DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Hospital for the Chronically Ill **DATE SURVEY COMPLETED:** December 12, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification with Complaints survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 12/09/24 - 12/12/24. Survey Census: 73 Sample Size: 21 Supplemental Residents: 2		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**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.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed December 12,2025: E18, E20, E23, E31, E36.	3201.1.2 Cross Refer to the CMS 2567-L survey completed December 12,2025: E18, E20, E23, E31, E36.	01/31/25

Provider's Signature _____ Title NHA Date 01/03/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085035	A. BUILDING _____ B. WING _____	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD SMYRNA, DE 19977

(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
E 000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 12/09/24 through 12/12/24. The facility was found to not be in compliance with 42 CFR 483.73.	E 000		
E 018 SS=F	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) §403.748(b)(2), §416.54(b)(1), §418.113(b)(6)(ii) and (v), §441.184(b)(2), §460.84(b)(2), §482.15(b)(2), §483.73(b)(2), §483.475(b)(2), §485.542(b)(2), §485.625(b)(2), §485.920(b)(1), §486.360(b)(1), §494.62(b)(1). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location.	E 018		1/31/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/03/2025

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.

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E 018	Continued From page 1 *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance. (v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location. *[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For OPOs at § 486.360(b):] Policies and	E 018		

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E 018	Continued From page 2 procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. *[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interviews and facility policy review, the facility failed to develop a policy and procedure for an adequate tracking system for residents and staff as part of its emergency plan. This facility failure could cause a breach in protected health information and residents not being able to be located in the event of an emergency. Findings include: Review of the facility's policy titled, "Delaware Hospital for the Chronically Ill Emergency Operations Plan," dated 08/21/24, revealed "Resident Tracking Each resident who is being transported to a destination site is triaged according to EMS triage protocols and triage tag number for tracking, Each resident chart should have a copy of a completed HICS 260 Resident Tracking Form and the corresponding triage tag for the purpose of tracking the resident. The Discharge Unit will maintain a HICS 255 Master Resident Tracking Form. As residents are discharged. information from the individual resident's HICS 260 will be entered into the HICS 255. The EMS Transportation Unit Leader will track the resident using the tag number assigned to the resident. Demographics information for all	E 018	A. The facility failed to develop a policy and procedure for an adequate tracking system for residents and staff as part of its emergency plan. The facility revised and updated its emergency preparedness policies and procedures to include a system to track the location of on-duty staff, sheltered residents in the facility's care, and specific name and location of the receiving facility during an emergency (Attachment #1). All supervisors and managers will be trained on the updated policies and procedures regarding the tracking system by the Risk Manager, Training Administrator II, or designee by 01/31/2025. B. All residents in the facility have the potential to be affected by this deficient practice. The facility revised and updated its emergency preparedness policies and procedures to include a tracking system in identifying on-duty staff and sheltered residents in the facility's care during an emergency. All supervisors and managers will be trained on the updated policies and procedures regarding the tracking system	

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E 018	Continued From page 3 residents, both those who were discharged and those who are being evacuated along with the triage tag number are to be entered into the electronic centralized database within one hour or. as soon as possible. of the resident leaving the healthcare facility. DHCI will maintain current photo identification cards for each resident." During an interview on 12/11/24, at 1:31 PM with the Assistant Hospital Director (AHD) and Risk Manager, they described their emergency identification system. Continued interview revealed each unit maintained emergency kits containing residents' names, unit numbers, diagnoses, code statuses, and diet requirements. This information was recorded on two tags, one attached to the resident's clothing, and another kept by nursing staff. However, when questioned about formal policies and procedures, both the Risk Manager and AHD confirmed that the emergency preparedness plan lacked specific protocols for tracking residents and staff. During an interview on 12/12/24, at 10:46 AM with the Hospital Administrator, Risk Manager, and Assistant Hospital Director (AHD), the AHD acknowledged the absence of formal policies and procedures for tracking. They currently rely on monthly, daily, and weekly schedules to monitor staff assignments and adjustments. For resident tracking, they used unit rosters and daily census reports to document resident locations, including those in the building, on leave of absence, or hospitalized. While their primary strategy was to shelter in place, the Hospital Administrator recognized the need to revise their entire process and implement a more comprehensive method for tracking both residents and staff.	E 018	by the Risk Manager, Training Administrator II, or designee. C. The root cause of this deficient practice is a knowledge deficit related to the requirement that the facility must have a system to track the location of staff and residents in the facility's care during an emergency. All supervisors and managers will be trained by the Risk Manager, Training Administrator II, or designee regarding the updated policies and procedures to ensure the accurate tracking of staff and residents during and after an emergency. This includes implementing the use of HICS 255 Master Evaluation Tracking Form (Attachment #2), HICS 260 Patient Evacuation/Transfer Tracking Form (Attachment #3), and Staff Tracking Form (Attachment #4) to document real-time movement and location during emergency situations. In addition, the Risk Manager will conduct quarterly evacuation drills/trainings, shelter in place, and review the tracking forms after each drill/training or actual emergency event to ensure accuracy and adherence to the tracking protocol. D. To ensure compliance, the Continuous Quality Improvement Nurse (CQI RN III) will complete monthly audits of the tracking forms and evacuation drill(s)/training(s) using the Emergency Preparedness (EP) Audit Tool (Attachment #5) for three (3) consecutive months with 100 percent compliance. If 100 percent compliance has been	

