STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs Rehabilitation at Brandywine	505 Greenbank Road Wilmington, DE 19808

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Number of residents sampled: Number of residents cited: (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and facility policy review, the facility failed to respect a resident's right to refuse a medication for 1 (Resident #181) of 7 sampled residents reviewed for choices.Findings included:A facility policy titled, Promoting/Maintaining Resident Dignity, revised 02/2025, indicated, 2. During interactions with residents, staff must report, document and act upon information regarding resident preferences.Resident #181's admission Record revealed the facility admitted the resident on 03/25/2025. According to the admission Record, the resident had a medical history that included diagnoses of anxiety disorder, conversion disorder, rheumatoid arthritis, and depression. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/01/2025, revealed Resident #181 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition.Resident #181's Care Plan Report, revealed a focus area initiated on 03/02/2025, that indicated the resident had the potential for constipation. Interventions directed staff to administer bowel medications and provide interventions as ordered. Further review revealed staff were to monitor and document bowel sounds and abdominal distention if Resident #181 refused bowel interventions.Resident #181's Order Summary Report, with active orders as of 04/07/2025, revealed an order dated 03/02/2025 for Dulcolax suppository 10 milligrams (mg) with instructions to inserted rectally as needed if the resident did not have a bowel movement after milk of magnesia was administered. Resident #181's 04/2025 Medication Administration Record revealed that Registered Nurse (RN) #13 documented that they administered Dulcolax suppository 10 mg on 04/07/2025.A Council Concern/Recommendation Form, dated 04/10/2025, indicated Resident #181's family had expressed concern about a bowel suppository being administered to Resident #181. A typed Interview with [Resident #181] document dated 04/09/2025 indicated that Resident #181 stated that they had told the nurse (RN #13) that they did not want a suppository medication because they had already had a bowel movement earlier in the day. The document revealed Resident #181 stated that the nurse asked them several times about taking the medication, and Resident #181 felt like the RN was calling them a liar. The document revealed Resident #181 stated the nurse asked them again to take the suppository with their nighttime medications, and the resident had agreed to the medication. A bowel movement record revealed Resident #181 had a large bowel movement on 04/07/2025 at 9:30 AM and a medium bowel movement at 2:21 PM. During a telephone interview on 12/07/2025 at 10:45 AM, RN #13 stated he had been notified by the unit supervisor that Resident #181 was on the bowel protocol due to not having a bowel movement for three days. RN #13 stated there was a printed list of residents who did not have a bowel movement, and Resident #181 was on the list. RN #13 stated he had attempted several times to administer the suppository to Resident #181, but Resident #181 had refused. RN #13 stated he was not aware of any documentation that Resident #181 had a bowel movement earlier in the day. RN #13 stated that when he administered nighttime medications, he had reiterated to Resident #181 that it was important to take their medications, and Resident #181 had agreed and accepted the medication. RN #13 stated he did not see any documentation that Resident #181 had a bowel movement earlier that day. During an interview on 12/07/2025 at 12:08 PM, Licensed Practical Nurse (LPN) Supervisor #4 stated if a resident was on the bowel program list and the resident reported that they had a bowel movement, she would do a bowel assessment and try to verify that the resident had a bowel movement. LPN Supervisor #4 stated she would talk to the assigned certified nurse aide (CNA) and review the electronic health record (EHR) to confirm whether the resident had a bowel movement prior to making additional attempts to administer the suppository. During an interview on 02/07/2025 at 12:43 PM, the Assistant Director of Nursing (ADON) stated the bowel protocol list was printed every morning and included any residents who had not had a bowel movement documented in the previous nine shifts. The ADON stated the list was provided to the nurse, who should attempt to administer milk of magnesia during the day. The ADON stated that if the milk of magnesia was not effective, the evening shift nurse should administer a suppository. The ADON stated that if a resident told the nurse they had a bowel movement, the nurse should check the EHR to see if a bowel movement was documented prior to attempting to administer the suppository. The ADON stated that if the resident already had a bowel movement, the nurse should not continue with the bowel protocol.During an interview on 12/07/2025 at 1:02 PM, LPN #14, the Quality Assurance nurse, stated the bowel protocol list was printed every morning, and any resident who had not had a bowel movement in three days would be on the list. LPN #14 stated if a resident told the nurse they had already had a bowel movement, the nurse should stop attempting to administer the medication and

