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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Hospital F/t Chronically Ill (DHCI) **DATE SURVEY COMPLETED: March 16, 2021**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection on March 10, 2021 through March 16, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 90. The survey sample totaled seven (7) residents.		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **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 March 16, 2021: F604, F609, F657, and F943.	**3201.1.2** Cross Reference to the CMS 2567-L survey completed March 16, 2021: F604, F609, F657, and F943.	04/20/2021

Provider's Signature _____ Title NHA Date 04/01/2021

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 03/16/2021

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

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F 000	INITIAL COMMENTS An unannounced Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection on March 10, 2021 through March 16, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census the first day of the survey was 90. The survey sample totaled seven (7) residents. Abbreviations/definitions used are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; HA - Hospital Administrator; NHA - Nursing Home Administrator; RN - Registered Nurse; BM - bowel movement; G tube (Gastric tube) - feeding tube that is placed through the abdomen going directly into the stomach for feeding; TBI - traumatic brain injury.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).	F 604		4/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/01/2021

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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F 604	Continued From page 1 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure for one (R3) out of three sampled residents for resident rights that a physical restraint was not used for staff convenience and in the absence of a medical symptom. Findings include: 10/18/2016 (last revision date) - The facility policy entitled "Restraint Policy" included that the facility "prohibits the use of restraints for discipline or convenience..." and that a physical restraint is "defined as any manual method or physical or mechanical device, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body ...convenience is defined as any action taken by	F 604	F-604 Right to be Free from Physical Restraints A. Individual/Resident Impacted The facility failed to ensure that R3 was free from physical restraint. The facility failed to identify a restraint when a sheet was tied to the bed restricting access to the resident□s body. This was an isolated incident and not a facility practice. E7 received refresher training on abuse/physical restraint and dignity on 03/19/21. The Restraint Policy and the Protection from Abuse and Responding to Reportable Incidents Policy were updated to include clarification of freedom of	

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F 604	Continued From page 2 the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest." Review of R3's clinical record revealed: 5/14/2015 - R3 was admitted to the facility. 10/1/2020 (last reviewed and revised by facility) - R3's care plan for safety documented, "I have the potential to place inappropriate items in my mouth; split gauze, wash clothes, blankets and call bell because I have a TBI (traumatic brain injury) and get confused." Interventions were to "keep an eye on my behaviors, report any of my behaviors that might cause me harm to my nurse, frequently monitor me because I don't use a call bell and monitor me for putting inappropriate items in my mouth." Review of a facility incident report documented: 11/21/2020 10:40 AM - In an employee interview statement, E4 (RN) wrote on 11/20/2020 at 8:30 AM, "I was feeding another resident when...I noticed the sheet was tied to the frame. This nurse immediately went and told the unit manager. Resident not in distress at the time and sheet released from bedframe." 11/21/2020 11:05 AM - A telephone statement taken from E6 (RN, UM) by E5 (RN, Supervisor) documented, "(E6) confirmed that she was told after breakfast on 11/20/2020 that sheet that was across resident's chest was tied to the bed frame. (E6) also confirmed that she told the informing Nurse (E4) that she would take care of it. (E6) states that she wrote it down with the intention to	F 604	movement, physical restraints, staff convenience, and examples of physical restraints (Attachments 1 & 2). All staff will receive training on the revised Restraint Policy and the Protection from Abuse and Responding to Reportable Incidents Policy by the Training Administrator II or designee by 04/20/2021. B. Identification of other residents All residents have the potential to be affected by this deficient practice in which the facility failed to ensure that R3 was free from physical restraints. An environmental round was completed, and residents were assessed by the Director of Nursing (DON) to ensure no other residents were impacted by this deficient practice. All staff will receive training on abuse/physical restraints and residents dignity C. System Changes The root cause of this deficient practice is a knowledge deficit regarding what constitutes a physical restraint. The Restraint Policy was revised to include clarification of freedom of movement, physical restraints, staff convenience, and examples of physical restraints. All staff will receive training on the updated Restraint Policy and the Protection from Abuse and Responding to Reportable Incidents Policy by the Training Administrator II or designee. The Unit Managers and Nursing Supervisors will continue to monitor residents on all shifts	