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E 018	Continued From page 4	E 018	achieved, then, the Continuous Quality Improvement Nurse (CQI RN III) will complete quarterly audits of the tracking forms and evacuation drill(s) for three (3) consecutive quarters with 100 percent compliance. The results of these audits will be reviewed at the quarterly QAPI Steering Committee meetings. If it is determined that 100 percent compliance is achieved for three (3) consecutive quarters, then, the facility will conclude that we have successfully addressed this deficient practice.	
E 020 SS=D	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.542(b)(3), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of	E 020		1/31/25

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E 020	Continued From page 5 evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2) and REHs at §485.542(b)(3):] Safe evacuation from the [RNHCI or ASC or REHs] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and facility policy review, the facility failed to establish policies and procedures for managing residents who refuse to evacuate during emergencies. This deficient practice had the potential to compromise the safety of building evacuations and put residents at risk.	E 020	A. The facility failed to establish policies and procedures for managing residents who refuse to evacuate during emergencies. The facility revised and updated its emergency preparedness policies and procedures to include	

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E 020	Continued From page 6 Findings include: Review of the facility policy titled, "Delaware Hospital for the Chronically Ill Emergency Operations Plan," dated 08/21/24, revealed, "The purpose of this Emergency Operation Plan is to provide a facility-wide comprehensive emergency response to a disaster event. The plan seeks to limit the effects of the disaster. The plan provides for planned measures to preserve life and minimize damage. The plan provides for response during a disaster emergency, to include the evacuation of its residents and staff within the facility' to a nearby facility or safe facility at further distance. The plan provides for assistance and establishes a recovery system to return the facility to its normal operations." During an interview on 12/11/24 at 1:31 PM, the Assistant Hospital Director (AHD) and Risk Manager admitted having no knowledge of relevant policies, despite acknowledging the heightened risks for residents with dementia who may experience confusion and exhibit combative behavior. When specifically asked about the Long Term Care Emergency Preparedness Procedures outlined in 42 CFR 483.73, both the ADA and Risk Manager confirmed they were unaware of these regulatory requirements. During an interview on 12/12/24 at 10:46 AM, the Hospital Administrator, ADA, and Risk Manager, the ADA confirmed the existence of an evacuation plan but acknowledged it lacked specific protocols for managing residents who refuse to evacuate.	E 020	consideration of care and treatment needs for evacuees (Attachment #1). This includes staff responsibilities, transportation, identification of evacuation location, and primary and alternate means of communication with external sources of assistance for a safe evacuation. All nursing staff will be trained on de-escalation techniques by the Risk Manager, Training Administrator II, or designee by 01/31/2025. B. All residents in the facility have the potential to be affected by this deficient practice. The facility revised and updated its emergency preparedness policies and procedures to include consideration of care and treatment needs for residents, staff responsibilities, transportation, identification of evacuation location, and primary and alternate means of communication with external sources of assistance. Additionally, the revision includes policies and procedures for managing residents who refuse to evacuate during emergencies. All nursing staff will be trained on de-escalation techniques to include how to provide encouragement and support to those residents who are finding it difficult or refuse to evacuate the facility. C. The root cause of this deficient practice is a knowledge deficit related to the requirement that the facility must have established policies and procedures for managing residents who refuse to evacuate during emergencies. The facility revised and updated its emergency	