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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. Number of residents sampled: Number of residents cited: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, record review, facility document review, and interview, the facility failed to report allegations of abuse or injuries of unknown origin to the state survey agency within required timeframes, which affected 3 (Residents #67, #178, and #185) of 7 residents reviewed for abuse or injuries of unknown origin.Findings included:A facility policy titled, Abuse, Neglect and Exploitation, revised 05/2025, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy revealed the Guidelines included, 2. The facility will designate an Abuse Prevention Coordinator in the facility who is responsible for reporting allegations or suspected abuse, neglect, or exploitation to the state survey agency and other officials in accordance with state law. The policy revealed, IV. Identification of Abuse, Neglect and Exploitation included, B. Possible indicators of abuse include, but are not limited to, which included, 1. Resident, staff or family report of abuse, 3. Physical injury of a resident, of unknown source, 5. Verbal abuse of a resident overheard, 6. Physical abuse of a resident observed, and 7. Psychological abuse of a resident observed. The policy revealed, VII. Reporting/Response included, A. The facility will have written procedures that include, which included, 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. [exempli gratia; for example], law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.1. Resident #185's admission Record indicated the facility admitted the resident on 02/26/2025. According to the admission Record, the resident had a medical history that included diagnoses of type two diabetes mellitus, cirrhosis of the liver, and aphasia.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/04/2025, revealed Resident #185 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment.Resident #185's Care Plan Report included a focus area revised on 08/25/2025, that indicated that the resident had a behavior problem of refusing medications, weights, showers, repositioning, and hygiene care related to their disease process. Interventions initiated 07/20/2023 directed staff to anticipate and meet the resident's needs, provide the opportunity for positive interaction, and to explain all procedures to the resident before starting and to allow the resident to adjust to changes. Resident #185's Progress Notes revealed a note, dated 08/10/2025, that revealed the Medical Director (MD) assessed Resident #185 following an incident with staff earlier in the day. The note indicated that there were no reports of injury, and the resident appeared to be at their usual baseline and denied any complaints. Resident #185's Progress Notes revealed a note, dated 08/11/2025, that revealed the MD followed up with the resident following an incident over the weekend, and the resident remained unaffected with no new injuries. Certified Nursing Assistant (CNA) #2's typed statement, dated 08/10/2025, revealed that CNA #2 asked Licensed Practical Nurse (LPN) #1 at 5:30 AM to assist her with Resident #185's care due to the resident being combative. Per CNA #2's statement, LPN #1 called Resident #185 an expletive and ignorant, and hit the resident on their hand and their face. The statement indicated that CNA #2 did not intervene and protect the resident because she was in shock. Registered Nurse (RN) Supervisor #3's undated typed statement indicated that CNA #2 asked to speak with her after her shift was over on 08/10/2025 and reported to her that she and LPN #1 were in Resident #185's room providing care earlier in the overnight shift. Per the statement, CNA #2 further reported that she witnessed LPN #1 hitting Resident #185 on the body and yelling at them. The statement indicated that CNA #2 then asked RN Supervisor #3 not to say anything until after LPN #1 was out of the building before anyone was notified.A typed Interview with [Resident #185], dated 08/10/2025 at 12:41 PM, indicated that #185 stated yes, when asked if they experienced any issues overnight but could not further elaborate. An Incident Reporting System report, completed by the Director of Nursing (DON) indicated that CNA #2 reported that Resident #185 was combative during care, and LPN #1 was allegedly rough with the resident while assisting CNA #2. The report indicated that the abuse allegation was discovered on 08/10/2025 at 9:07 AM, over four hours after the alleged incident. During an interview on 12/03/2025 at 8:01 AM, the DON stated that she received a call from RN Supervisor #3 on her way to work on 08/10/2025. Per the DON, RN Supervisor #3 reported to her that CNA #2 came to her and told her she felt LPN #1 was rough with Resident #185 when providing care. The

