

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET WILMINGTON, DE 19806</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p><b>INITIAL COMMENTS</b></p> <p>An unannounced complaint survey was conducted at this facility from April 3, 2014 through April 9, 2014. The deficiencies cited in this report are based on record reviews, interviews, and review of other documentation as indicated. The facility census the first day of the survey was 90. The sample size included two (2) active records.</p>	F 000	<p>This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. Submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>	
F 157 SS=D	<p><b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b></p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>	F 157	<p>A. The legal representative for R1 is now being notified of all significant changes in R1's physical status.</p> <p>B. All residents that have significant changes in their physical status are at risk for being affected by this deficient practice.</p>	<p>6/25/14</p> 

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Diana M. Swain</i>	TITLE  <i>S15114</i>	(X6) DATE
--	----------------------------	-----------

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET WILMINGTON, DE 19806</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	Continued From page 1  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other documentation, it was determined that the facility failed to notify the resident's legal representative for one (R1) out of 2 sampled residents when there were significant changes in R1's physical status. Findings include:  The facility's policy entitled "Notification of Change of Condition: Resident and Responsible Party/Guardian", last revised in November 2010, stated, "... 1. When any one of the following instances occurs, the resident, and the resident's responsible party or guardian will be notified: a. There is a significant change in the resident's physical ... status ... and the need to alter therapy (i.e. medications, treatments) ... f. There has been any break in the resident's skin integrity ... 2. The nurse must document the name of the person notified, the reason for notification, date and time in the nurse's notes ... 3. If *official notification has not occurred by the end of a shift, the next shift will continue to try to reach the family and the resident will be placed on the 24-hour report. The resident will remain on report until *official notification occurs and is documented in the nurse's notes. *Official notification exists ONLY when there is actual contact, (not an answering service, machine or busy signal). Attempts must continue and be documented until responsible party is contacted."	F 157	C. (1) Regency Healthcare and Rehabilitation will begin using a 24 Hour Report /Change in Condition Report that indicates if the Responsible party has been notified or not. (Attachment A). (2) The Staff Educator will educate licensed nursing staff on the 24 Hour Report /Change in Condition Report.  D. On an ongoing basis the 24 Hour Report/Change in Condition Report will be reviewed in the morning meeting. The D.ON./designee will calculate compliance for notification of the resident's legal party on a weekly basis. Compliance rate will be reported in monthly QA & A until 100% compliance is achieved for 3 months and ongoing as needed.	6/25/14 	

*Lucy m Sen 5/5/14*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET</b> <b>WILMINGTON, DE 19806</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 157	<p>Continued From page 2</p> <p>R1 was admitted to the facility on 4/28/06 with a diagnosis of Multiple Sclerosis (nervous system disease that affects the brain and spinal cord). The quarterly Minimum Data Set (MDS) assessment, dated 2/16/13, stated that R1 was able to make his/her own decisions.</p> <p>a. A nurse's note, dated 3/7/14 and timed 10:19 AM, revealed a physician order that included two new medications and a consult for hospice. The nurse's note stated, "... Family member called message left to call facility back regarding (sic) new order."</p> <p>Further review of nurse's notes from 3/7/14 through 3/10/14 revealed the absence of official notification to the Power of Attorney (POA) by the facility when there was a significant change.</p> <p>b. A nurse's note, dated 3/20/14 and timed 10:01 AM, revealed that R1 had two (2) open areas on her left and right buttock. The nurse's note stated "... rp (reporting person) notified."</p> <p>A second nurse's note, dated 3/20/14 and timed 11:00 AM, stated "new orders; d/c (discontinue) current valium (medication to relax muscles); start valium 5mg one tab (tablet) bid (twice a day) ...; fentanyl (medication for pain) patch ...; new tx (treatment) order; duoderm (absorbent wound dressing) to r (right) and l (left) buttocks open areas ...; rp notified x 3 attempts message left awaiting a call back".</p> <p>Further review of nurse's notes from 3/20/14 through 3/26/14 revealed the absence of official notification to the POA by the facility when open areas were identified on R1's buttocks and there was a change in therapy.</p>	F 157			