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E 020	Continued From page 7	E 020	preparedness policies and procedures to include consideration of care and treatment needs for evacuees. This includes staff responsibilities, transportation, identification of evacuation location, and primary and alternate means of communication with external sources of assistance. All nursing staff will be trained on how to facilitate safe evacuation for residents who refuse to leave the facility. D. To ensure compliance, the Continuous Quality Improvement Nurse (CQI RN III) will complete monthly reviews of training database to ensure de-escalation training is completed using the EP Audit Tool (Attachment #5) for three (3) consecutive months with 100 percent compliance. If 100 percent compliance has been achieved, then, the Continuous Quality Improvement Nurse (CQI RN III) will complete quarterly audits of the tracking form for three (3) consecutive quarters with 100 percent compliance. The results of these audits will be reviewed at the quarterly QAPI Steering Committee meetings. If it is determined that 100 percent compliance is achieved for three (3) consecutive quarters, then, the facility will conclude that we have successfully addressed this deficient practice.	
E 023 SS=D	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) §403.748(b)(5), §416.54(b)(4), §418.113(b)(3), §441.184(b)(5), §460.84(b)(6), §482.15(b)(5), §483.73(b)(5), §483.475(b)(5), §484.102(b)(4),	E 023		1/31/25

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E 023	Continued From page 8 §485.68(b)(3), §485.542(b)(5), §485.625(b)(5), §485.727(b)(3), §485.920(b)(4), §486.360(b)(2), §491.12(b)(3), §494.62(b)(4). [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b) and REHs at §485.542(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records. This REQUIREMENT is not met as evidenced by:	E 023		

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E 023	Continued From page 9 Based on interviews and facility policy review, the facility failed to establish policies and procedures for a medical documentation system that would preserve and protect confidential patient information while ensuring records remain secure and accessible. This deficiency could compromise protected health information for all 73 residents during an emergency. Findings include: Review of the facility's policy titled, "Delaware Hospital for the Chronically Ill Emergency Operations Plan," dates 08/21/24 revealed "Resident Tracking each resident who is being transported to a destination site is triaged according to EMS triage protocols and triage tag number for tracking, Each resident chart should have a copy of a completed HICS 260 Resident Tracking Form and the corresponding triage tag for the purpose of tracking the resident. The Discharge Unit will maintain a HICS 255 Master Resident Tracking Form. As residents are discharged. information from the individual resident's HICS 260 will be entered into the HICS 255. The EMS Transportation Unit Leader will track the resident using the tag number assigned to the resident. Demographics information for all residents. both those who were discharged and those who are being evacuated along with the triage tag number. are to be entered into the electronic. centralized database within one hour or. as soon as possible. of the resident leaving the healthcare facility. DHCI will maintain current photo identification cards for each resident." During an interview on 12/11/24 at 1:31 PM, the Assistant Hospital Director (AHD) and Risk	E 023	A. The facility failed to establish policies and procedures for a medical documentation system that would preserve and protect confidential patient information while ensuring the records remain secure and accessible. The facility revised and updated its emergency preparedness policies and procedures (Attachment #1) to include a combination lock system that is HIPAA compliant to protect confidentiality of patient information, and secure and maintain availability of records. All nursing staff will be trained on the procedures to protect access of medical records while transporting during evacuation by the Risk Manager, Training Administrator II, or designee by 01/31/2025. B. All residents in the facility have the potential to be affected by this deficient practice. The facility revised and updated its emergency preparedness policies and procedures to include a method to preserve patient information, protect confidentiality of patient information, and secure and maintain availability of records. All nursing staff will be trained on the updated policies and procedures to include the use of a combination lock HIPAA Compliant Bag by the Risk Manager, Training Administrator II, or designee. C. The root cause of this deficient practice is a knowledge deficit related to the requirement that the facility failed to establish policies and procedures for a medical documentation system that would	