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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. Number of residents sampled: Number of residents cited: (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, record review, facility document review, and interview, the facility failed to thoroughly investigate an allegation of staff-to-resident physical and verbal abuse for 1 (Resident #185) of 7 residents reviewed for abuse or injuries of unknown origin.Findings included:A facility policy titled, Abuse, Neglect and Exploitation, revised 05/2025, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy revealed, VI. Protection of Resident, which included, The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.Resident #185's admission Record indicated the facility admitted the resident on 02/26/2025. According to the admission Record, the resident had a medical history that included diagnoses of type two diabetes mellitus, cirrhosis of the liver, and aphasia.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/04/2025, revealed Resident #185 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment.Resident #185's Care Plan Report included a focus area revised on 08/25/2025, that indicated that the resident had a behavior problem of refusing medications, weights, showers, repositioning, and hygiene care related to their disease process. Interventions initiated 07/20/2023 directed staff to anticipate and meet the resident's needs, provide the opportunity for positive interaction, and to explain all procedures to the resident before starting and to allow the resident to adjust to changes. Resident #185's Progress Notes revealed a note, dated 08/10/2025, that revealed the Medical Director (MD) assessed Resident #185 following an incident with staff earlier in the day. The note indicated that there were no reports of injury, and the resident appeared to be at their usual baseline and denied any complaints. Resident #185's Progress Notes revealed a note, dated 08/11/2025, that revealed the MD followed up with the resident following an incident over the weekend, and the resident remained unaffected with no new injuries. Certified Nursing Assistant (CNA) #2's typed statement, dated 08/10/2025, revealed that CNA #2 asked Licensed Practical Nurse (LPN) #1 at 5:30 AM to assist her with Resident #185's care due to the resident being combative. Per CNA #2's statement, LPN #1 called Resident #185 an expletive and ignorant, and hit the resident on their hand and their face. The statement indicated that CNA #2 did not intervene and protect the resident because she was in shock. Registered Nurse (RN) Supervisor #3's undated typed statement indicated that CNA #2 asked to speak with her after her shift was over on 08/10/2025 and reported to her that she and LPN #1 were in Resident #185's room providing care earlier in the overnight shift. Per the statement, CNA #2 further reported that she witnessed LPN #1 hitting Resident #185 on the body and yelling at them. The statement indicated that CNA #2 then asked RN Supervisor #3 not to say anything until after LPN #1 was out of the building before anyone was notified.A typed Interview with [Resident #185], dated 08/10/2025 at 12:41 PM, indicated that #185 stated yes, when asked if they experienced any issues overnight but could not further elaborate. The facility's DHCQ [Department of Health Care Quality] FRI [facility reported incident], dated 08/14/2025, indicated that CNA #2 reported that Resident #185 was combative during care and LPN #1 was allegedly rough with the resident while assisting CNA #2. The document indicated that the Nurse Practitioner (NP) and family were made aware of the allegation, and LPN #1 was immediately placed on administrative leave. Per the document, local police were notified and responded. The document indicated that after the police interview with CNA #2, and the alleged victim, the officer found no evidence of abuse or criminal activity. The MD was in the facility and conducted a physical exam on 08/10/2025 and found no evidence of abuse or trauma. A head-to-toe assessment was completed, and findings were within normal limits. Other residents with appropriate BIMS assigned to the accused nurse were interviewed, and all reported no concerns. Statements were obtained from LPN #1, CNA #2, and RN Supervisor #3, and findings were inconclusive. This abuse allegation was reported to the state agency on 08/10/2025 at 9:07 AM. The facility's investigation revealed no evidence of cognitively impaired residents being assessed for signs of physical abuse following the incident.LPN #1's time sheet indicated she clocked in on 08/09/2025 at 11:15 PM and clocked out on 08/10/2025 at 7:22 AM, over an hour and a half after the alleged incident occurred. LPN #1's personnel file included a letter from the state's DHCQ, dated 11/25/2025, that indicated the Division of Long-Term Care Residents Protection substantiated a finding against LPN #1 and added her to the Adult Abuse Registry for two years starting on 11/25/2025. The letter indicated that on 08/10/2025, a CNA witnessed LPN #1 using

