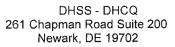


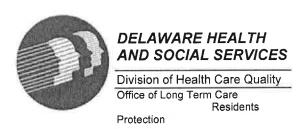
STATE SURVEY REPORT Page 1

NAME OF FACILITY: Wilmington Nursing & Rehabilitation Center 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.		
3201	An unannounced Follow-Up Survey to the Complaint and Extended Survey ending April 10, 2024 was conducted at this facility from May 30, 2024 through June 3, 2024. The deficiencies contained in this report are based on observations, interviews, review of resident's clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 117. The sample totaled ten (10) 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 June 3, 2024: cross refer: F684 and F686.	Cross Refer to the CMS 2567-L survey completed June 3, 2024: cross refer: F684 and F686.	6/12/2024

Provider's Signature	Renee Boyer_	Title	LNHA	Date _6/11/2024
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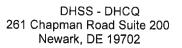


STATE SURVEY REPORT Page 2

NAME OF FACILITY: Wilmington Nursing & Rehabilitation Center 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The state of the s		1
		F684 A. R9 still resides at the facility. R9 eye appointment was scheduled, and he attended that appointment. E13 was immediately educated on admission appointments and scheduling. B. All residents admitted to the facility	6/12/2024
		with appointments needed have the potential to be affected. An audit was completed of the last 30 days of admission were audited to verify any appointments were scheduled as appropriate. If any appointment	
		identified as needing to be scheduled, they were scheduled immediately. C. Root cause analysis identified the unit clerk failed to follow up on admission paperwork to ensure appointments were scheduled and	
		nursing staff failed to review new admission appointments to verify completion due to lack of process. Facility implemented a new process where admission appointments are reviewed during morning clinical	
		meetings to validate appointments is scheduled or changed and scheduled. Any appointment needed will be placed on the new Resident Appointment Form. This form will	
		then be given to the appointment scheduler for completion. Once the appointment has been scheduled, a copy of the completed form is given to the UM/DON. DON/SDC or designee have educated the appointment	
		schedulers (unit clerk, admission staff), ADON and unit manager on the	

Provider's Signature	Renee Boyer_	Title	LNHA	Date _	_6/11/2024
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STATE SURVEY REPORT Page 3

NAME OF FACILITY: Wilmington Nursing & Rehabilitation Center 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		new process D. NHA, DON, or designee will audit admission paperwork for any appointments to ensure they are scheduled appropriately, are on the calendar, and appointment form is completed in its entirety daily x 4 weeks until 100% compliance is met, then weekly x 4 until 100% compliance is met and then monthly x 4 until 100% compliance is met. Date of Compliance: 6/12/24	
		F686 A. R10 still resides at the facility. NP made aware of area on 6/3/24 and new order obtained for treatment to area. B. All residents who have skin impairment have the potential to be affected. All current residents had a head-to-toe skin check completed. Any new identified skin impairments were reported to the provider and treatment obtained if applicable. C. Root cause analysis showed that nursing staff failed to complete the skin check observation tool and just initialed the Tar noting it as completed related to lack of knowledge that the observation tool needed to be completed as well. In addition, nursing staff who identified the skin impairment failed to notify the provider and obtain an order for treatment. A new process has been implemented where the wound nurse	6/12/2024

Provider's Signature <i>Rene</i>	e Boyer	Title	LNHA	Date	6/11/2024



DHSS - DHCQ 261 Chapman Road Suite 200 Newark, DE 19702

Office of Long Term Care
Residents

Protection

STATE SURVEY REPORT
Page 4

NAME OF FACILITY: Wilmington Nursing & Rehabilitation Center 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	Opecinic Denciciones	CONNECTION OF DEFICIENCES	57,12
		completed and documented appropriately in the chart. DON/SDC or designee have educated nursing staff on completion of weekly wound checks being completed, completion of the skin observation tool, and notification of the provider when a new area has been identified. DON will educate ADON and UM that new admission skin checks will be reviewed by UM or designee to verify accuracy and ensure any treatments were put into place. D. NHA, DON or designee will audit weekly skin checks to ensure skin observation tools were completed and any skin impairments have treatment in place daily x 4 weeks until 100% met, then weekly x 4 weeks until 100% met, and then monthly x 4 months until 100% compliance met. NHA, DON or designee will audit new admission skin checks to verify accuracy and ensure treatments are in place daily x 4 weeks until 100% compliance is met, then weekly x 4 until 100% compliance is met, then weekly x 4 until 100% compliance is met and then monthly x 4 months until 100% compliance is met Date of Compliance: 6/12/24	

Provider's Signature ${m{\mathcal{R}}}$ enee ${m{\mathcal{G}}}$	BoyerTitle_	LNHA	Date _6/11/2024
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PRINTED: 06/13/2024 FORM APPROVED OMB NO. 0938-0391