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E 023	Continued From page 10 Manager described their emergency identification system: each unit maintained emergency kits containing residents' names, unit numbers, diagnoses, code statuses, and diet requirements. This information was provided on two tags, one attached to the resident's clothing, and another retained by nursing staff. When questioned about formal policies and procedures, both the Risk Manager and AHD acknowledged there was no specific policy for securing and maintaining resident records during emergencies. The AHD mentioned they could access information through Point Click Care's cloud system, but when asked about contingency plans if Point Click Care became inaccessible, the AHD provided no response. During an interview on 12/12/24, at 10:46 AM with the Hospital Administrator, Risk Manager, and Assistant Hospital Director (AHD), the AHD explained they rely on Point Click Care (PCC), a web-based system accessible from any location with internet connectivity or hotspot access. When questioned about contingency plans in the event computers are unavailable, the Hospital Administrator acknowledged this was an area requiring development.	E 023	preserve and protect resident information while ensuring records remain secure and accessible during an emergency. All nursing staff will be trained on the policies and procedures for a medical documentation system to include the procedures on the use of a combination lock HIPAA Compliant Bag during an emergency by the Risk Manager, Training Administrator II, or designee. D. To ensure compliance, the Continuous Quality Improvement Nurse (CQI RN III) will complete monthly audits of each residents□ combination lock HIPAA Compliant Bag to ensure each resident's medical information is up to date, secure, and available using the EP Audit Tool (Attachment #5) for three (3) consecutive months with 100 percent compliance. If 100 percent compliance has been achieved, then, the Continuous Quality Improvement Nurse (CQI RN III) will complete quarterly audits to ensure each resident's medical information is up to date, secure, and available for three (3) consecutive quarters with 100 percent compliance. The results of these audits will be reviewed at the quarterly QAPI Steering Committee meetings. If it is determined that 100 percent compliance is achieved for three (3) consecutive quarters, then, the facility will conclude that we have successfully addressed this deficient practice.	
E 031 SS=F	Emergency Officials Contact Information CFR(s): 483.73(c)(2)	E 031		1/31/25

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	085035	A. BUILDING _____ B. WING _____	C 12/12/2024

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E 031	Continued From page 11 §403.748(c)(2), §416.54(c)(2), §418.113(c)(2), §441.184(c)(2), §460.84(c)(2), §482.15(c)(2), §483.73(c)(2), §483.475(c)(2), §484.102(c)(2), §485.68(c)(2), §485.542(c)(2), §485.625(c)(2), §485.727(c)(2), §485.920(c)(2), §486.360(c)(2), §491.12(c)(2), §494.62(c)(2). [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by: Based on interview and facility policy review, the	E 031	A. The facility failed to maintain a	

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E 031	Continued From page 12 facility failed to maintain a communications plan with required authorities. The plan lacked essential contact information for federal, state, tribal, regional, and local emergency preparedness staff, the State Licensing and Certification Agency, the Office of the State Long Term Care Ombudsman, and other sources of assistance. This deficiency could impede effective communication during emergencies, potentially affecting all 73 residents. Findings include: Review of the facility policy titled, "Delaware Hospital for the Chronically Ill Emergency Operations Plan," dated 08/21/24 revealed, "The purpose of this Emergency Operation Plan is to provide a facility-wide comprehensive emergency response to a disaster event. The plan seeks to limit the effects of the disaster. The plan provides for planned measures to preserve life and minimize damage. The plan provides for response during a disaster emergency, to include the evacuation of its residents and staff within the facility to a nearby facility or safe facility at further distance. The plan provides for assistance and establishes a recovery system to return the facility to its normal operations." During an interview on 12/11/24 at 1:31 PM, the Assistant Hospital Director (AHD) and Risk Manager indicated that their communications were limited to on-campus leadership, with the exception of state health operations contacts. During an interview on 12/12/24 at 10:46 AM with the Hospital Administrator, ADA, and Risk Manager, the Hospital Administrator confirmed they lacked a comprehensive emergency contact	E 031	communication plan which lacked essential contact information for Federal, State, tribal, regional, local emergency preparedness staff, and other sources of assistance. The facility revised and updated its emergency preparedness policies and procedures to include essential contact information (Attachment #1). Incident Command System (ICS) members will be in-serviced on the revised emergency contact information by the Risk Manager or designee by 01/31/2025. B. All residents in the facility have the potential to be affected by this deficient practice. The facility revised and updated its emergency preparedness policies and procedures to include the revised communication plan with essential contact information (Attachment #1). Incident Command System (ICS) members will be in-serviced on the updated communication plan by the Risk Manager or designee. C. The root cause of this deficient practice is a knowledge deficit related to the requirement that the facility must maintain a communication plan with required authorities to include essential contact information. Incident Command System (ICS) members will be in-serviced regarding the essential contact information for Federal, State, tribal, regional, local emergency preparedness staff, and other required sources of assistance during emergencies by the Risk Manager or designee. Additionally,	

