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	05/22/2026

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 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 record review and interview it was determined that for one (R108) out of twenty-eight sampled residents the facility failed to create an individualized care plan to address R108's use of a specialized TLSO brace. Findings include:7/18/25 - R108 was admitted to the facility with multiple diagnoses including a broken bone in her back [lumbar]. 7/21/25 - Care plans were initiated for R108. Review of the care plans lacked evidence of a care plan created for R108's TLSO brace. 7/22/25 - An admission MDS assessment documented that R108 had fractures as active diagnoses and required partial moderate assistance with upper body dressing. 8/20/25 8:52 PM - A neurologist consultant appointment note in R108's clinical record documented, continue to wear brace, must be supporting of her lumbar spine. 8/25/25 - A physician's progress note in R108's clinical record documented, Patient had L1 compression fracture. Patient was evaluated at bedside, stating that she is feeling weak. She has a (TLSO) brace, seems to be very wide as it is going to her chest. Also, she is not strong enough to able to apply a very tightly, which may be impeding her healing of the fracture. July 2025 - POC documentation attested to application of the TLSO brace at all times. August 2025 - POC documentation attested to application of the TLSO brace at all times. 5/22/26 12:11 PM - During an interview E4 (CNA) reported that in general instruction about TLSO braces is through verbal report. 5/22/26 2:54 PM - During an interview E2 (DON) confirmed that the facility failed to develop a care plan related to R108's use of the TLSO brace and interventions for its application, positioning and tightness for desired outcome. 5/22/26 3:40 PM - Findings were reviewed at the exit conference with E1 (NHA) and E2 (DON).

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 (R108) out of four residents reviewed for hospitalization the facility failed to ensure that the residents discharge medication orders were correctly transcribed. The incorrect transcription resulted in the administration of a decreased dosage of R108's antidepressant medication. Findings include: Review of R108's clinical record revealed:7/14/25 - 7/18/25 - R108 was hospitalized . Discharge instructions dated 7/18/25 directed that R108 continue prescribed medications, including fluoxetine 20 mg daily for depression. 7/18/25 - R108 was admitted to the facility with multiple diagnoses including depression. 7/19/25 - A physician's order was written for R108 to receive fluoxetine 10 mg daily for depression. The clinical record was unclear why the antidepressant medication dosage was reduced from the order on the discharge documentation. 7/22/25 - An admission MDS assessment documented that R108 had a diagnosis of depression and received antidepressant medication. 7/24/25 - An initial psychology visit note documented that R108 had mild depression. 7/26/25 - A care plan for depression was created for R108 with the intervention to administer medication according to physician's order. July 2025 - Review of R108's MAR revealed thirteen doses of fluoxetine 10 mg given. August 2025 - Review of R108's MAR revealed four doses of fluoxetine 10 mg given. 8/4/25 - A psychiatry progress note in R108's clinical record documented Depression/Anxiety. Change fluoxetine to 20 mg to target mood. 8/4/25 - A physician's order was written to increase R108's fluoxetine from 10 mg daily to 20 mg daily for depression. 8/4/25 - 4:11 PM - A progress note in R108's clinical record documented, Per daughter the patient is on 20 mg of [fluoxetine], records review noted a transcription error and daughter was made aware of this and attending physicians as well as Psych NP was notified and the medication was updated to the home does of 20 mg daily. 5/22/26 2:54 PM - E2 (DON) confirmed that the facility failed to correctly transcribe the initial order for R108's antidepressant medication resulting in seventeen undermedicated doses. 5/22/26 3:40 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.

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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 two (R77 and R2) out of six residents reviewed for unnecessary medications the facility failed to ensure prompt pharmacy services were provided to newly admitted residents resulting in missed doses of medications. Findings include:3/28/24 - The facility policy for admissions documented that persons will be accepted for admission on ly if the services and or care provided can reasonably be provided. 1. Review of R77s' clinical record revealed: 4/4/26 8:00 PM - R77 was admitted to the facility with multiple diagnoses including anxiety. 4/4/26 - A physician's order was written for R77 to receive clonazepam twice daily for anxiety. 4/4/26 11:24 PM - A progress note in R77's clinical record documented that the resident was not given their ordered clonazepam because staff was waiting for pharmacy to clear order. 4/5/26 8:07 AM - A progress note in R77's clinical record documented that the resident was not given their ordered clonazepam because pharmacy was awaiting signature. 4/5/26 10:48 PM - A progress note in R77's clinical record documented Medication not available. Called pharmacy, prescription on file not valid. Called team health, spoke with NP and requested script to be sent to pharmacy. NP herself was unable to send prescription but will attempt to get peer to send script to pharmacy. Provided with pharmacy phone and fax numbers. April 2026 - Review of R77's MAR revealed missed doses of the resident's anxiety medication on the following dates/times:4/4 - 10:00 PM4/5 - 8:00 AM4/5 - 10:00 PM. 4/6/26 - A pharmacy invoice of delivered medications documented arrival of R77's clonazepam. 5/18/26 9:45 AM - During an interview R77 stated, They stopped my medication I have severe anxiety. They stopped my Klonopin/clonazepam for no reason when I came. 2. Review of the Medex Drug information website revealed, Missing doses of quetiapine significantly increases the risk of relapse for conditions like schizophrenia and bipolar disorder. Understanding what happens if you miss doses of quetiapine is crucial for managing your mental health effectively and preventing complications. What Happens if you Miss Doses of Quetiapine? medexdrg.com. Review of R2's clinical record revealed; 4/8/26 3:24 PM - R2 was admitted to the facility with multiple diagnoses including Major Depressive and Mood disorder. 4/8/26 - A physician's order was written for R2 to receive quetiapine an antipsychotic medication daily at 9:00 PM for mood disorder. 4/9/26 3:22 AM - A progress note in R2's clinical record documented that R2 did not receive the quetiapine because it was not yet delivered from the pharmacy. 4/9/26 3:33 PM - A pharmacy invoice of delivered medications documented that R2's quetiapine was delivered. 4/9/26 - 11:49 PM - A progress note in R2's clinical record documented that R2 did not receive the quetiapine because it was not yet delivered from the pharmacy. 4/14/26 - An admission MDS assessment documented that R2 received antipsychotic medications. 4/14/26 - A care plan was created for R2's use of antipsychotic medications. April 2026 - Review of R2's MAR lacked evidence that R2 received the ordered quetiapine on 4/8 and 4/9. 5/20/26 10:51 AM - During an interview E15 (RNUM) confirmed that R2's medications were not administered for two doses. E15 stated if we call the pharmacy before 6:00 PM then they will deliver by the next day. During the same interview E15 (RN) and staff developer reported, if it is a STAT medication than we can usually get it right away but most medications come the following morning. 5/20/26 10:56 AM - During an interview E8 (LPN) confirmed that at times newly admitted residents do not have all their medications. E8 stated, We then go to back up and tell the supervisor. 5/20/26 10:59 AM - During an interview E14 (LPN) confirmed that sometimes newly admitted residents do not have all their medications. E14 stated, When they don't we check the emergency box to see if any of the medication is there. We call the doctor to see if we can get a hold. Review of the facilities emergency medication inventory list revealed that quetiapine is not a medication stored int he emergency box. 5/21/26 11:52 AM - During an interview E2 (DON) confirmed that pharmacy delivery for new residents can be 24 to 48 hours resulting in missed dosages of medication for R2 and R77. E2 stated, The delivery run is 11:00 AM and (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3:00 AM and something in the afternoon. Our pharmacy is in Baltimore so it takes time. 5/22/25 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).