*Sharon M. Swain 5/5/14*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET</b> <b>WILMINGTON, DE 19806</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3  In an interview on 4/7/14 at 10:30 AM, F1 (R1's POA) stated that she was not notified about R1's hospice consult order on 3/7/14 in addition to the two open areas and change of therapy on 3/20/14.  Findings were reviewed with the E1 (Administrator) and E2 (Director of Nursing) on 4/9/14 at 4:10 PM.	F 157		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.	F 278	A. R2's MDS was corrected to reflect the proper coding.  B. All residents are at risk for being affected by this deficient practice.	6/25/14 ↓

*Jason Seem 5/5/14*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET</b> <b>WILMINGTON, DE 19806</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278	Continued From page 4 Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to accurately reflect the status of one (R2) out of 2 sampled residents. Findings include:  According to the admission history and physical assessment dated 7/17/13, R2 was admitted with conditions including blindness and use of an indwelling urinary catheter (appliance to empty the bladder).  Review of the quarterly Minimum Data Set (MDS) assessment, dated 3/11/14, revealed that R2 had adequate vision and did not have an indwelling urinary catheter.  In an interview on 4/9/14 at 2:52 PM, E3 (Registered Nurse Assessment Coordinator) confirmed the two errors on the 3/11/14 MDS assessment for R2.	F 278	C. (1) The Registered Nurse Assessment Coordinator will complete Point Click Care's Clinical training and tutorials on MDS Data Entry for MDS 3.0. (2) On an ongoing basis the Registered Nurse Assessment Coordinator will be responsible for completing all tutorial updates that are offered by Point Click Care that pertain to MDS 3.0 coding.  D. (1) The D.O.N./designee will audit various sections of the MDS for coding accuracy. The sample size of the audit will be 25% of the MDS's submitted monthly. (Attachment B). The results of the audit will be reported out in monthly QA & A until 100% compliance is achieved for 3 months, and ongoing as needed.	6/25/14	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	A. (1) R1 Nizoral Shampoo (medicated shampoo) was discontinued. (2) R1 personal hygiene is now being recorded and documented as per facility policy.		

*Done 5/5/14*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET</b> <b>WILMINGTON, DE 19806</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview and review of other documentation, it was determined that the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well-being in accordance with the plan of care for one (R1) out of 2 sampled residents. On 3/20/14, R1 was diagnosed with scalp dermatitis (abnormal skin condition) and the physician ordered to have her hair washed with a medicated shampoo two times a week for four weeks. The first application of the medicated shampoo to R1's hair was on 3/27/14, seven days after the physician ordered it. Findings include:</p> <p>The facility's policy entitled "Treatment Administration Technique and Documentation", last revised in June 2008, stated, "All treatments will be properly administered and documented on appropriate treatment record(s) to ensure all treatments are properly administered and documented, as ordered by physician."</p> <p>R1 was admitted to the facility on 4/28/06 with a diagnosis of Multiple Sclerosis (nervous system disease that affects the brain and spinal cord). The quarterly Minimum Data Set (MDS) assessment, dated 2/16/13, stated that R1 was cognitively intact (able to make own decisions) and required extensive assistance of one staff person for care.</p> <p>A physician order, dated 3/20/14 and timed 10:20 AM, stated, "shampoo hair c (with) Nizoral Shampoo (medicated shampoo) 2 x wk x 4 wks (two times a week times four weeks) scalp dermatitis".</p>	F 309	<p>B. All residents have the potential to be affected by this deficient practice.</p> <p>C. (1) All medicated shampoos and soaps will be added to the C.N.A.'s Unit at a Glance under the comments section. The Unit at a Glance is updated daily by the A.D.O.N. (Attachment C). (2). The facility's Shower Scheduled sheet was revised to include a section for C.N.A.'s to indicate if the nurse was notified of refusals of hygiene (Attachment D). The Staff Educator will educate C.N.A.'s on the revised Shower Schedule form. (3) The Staff Educator will educate licensed nurse on the need to document in nursing notes resident's refusing personal hygiene, and what additional attempts to provide hygiene was tried.</p>	6/25/14	