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E 031	Continued From page 13 list for officials.	E 031	the Risk Manager will ensure that the essential contact information is discussed and current at each monthly Safety Committee Meeting. D. To ensure compliance, the Continuous Quality Improvement Nurse (CQI RN III) will complete monthly reviews of the Safety Committee Meeting minutes to verify the accuracy and completeness of the essential contact information using the EP Audit Tool (Attachment #5) for three (3) consecutive months with 100 percent compliance. If 100 percent compliance has been achieved, then, the Continuous Quality Improvement Nurse (CQI RN III) will complete quarterly audits of the Safety Committee Meeting minutes for three (3) consecutive quarters with 100 percent compliance. The results of these audits will be reviewed at the quarterly QAPI Steering Committee meetings. If it is determined that 100 percent compliance is achieved for three (3) consecutive quarters, then, the facility will conclude that we have successfully addressed this deficient practice.	
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54,	E 036		1/31/25

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E 036	Continued From page 14 Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and	E 036		

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E 036	Continued From page 15 testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. This REQUIREMENT is not met as evidenced by: Based on the interview and facility policy review, the facility failed to develop and maintain an emergency preparedness training and testing program that required annual review and updates. This deficient practice placed all 73 residents, along with staff members and visitors, at an increased risk of harm during emergency situations. Findings include: Review of the facility policy titled, "Delaware Hospital for the Chronically Ill Emergency Operations Plan," dated 08/21/24 revealed, "The purpose of this Emergency Operation Plan is to provide a facility-wide comprehensive emergency response to a disaster event. The plan seeks to limit the effects of the disaster. The plan provides for planned measures to preserve life and minimize damage. The plan provides for	E 036	A. The facility failed to develop and maintain an emergency preparedness training and testing program that required annual review and updates. The facility will develop and implement a comprehensive training program for all staff, contractors, and volunteers on emergency preparedness requirements. The facility Risk Manager will conduct quarterly testing exercises based on the facility Hazard Vulnerability Analysis. All staff will be trained on emergency preparedness by the Risk Manager, Training Administrator II or designee by 01/31/2025. B. All residents, staff, and visitors in the facility have the potential to be affected by this deficient practice. The facility will develop and implement a comprehensive	

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E 036	Continued From page 16 response during a disaster emergency, to include the evacuation of its residents and staff within the facility to a nearby facility or safe facility at further distance. The plan provides for assistance and establishes a recovery system to return the facility to its normal operations." During an interview on 12/12/24 at 10:46 AM, the Hospital Administrator ADA, and Risk Manager indicated that while they conduct fire drills, they did not have a comprehensive training and testing program in place. Staff members were not formally trained or tested on safety procedures.	E 036	training and testing program for all staff, contractors, and volunteers on emergency preparedness requirements to include emergency response protocols, and evacuation and communication plans during emergencies. All staff will be trained on emergency preparedness by the Risk Manager, Training Administrator II, or designee. C. The root cause of this deficient practice is a knowledge deficit related to the requirement that the facility must develop and maintain an emergency preparedness training and testing program that require annual review and updates. All staff will be trained on the facility emergency preparedness and testing program to include the facility Hazard Vulnerability Analysis by the Risk Manager, Training Administrator II or designee. The Risk Manager or designee will review emergency preparedness as it relates to the facility Hazard Vulnerability Analysis quarterly at the Residents Council meetings. The Risk Manager or designee will schedule and conduct quarterly emergency preparedness drills/trainings to test the readiness of staff and the facility's emergency system(s). D. To ensure compliance, the Continuous Quality Improvement Nurse (CQI RN III) will complete quarterly audits of the emergency preparedness training and testing program using the EP Audit Tool (Attachment #5) to ensure staff readiness for compliance in emergency situations for three (3) consecutive	

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E 036	Continued From page 17	E 036	quarters with 100 percent compliance. The results of these audits will be reviewed at the quarterly QAPI Steering Committee meetings. If it is determined that 100 percent compliance is achieved for three (3) consecutive quarters, then, the facility will conclude that we have successfully addressed this deficient practice.	
F 000	INITIAL COMMENTS A Recertification with Complaints survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 12/09/24 - 12/12/24 Survey Census: 73 Sample Size: 21 Supplemental Residents: 2	F 000		