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F 604	Continued From page 3 talk to the staff to tell them not to do that. (E6) went on to say it slipped her mind. (E6) stated that she was not aware that she should have informed the supervisor." 11/21/2020 11:40 AM - A telephone statement taken from E7 (CNA) by E5 (RN, Supervisor) documented, "(E7) was told on the morning on 11/20/2020 it was noticed that the resident's sheet was tied to the bed frame. (E7) was asked if she recalled this. (E7) replied yes. (E7) was asked if she did this. (E7) stated yes, adding that the sheet was only tucked not tie (sic). She was told more than one staff saw the sheet was tied. (E7) was asked again if she tied the sheet. (E7) stated yes. When asked why she did this, (E7) stated because he plays in his feces. She stated it was to keep the sheet in place so he can't get to his BM. (E7) added that the sheet was across the resident's chest and his arms were not under the sheet, keeping the sheet between the resident's arms and his brief." 11/24/2020 - R3's care plan for safety was revised to include "I have the potential to place inappropriate items in my mouth... pieces of my diaper, feces...". Interventions were added to..."frequently monitor me because I cannot use a call bell and have tried to pull out my G tube" (feeding tube) and "check on me frequently while I am in bed...". 3/11/2021 1:50 PM - During an interview, E9 (CNA) stated that to prevent R3 from getting his hands into his diaper she gives him a little stuffed bear or a squeeze stress ball to hold in his right hand. He is not able to use his left hand because his left arm is paralyzed.	F 604	to ensure that residents are free from abuse/physical restraints. D. Success Evaluation The Unit Managers and Nursing Supervisors will continue to monitor residents on all shifts to ensure that residents are free from abuse/physical restraints. Any deficient practices identified will be immediately addressed and findings reported to the DON for appropriate corrective action. Additionally, the Continuous Quality Improvement Nurse (CQI RN III) or designee will conduct random weekly observations using the Nursing Services Audit Tool (Attachment 3) to ensure 100 percent compliance for 10 consecutive weeks. Thereafter, random audits will continue on a monthly basis. The results of these audits will be reviewed at monthly QAPI committee meetings. If it is determined that 100 percent compliance is achieved for 4 consecutive months, then we will conclude that we have successfully addressed the cited deficient practice.	

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F 604	Continued From page 4 3/11/2021 2:30 PM - During an interview, E1 (NHA) stated that the facility is restraint free and utilizes personalized care plans. He added that he felt this incident was a care plan issue as staff were aware that R3 played in his feces, but it had not been addressed as a behavior in the care plan. E1 stated that the care plan was revised to include this behavior. E1 added he did not feel the sheet was a restraint because R3 had the ability to move his arms. 3/11/2021 3:35 PM - During an interview, E10 (CNA) stated that they do not need to restrain R3, they just put a rolled wash cloth in his right hand and when cleaning R3 after he has had a bowel movement they use two staff. The facility failed to identify that R3 was restrained with a sheet tied to the bed for staff convenience and restriction from access to his body. 3/16/2021 4:15 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Hospital Administrator) during the exit conference.	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events	F 609		4/20/21

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F 609	Continued From page 5 that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the State of Delaware Division of Healthcare Quality (DHCQ) Incident Referral System, it was determined that the facility failed to immediately report an allegation of mistreatment for one (R3) out of four residents sampled for abuse/neglect/mistreatment. Findings include: Cross refer F604 11/21/2020 1:24 PM - E5 (RN, supervisor) reported to the DHCQ Incident Reporting System an allegation of mistreatment of (R3) that was observed on 11/20/2020 at 8:32 AM by E4 (RN). E4 immediately informed E6 (RN, UM). 3/15/2021 12:30 PM - During an interview, E3 (Hospital Administrator) confirmed that the facility was aware of allegations of mistreatment on	F 609	F-609 Reporting of Alleged Violations A. Individual/Resident Impacted The facility failed to immediately report an allegation of mistreatment for one (R3) out of four residents sampled for abuse/neglect/mistreatment. E7 received refresher training on abuse/physical restraint and dignity on 03/19/2021. All staff will receive training on the revised Restraint Policy by the Training Administrator II or designee by 04/20/2021. All staff will receive refresher training on the requirement to report all allegations of abuse, neglect, and mistreatment by the Training Administrator II or designee by 04/20/2021.	