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Number of residents sampled: Number of residents cited: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on facility policy review, record review, facility document review, and interview the facility failed to ensure that residents were free from accident hazards related to the inappropriate use of a mechanical lift, which affected 1 (Resident #184) of 10 residents reviewed for accidents.Findings included:A facility policy titled, Safe Lifting and Movement of Residents, revised 06/2025, indicated, In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. The policy revealed, 1. Resident safety, dignity, comfort and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents.An admission Record indicated the facility admitted Resident #184 on 04/11/2025. According to the admission Record, the resident had a medical history that included diagnoses of unspecified abnormalities of gait and mobility, unspecified lack of coordination, and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a stroke) affecting left non-dominant side.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/11/2025, revealed Resident #184 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated that Resident #184 was dependent on staff for chair/bed-to-chair transfers.Resident #184's June 2025 Documentation Survey Report, which was the resident's Kardex (a guide for direct caregivers that outlined each resident's care needs), indicated that Resident #184 required transfers with the use of a mechanical lift. The document indicated that resident transfers were to be done with the assistance of two people.Resident #184's Progress Notes revealed a note, dated 06/17/2025 at 2:45 PM, that revealed that Resident#184 was found on the floor next to the bed, still connected to their mechanical lift. The note indicated that the certified nursing assistant (CNA) was trying to transfer the resident from the chair to the bed. The note indicated that Resident #184 complained of pain to the right elbow, neck, and back at a pain level of 8 out of 10. Per the note, the resident stated that they had fallen from the mechanical lift. The note revealed that the resident was sent to the emergency room, per physician orders. The document indicated that the resident's family member was present at the time and accompanied the resident to the hospital.Resident #184's Emergency Department instructions, dated 06/18/2025 at 3:24 AM, indicated that while at the emergency department, an X-ray imaging of Resident #184's extremities was obtained and showed no factures or dislocations. The document indicated that a computed tomography (CT) scan showed no acute findings worrisome of fractures, dislocations, or bleeds. Resident #184's Progress Notes revealed a note, dated 06/18/2025 at 10:09 AM, that indicated that the Interdisciplinary Team (IDT) reviewed the resident's fall from 06/17/2025. The note indicated that a root cause analysis was conducted, which determined that the mechanical lift legs had made contact to the base of the geriatric chair, causing the resident's weight to shift and tilt the lift further, resulting in the resident being lowered to the floor. The note indicated that an assessment of the functionality of the mechanical lift was completed, with no issues identified.An Interview Statement, dated 06/18/2025 from Resident #184's family member (FM), FM #34, indicated that CNA #8 was unable to find anyone to assist her in putting the resident back in bed, so FM #34 offered to help CNA #8 transfer the resident. The statement indicated that the mechanical lift did not clear the top of the bed, and they were not able to swing the mechanical lift around. The statement indicated that CNA #8 tried to pull Resident #184 onto the bed when the resident's body shifted, the mechanical lift tilted over and fell to the side, and the resident was lowered to the floor by FM #34 and CNA #8.During an interview on 12/03/2025 at 1:18 PM, Licensed Practical Nurse (LPN) #7 stated that the facility process was that staff were to use two staff persons when operating the mechanical lift. LPN #7 stated that she was at the nurses' station when Resident #184's family member came and asked for help. The LPN stated that when she entered the resident's room, the resident was noted on the right side of the bed on the floor. She stated that there was only one staff person present in the room at that time with the mechanical lift. During an interview on 12/03/2025 at 1:51 PM, CNA #8 stated that she no longer worked for the facility and up until 06/2025, had been employed by the facility for a year and a half. CNA #8 stated that when she transferred a resident using the mechanical lift, it required the use of two people. She stated that on 06/18/2025, Resident #184 had come in from outside with their family member and needed to be transferred into the bed. CNA #8 stated that she was impatient and used the lift to transfer Resident #184 by herself, and she was not supposed to transfer the resident with the mechanical lift by herself. During an interview on 12/06/2025 at 10:49 AM, Director of Nursing (DON) stated that the facility had a process related