*Debra Deen 5/5/14*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET</b> <b>WILMINGTON, DE 19806</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 6</p> <p>Review of a pharmacy delivery receipt, dated 3/20/14 and timed 4:36 PM, revealed the medicated shampoo was received and signed by E4 (Registered Nurse).</p> <p>Review of R1's shower schedule for March 2014 revealed that R1 was scheduled for showers every Monday and Thursday on the 3:00 PM to 11:00 PM shift. The shower schedule form stated, "CNA's (Certified Nurse's Aides) on each shift are responsible for documenting the type of personal hygiene provided. If the resident refuses personal hygiene offered then alternate shifts are to continue to offer and document if given. *If resident refuses the personal hygiene care offered it is to be reported to the nurse caring for the resident so the refusal can be documented."</p> <p>According to the March 2014 Shower Schedule for R1, E5 (CNA) documented "R" (refused) on Thursday, 3/20/14.</p> <p>Review of the Nurse's Notes on 3/20/14 revealed absence of documentation of the shower refusal by R1. Further review of the nurse's notes from 3/21/14 through 3/23/14 revealed the absence of additional attempts to shower R1.</p> <p>R1 was scheduled to have a shower on Monday, 3/24/14, on the 3:00 PM to 11:00 PM shift. According to the March 2014 Shower Schedule, E6 (CNA) documented "BB" (bed bath) on Monday, 3/24/14.</p> <p>In an interview on 4/9/14 at 10:00 AM, E6 stated she gave R1 a bed bath on Monday evening, 3/24/14. E6 stated, "I don't wash the hair with a bed bath." In addition, E6 stated that she was not aware of a medicated shampoo for R1.</p>	F 309	<p>D.) (1) The D.O.N/designee will audit 100% of residents that are ordered medicated shampoos and soaps to review compliance of treatments being documented on the Unit at Glance form, and TAR's. (Attachment E). The audit will occur weekly. The results of the audit will be reported out in monthly QA &amp; A until 100% compliance is achieved for 3 months, and ongoing as needed.</p> <p>(2) The D.O.N/designee will review 50% of all residents Shower Schedule to review compliance of that C.N.A. that refusal of hygiene were reported by the C.N.A. to the nurse, and that the nurse documented in the nursing notes the refusal, along with additional attempts to provide care. (Attachment E). The results of the audit will be reported out in monthly QA &amp; A until 100% compliance is achieved for 3 months, and ongoing as needed.</p>	6/25/14	

*Denise Sevin 5/4/14*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>04/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET WILMINGTON, DE 19806</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 7  Review of the March 2014 Shower Schedule revealed that R1 was showered with the medicated shampoo on Thursday, 3/27/14. The first application of the medicated shampoo occurred seven days after the physician ordered the treatment on 3/20/14.  The facility failed to provide the necessary care and services in accordance with R1's plan of care when a 3/20/14 physician's order for treating an abnormal skin condition with a medicated shampoo was not administered until 3/27/14, seven days later.  Findings were reviewed with the E1 (Administrator) and E2 (Director of Nursing) on 4/9/14 at 4:10 PM.	F 309			
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.  This REQUIREMENT is not met as evidenced by: Cross refer to F309. Based on record review, interview and review of other documentation, it was determined that the facility failed to provide the necessary services to maintain personal hygiene for one (R1) out of 2 sampled dependent residents. Findings include:  The facility's policy entitled "Assistance with	F 312	A. (1) R1 Nizoral Shampoo (medicated shampoo) was discontinued. (2) R1 personal hygiene is now being recorded and documented as per facility policy.  B. All residents have the potential to be affected by this deficient practice.	6/25/14  ↓	