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F 609	Continued From page 6 11/20/2020 at 8:32 AM, but failed to immediately report the allegations to the State Agency. 3/16/2021 4:15 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Hospital Administrator) during the exit conference.	F 609	B. Identification of other residents All residents have the potential to be affected by this deficient practice in which the facility failed to immediately report an allegation of abuse, neglect, and mistreatment. E6 was re-educated by the DON regarding the recuirement to immediately report any allegations of abuse, neglect, and mistreatment. C. System Changes The root cause of this deficient practice is staff□s failure to follow the facility□s policy on Protection from Abuse and Responding to Reportable Incidents. All staff will receive refresher training on the requirement to immediately report any allegations of abuse, neglect, and mistreatment by the Training Administrator II or designee. D. Success Evaluation The Nursing Home Administrator, Hospital Administrator, QA Administrator and DON or designees will immediately be notified regarding any allegations of abuse, neglect, and mistreatment to ensure timely reporting to the state survey agency. The Nursing Home Administrator will immediately address any deficient practices identified with appropriate corrective actions. The Nursing Home Administrator will meet with the Hospital Administrator, QA Administrator and Director of Nursing or designees to ensure timely reporting for 100% accuracy for 10 consecutive weeks and then	

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F 609	Continued From page 7	F 609	monthly for 3 consecutive months. The results will be discussed at the monthly QAPI Committee Meetings and reported at the Quarterly QAPI Steering Committee meetings. When the facility reaches 100% compliance for 3 consecutive months, then the facility will conclude that they have successfully addressed the deficient practice.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		4/20/21

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F 657	Continued From page 8 assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R3) out of three sampled residents for care plans, the facility failed to review and revise R3's care plan to address behaviors of placing his hands in his pants and getting feces on his hands. Findings include: Review of R3's clinical record revealed: 5/14/2015 - R3 was admitted to the facility. 10/1/2020 (reviewed) - R3's care plan for safety documented, "I have the potential to place inappropriate items in my mouth; split gauze, wash clothes, blankets and call bell because I have a TBI (traumatic brain injury) and get confused." Interventions were to "keep an eye on my behaviors, report any of my behaviors that might cause me harm to my nurse, frequently monitor me because I don't use a call bell and monitor me for putting inappropriate items in my mouth." Review of a facility incident report documented: 11/21/2020 11:40 AM - A telephone statement taken from E7 (CNA) by E5 (RN, Supervisor) documented, "(E7) was told on the morning on 11/20/2020 it was noticed that the resident's sheet was tied to the bed frame. (E7) was asked if she recalled this. (E7) replied yes. (E7) was asked if she did this. (E7) stated yes, adding that the sheet was only tucked not tie (sic). She was told more than one staff saw the sheet was tied. (E7) was asked again if she tied the sheet. (E7) stated yes. When asked why she did this, (E7)	F 657	F-Tag 657 - Care Plan Timing and Revision A. The facility failed to review and revise R3's plan of care to address resident's behaviors of placing his hands in his pants and getting feces on his hands. Once the facility was notified of the deficient practice, corrective action was taken by the Unit Manager by updating and revising R3's care plan to address these behaviors on 03/17/2021. B. All residents have the potential to be affected by this deficient practice of not reviewing and revising resident care plans. A sweep of all residents' behavioral plan of care will be completed by 04/20/2021 to ensure the residents' behaviors are accurately identified and care planned. C. The root cause of this deficient practice is knowledge deficit of not identifying and care planning resident behaviors accurately. All licensed nursing staff will be in-serviced by the DON and Trainer Administrator II or designees regarding the need of developing and updating a comprehensive individualized care plan to reflect resident behaviors by 04/20/2021. D. All residents' behavioral care plans will be reviewed by the RN Unit Manager	

