON) stated that the physician will discuss advanced care options with the residents during an exam. 2. Review of R76's clinical record revealed: 4/23/25 - R76 was admitted to the facility. 4/24/25 - A BIM's assessment was completed for R76 with a score of 15 indicating R76 was cognitively intact. 4/24/25 4:02 PM - A social history assessment was completed for R76 and documented that R76 was a full code. The assessment did not determine if R76 had an advanced directive or wanted to formulate one. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/14/25 10:38 AM - During an interview, E18 (Clinical Liaison) confirmed that the admitting nurse is responsible to review admission documents with the residents upon admission. 5/14/25 10:42 AM - During an interview, E13 (LPN) confirmed that the admitting nurse is responsible to complete the resident assessments. 5/14/25 12:17 PM - During an interview, E1 (NHA) and E2 (DON) stated that the physician will discuss advanced care options with the residents during an exam. 3. Review of R234's clinical record revealed: 5/9/25 - R234 was admitted to the facility. 5/10/25 12:02 PM - A BIM's assessment was completed for R234 with a score of 15 indicating R234 was cognitively intact. 5/11/25 6:30 AM - A social history assessment was completed for R234 and documented that R234 was a full code. The assessment did not determine if R234 had an advanced directive or wanted to formulate one. 5/14/25 10:38 AM - During an interview, E18 (Clinical Liaison) confirmed that the admitting nurse is responsible to review admission documents with the residents upon admission. 5/14/25 10:42 AM - During an interview, E13 (LPN) confirmed that the admitting nurse is responsible to complete the resident assessments. 5/14/25 12:17 PM - During an interview, E1 (NHA) and E2 (DON) stated that the physician will discuss advanced care options with the residents during an exam. The facility lacked evidence of offering an opportunity to formulate an advance directive for R38, R76 and R234. 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).

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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 - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, it was determined that for one (R24) out of two residents reviewed for abuse, the facility failed to report the allegations of abuse to the State Agency within two hours. Findings include: A facility policy titled, Abuse and Neglect Prohibition last revised October 12, 2022, documented: 1. State Reporting Obligations: The facility will report all allegations and substantiated occurrences of abuse, neglect . to the administrator, State Survey Agency . in accordance with Federal and State law through established procedures. a. If the events that caused the allegation involve abuse .a report is made not later than 2 hours after the management staff becomes aware of the allegation 1. Review of R24's clinical record revealed: 4/15/25 - R24 was admitted to the facility. 4/16/25 - A BIMS assessment documented that R24 was cognitively intact with a score of 15. 5/10/25 - R24 stated that nursing staff touched her inappropriately while taking vital signs. 5/12/25 3:01 PM - E1 (ED) reported the allegation of abuse incident to the State Agency. 5/19/25 9:22 AM - During an interview, E10 (RN) stated that on 5/10/25, E11 (LPN) notified her about an allegation of abuse from R24. E10 stated that she went to interview R24, and R24 stated that a nurse on the overnight shift had touched the side of her breast while taking her vital signs. E10 then stated she let E2 (DON) know that same day. E10 then continued to do interviews for the investigation. 5/19/25 1:35 PM - During an interview, E2 stated that E10 did tell her about the incident from R24 on 5/10/24 and asked E10 to do the investigation. E2 further confirmed this was an allegation of abuse and explained that was why the investigation was started that day. The report of the alleged abuse was submitted two days after the alleged incident occurred. 5/20/25 2:15 PM - Findings were reviewed with E1 and E2.

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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 interview and record review it was determined that for one (R38) out of twenty-four residents reviewed in the investigative sample, the facility failed to follow a physician's order. Findings include: 1. Review of R38's clinical record revealed: 4/30/25 - R38 was admitted to the facility. 4/30/25 - A physician's order was written for metoprolol tartrate 25 mg give one tablet by mouth two times a day for hypertension and hold for SBP (systolic blood pressure) less than 110 and heart rate less than 60. 5/2025 - The May MAR documented metorprolol tartrate 25 mg given on the following dates when the systolic blood pressure or heart fell outside of the parameters: -5/11/25 BP 124/59 HR 55. -5/13/25 BP 128/62 HR 58. -5/14/25 BP 145/60 HR 55. -5/15/25 BP 143/62 HR 55. 5/20/25 9:41 AM - During an interview, E5 (NP) stated the expectation with medications not meeting parameters to administer should be reported to the medical provider and the expectation was for the medication to be held. E5 confirmed that she was not aware of R38's medication being held for parameters and confirmed that medication was administered with no adverse effects noted. 5/20/25 10:40 AM - During an interview, E15 (RN) stated the expectation with medications not meeting parameters would be to hold the medication and explain to the resident why it is being held. E15 also stated that the medication being held should be reported to the provider. E15 confirmed that R38's medication was administered from the aforementioned dates. 5/20/25 2:15 PM - Findings were reviewed with E1 (ED) and E2 (DON).