*Done Seen 5/19/14*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2014</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET WILMINGTON, DE 19806</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 312	<p>Continued From page 8</p> <p>Activities of Daily Living: Quality of Care", last revised in June 2008, stated, "... the facility must ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain ... personal ... hygiene ...1. Each resident shall be given proper personal attention and care of skin ...".</p> <p>According to the quarterly Minimum Data Set (MDS) assessment, dated 2/16/13, R1 was able to make his/her own decisions and she required extensive assistance with one staff person for personal hygiene and bathing.</p> <p>A physician order, dated 11/7/13, stated R1's shower days were Monday and Thursday during the 3:00 PM to 11:00 PM shift.</p> <p>Review of the March 2014 Shower Schedule revealed that R1 had a shower on 3/13/14. The next documented shower was on 3/27/14; 14 days later. R1 was scheduled for showers on 3/17/14, 3/20/14 and 3/24/14, but did not receive them.</p> <p>According to the March 2014 Shower Schedule, R1 received a bed bath by E8 (Certified Nurse's Aide/CNA) after an initial refusal on 3/17/14. In an interview on 4/8/14 at 4:30 PM, E8 (CNA) stated that she gave R1 a bed bath, but did not wash her hair on 3/17/14.</p> <p>According to the March 2014 Shower Schedule, E5 (CNA) documented "R" (refused) on 3/20/14. Review of R1's clinical record revealed an absence of details on R1's refusal of a shower and further attempts by staff to provide care at a later time.</p>	F 312	<p>C. (1) All medicated shampoos and soaps will be added to the C.N.A.'s Unit at a Glance under the comments section. The Unit at a Glance is updated daily (Attachment C). (2). The facility's Shower Scheduled sheet was revised to include a section for C.N.A.'s to indicate if the nurse was notified of refusals (Attachment D). The Staff Educator will educate C.N.A.'s on the revised Shower Schedule form. (3) The Staff Educator will educate licensed nurse on the need to document in nursing notes personal hygiene refusals, and additional attempts to provide hygiene care.</p>	6/25/14 ↓
-------	--	-------	--	--------------

*Done Seen 5/5/14*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET WILMINGTON, DE 19806</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 9 According to the March 2014 Shower Schedule, E6 (CNA) documented "BB" (bed bath) on 3/24/14. In an interview on 4/9/14 at 10:00 AM, E6 stated she gave R1 a bed bath, but did not wash her hair. In addition, E6 stated she was not aware of a medicated shampoo for R1 (ordered on 3/20/14). Review of R1's clinical record revealed the absence of details as to why a shower was not provided to R1.  In an interview on 4/3/14 at 2:30 PM, R1 stated she did not refuse to shower, but was told by staff that it was too late to receive a shower. R1 stated she felt "muffy" (dirty) until her hair was washed.  Findings were reviewed with the E1 (Administrator) and E2 (Director of Nursing) on 4/9/14 at 4:10 PM.	F 312	D.) (1) The D.O.N/designee will audit 100% of residents that are ordered medicated shampoos and soaps to review compliance of treatments being documented on the Unit at Glance form, and TAR's. (Attachment E). The audit will occur weekly. The results of the audit will be reported out in monthly QA & A until 100% compliance is achieved for 3 months, and ongoing as needed. (2) The D.O.N/designee will review 50% of all residents Shower Schedule to review compliance of that C.N.A. that refusal of hygiene were reported by the C.N.A. to the nurse , and that the nurse documented in the nursing notes the refusal, along with additional attempts to provide care. (Attachment F). The results of the audit will be reported out in monthly QA & A until 100% compliance is achieved for 3 months, and ongoing as needed.	6/25/14	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by:	F 514			

*due in Sec 5/5/14*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/09/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET</b> <b>WILMINGTON, DE 19806</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 9 According to the March 2014 Shower Schedule, E6 (CNA) documented "BB" (bed bath) on 3/24/14. In an interview on 4/9/14 at 10:00 AM, E6 stated she gave R1 a bed bath, but did not wash her hair. In addition, E6 stated she was not aware of a medicated shampoo for R1 (ordered on 3/20/14). Review of R1's clinical record revealed the absence of details as to why a shower was not provided to R1.  In an interview on 4/3/14 at 2:30 PM, R1 stated she did not refuse to shower, but was told by staff that it was too late to receive a shower. R1 stated she felt "muffy" (dirty) until her hair was washed.  Findings were reviewed with the E1 (Administrator) and E2 (Director of Nursing) on 4/9/14 at 4:10 PM.	F 312		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by:	F 514	A. R1's skin assessments are now up to date.  B. All residents have the potential to be affected by this deficient practice.	6/25/14 ↓