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F 657	Continued From page 9 stated because he plays in his feces. She stated it was to keep the sheet in place so he can't get to his BM. She added that the sheet was across the resident's chest and his arms were not under the sheet, keeping the sheet between the resident's arms and his brief." 11/23/2020 2:54 PM - In an employee interview statement, E7 (CNA) wrote "on the 19th into the 20th of November 1 I (E7) cared for this resident (R3) and after I was done, I used the sheet to covered him and left his 2 arms out, and also tuck the end of the sheet under the bed firm on the right side, which is just one side. The reason is for the resident to not play in his diaper, cause if there is a BM, then he will have it all over the bed and on his hand." 11/24/2020 - R3's care plan for safety was revised to include the potential to put "...pieces of my diaper, feces ..." in my mouth. Interventions were added to..."frequently monitor me because I cannot use a call bell and have tried to pull out my G tube" (feeding tube) and "check on me frequently while I am in bed ...". 12/1/2020 -The 5-Day Follow-Up to the State Agency included, "After speaking with all parties involved in this incident, the root cause... determined to be a lack of personalized care planning for (R3). Staff have reported behaviors of placing his hands in his pants and getting feces on his hands and he also will pull on his gastrostomy tube. Unfortunately, the care plan was not clear and only included the behavior of placing objects into his mouth." 3/11/2021 2:30 PM - During an interview, E1 (NHA) stated that he felt this incident was a care	F 657	or designee prior to the weekly IDT meetings to ensure that they are updated to reflect the residents behaviors. The Continuous Quality Improvement Nurse (CQI RN III) will audit 25% of the behavioral care plans weekly on a rotating schedule to determine if the residents behaviors are identified and care planned using the Nursing Services Audit Tool. The audits will be completed for 10 weeks, and thereafter on a monthly basis and the results of these audits will be reported at the monthly QAPI Committee meetings. If the audits indicate that the facility is in compliance for 4 consecutive months, then they will conclude that they have successfully addressed the deficient practice.	

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F 657	Continued From page 10 plan issue as staff were aware that resident played in his feces, but it had not been addressed as a behavior in the care plan. E1 stated the care plan was revised to include this behavior. 3/16/2021 4:15 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Hospital Administrator) during the exit conference.	F 657		
F 943 SS=D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to ensure that required training on abuse, neglect, exploitation and misappropriation of resident property was completed for one (E7) out of five randomly sampled staff members. Findings include: 8/14/2019 - The facility provided evidence of the	F 943	F-943 Abuse, Neglect. and Exploitation Training A. The facility failed to ensure that required annual training on abuse, neglect, exploitation and misappropriation of resident property was completed. E7 completed the annual mandatory training on abuse, neglect, exp oitation and	4/20/21

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 03/16/2021

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F 943	Continued From page 11 required training, dated 8/14/2019, for E7 (CNA); however, there was no evidence of ongoing annual training for 2020. 3/15/2021 12:30 PM - During an interview, E3 (Hospital Administrator) confirmed that the facility failed to have evidence that E7 (CNA) was provided the required annual training on abuse, neglect, exploitation and misappropriation of resident property in 2020. 3/16/2021 4:15 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Hospital Administrator) during the exit conference.	F 943	misappropriation of resident property on 03/19/2021 by the RN Supervisor. B. All residents in the facility have the potential to be affected by this deficient practice in which the facility failed to ensure that required training on abuse, neglect, exploitation, and misappropriation of resident property was completed for E7. All staff will receive training on the updated Protection from Abuse and Responding to Reportable Incidents Policy by the Training Administrator II or designee by 04/20/2021. C. The root cause of this deficient practice is a failure to ensure that the required annual mandatory training on abuse, neglect, exploitation, and misappropriation of resident property was completed. The Training Administrator II has developed a more accessible electronic version of the training materials. A database has been developed that will allow Training Staff to input and closely monitor staff□s completion of the annual mandatory training involving abuse, neglect, exploitation, and misappropriation of resident property. The Nursing Home Administrator will conduct meetings with the Training Administrator II to review updates on staff□s completion of the annual mandatory training on abuse, neglect, exploitation, and misappropriation of resident property. Appropriate corrective actions will be taken for staff who fail to complete the annual mandatory training as required by the facility□s abuse policies and procedures.	

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F 943	Continued From page 12	F 943	D. The Nursing Home Administrator will conduct weekly meetings with the Training Administrator II to review reported updates on staff□s completion of the annual mandatory training on abuse, neglect, exploitation, and misappropriation of resident property for 10 consecutive weeks and then monthly for 3 consecutive months until 100% completion is achieved. Appropriate corrective actions will be taken for staff who fail to complete the annual mandatory training as required by the facility□s abuse policies and procedures. The results will be discussed at the monthly QAPI Committee Meetings and reported at the Quarterly QAPI Steering Committee meetings. When the facility reaches 100% compliance, then the facility will conclude that they have successfully addressed the deficient practice.	