*den m Sen 5/5/14*

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>085012</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/09/2014</b>
--	---	--	--

NAME OF PROVIDER OR SUPPLIER  <b>REGENCY HEALTHCARE &amp; REHAB CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>801 N. BROOM STREET WILMINGTON, DE 19806</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 514	<p>Continued From page 10</p> <p>Based on record review and review of other documentation, it was determined that the facility failed to maintain complete clinical records, for one (R1) out of 2 sampled residents. Findings include:</p> <p>The facility's policy entitled "Prevention of Pressure Ulcers", last revised in June 2008, stated, "... 3. Nursing staff will routinely assess and document the condition of the resident's skin ..."</p> <p>Review of a physician order, dated 11/7/13, revealed that R1 was ordered to have a weekly skin assessment every Thursday on the 3:00 PM to 11:00 PM shift.</p> <p>R1 was care planned for potential of skin breakdown, last revised on 4/1/14, with an approach that included weekly skin assessments.</p> <p>Review of R1's medical record revealed the absence of a documented weekly skin assessment on Thursday, 3/6/14.</p> <p>Findings were confirmed by E1 (Administrator) on 4/9/14 at 4:10 PM.</p>	F 514	<p>C. The Unit Manager's morning meeting report has been revised to include outstanding skin checks (Attachment G). On an ongoing basis the Unit Managers will report out in morning meeting any outstanding skin check. The outstanding skin checks will be completed accordingly.</p> <p>D. The D.O.N./designee will audit the Unit Managers morning meeting sheets and calculate a compliance of skin checks on a weekly basis. The results of the audit will be reported out in monthly QA &amp; A until 100% compliance is achieved for 3 months, and ongoing as needed.</p>	<p>6/25/14</p> 
-------	---	-------	---	---

*Desem Series 5/5/14*



**DELAWARE HEALTH  
AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

STATE SURVEY REPORT

Page 1 of 2

NAME OF FACILITY: Regency Healthcare & Rehab Center

DATE SURVEY COMPLETED: April 9, 2014

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
<p>3201</p> <p>3201.1.0</p> <p>3201.1.2</p>	<p><b>The State Report incorporates by reference and also cites the findings specified in the Federal Report.</b></p> <p>An unannounced complaint survey was conducted at this facility from April 3, 2014 through April 9, 2014. The facility census the first day of the survey was 90. The survey sample totaled two (2) active residents. The survey process involved record reviews, interviews, and review of other documentation as indicated.</p> <p><b>Regulations for Skilled and Intermediate Care Facilities</b></p> <p><b>Scope</b></p> <p><b>Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.</b></p>	

Provider's Signature Debra M. Seeris Title RHA Date 5/5/14



**DELAWARE HEALTH AND SOCIAL SERVICES**

Division of Long Term Care  
Residents Protection

DHSS - DLTCRP  
3 Mill Road, Suite 308  
Wilmington, Delaware 19806  
(302) 577-6661

STATE SURVEY REPORT

Page 2 of 2

DATE SURVEY COMPLETED: April 9, 2014

NAME OF FACILITY: Regency Healthcare & Rehab Center

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	<p><b>This requirement is not met as evidenced by:</b></p> <p>Cross refer to the CMS 2567-L survey ending April 9, 2014, F157, F278, F309, F312 and F514.</p>	<p>Cross Reference with CMS 2567-L survey plan of correction F157 and F278, F309, F312 and F514 survey date ending April 9, 2014.</p> <p style="text-align: right;">6/25/14 ↓</p>

Provider's Signature Jane M. Sevin Title NHA Date 5/5/14