1		TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
	085028		B. WING		R-C	
	NAME OF PROVIDER OR SUPPLIER WILMINGTON NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 FOULK ROAD WILMINGTON, DE 19803	06/03/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE COMPLÉTION	
{F 000} IN	NITIAL COMMENT	S	{F 00	00}		
CO 20 co ob cli do on sa Ab as CN DO LP NF RD RD UN	omplaint and Exte. 024 was conducted 024 through June 3 contained in this representations, intervisinical records and ocumentation as in the first day of the ample totaled ten (cobreviations/definitions of follows: NA - Certified Nursing Na - Nursing Home	ews, review of resident's review of other facility dicated. The facility census e survey was 117. The 10) residents. ions used in this report are es Aide; ursing; etical Nurse; e Administrator; rector of Clinical Operations; se;			45	
Co Gla blir Sa spi Ulc	ornea - outer clear aucoma - a diseas ndness; icrum - large triang ine;	evere vision impairment; layer of the eye; e of the eye which can cause ular bone at the base of the skin or membrane.	{F 684	11	0/40/04	
SS=D CF § 4 Qu appr fac	FR(s): 483.25 183.25 Quality of cality of cality of care is a further to all treatme sility residents. Bas	are Indamental principle that Int and care provided to Interest of the comprehensive RISUPPLIER REPRESENTATIVE'S SIGNA	·	TITLE	6/12/24	

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.

Electronically Signed

06/11/2024

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		085028	B. WING _		R-C 06/03/2024	
	NAME OF PROVIDER OR SUPPLIER WILMINGTON NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 FOULK ROAD WILMINGTON, DE 19803	00/00/2027	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
{F 684}	that residents recei accordance with proportion practice, the compression of the compress	sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced review and interviews, it was one (R9) out of four residents of care, the facility failed to dent received treatment and with professional standards of acility failed to schedule a physician appointment for e: Ical record revealed: R9 was admitted to the facility bital stay for the treatment of (eye) ulcer on his left eye; R9 is including glaucoma and all discharge summary, ctronic medical record (Emr) dinstructions for the R9 to pointment with a hospital e care physician) within one incharge. A physician order was written ctor) for R9 to have an wup appointment within one	{F 684	F684 A. R9 still resides at the facility. R9 appointment was scheduled, and hattended that appointment. E13 was immediately educated on admission appointments and scheduling. B. All residents admitted to the factory appointments needed have the post to be affected. An audit was completed to be affected. An audit was completed to verify any appointments scheduled as appropriate. If any appointment identified as needing scheduled, they were scheduled immediately. C. Root cause analysis identified the clerk failed to follow up on admission paperwork to ensure appointments scheduled and nursing staff failed to review new admission appointment verify completion due to lack of profice admission appointments are reviewed during morning clinical materials to validate appointments is scheduled and scheduled. Any appointment appointment form. This fix will then be given to the appointment scheduler for completion. Once the	lity with ential eted of were to be	
c		r) revealed the lack of an pintment within one week for		appointment has been scheduled, a of the completed form is given to the		

STATEMEN AND PLAN	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	085028		B. WING			R-C 06/03/2024	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIF	, CODE	00/03/2024	
WILMIN	GTON NURSING & RE	EHABILITATION CENTER		700 FOULK ROAD WILMINGTON, DE 19803			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIAT	(X5) COMPLETION DATE	
{F 684}	R9. 5/31/24 1:30 PM - IClerk) confirmed that ophthalmology apport that she and E4 (Methat morning, the time ophthalmology apport that he has occasion that he is anxious to ophthalmologist to keep that he i	During an interview, E13 (Unit at R9 did not have an bintment scheduled yet, and edical Director) had discussed nely need for R9 to have a bintment scheduled. During an interview, R9 stated nal pain from his left eye, and a see the hospital know the healing status of his progress note was written by needuled for an ophthalmology 1/24 at 2:30 PM. The progress note was written by needuled for an ophthalmology 1/24 at 2:30 PM. The progress note was to have an ophthalmology one week of his 5/17/24 he appointment date was not more than two weeks after than two weeks with E1 and (ADON), E12 (RDCS) and	{F 68	UM/DON. DON/SDC or de educated the appointment (unit clerk, admission staff unit manager on the new property). NHA, DON, or designed admission paperwork for a appointments to ensure the scheduled appropriately, a calendar, and appointment completed in its entirety day until 100% compliance is reweekly x 4 until 100% compand then monthly x 4 until compliance is met. Date of Compliance: 6/12/2	t schedulers f), ADON and process e will audit any ey are are on the t form is aily x 4 week met, then apliance is m 100%	d s	
SS=D	Treatment/Svcs to Pr CFR(s): 483.25(b)(1)		F 686	6		6/12/24	
	§483.25(b) Skin Integ	grity					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
085028 B. WING			R-C 06/03/2024			
	NAME OF PROVIDER OR SUPPLIER WILMINGTON NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 700 FOULK ROAD WILMINGTON, DE 19803		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 686	resident, the facility (i) A resident receiv professional standar pressure ulcers and ulcers unless the indemonstrates that to (ii) A resident with professional standar promote healing, promote record review, it was (R10) out of one restreatment/services facility failed to initiate when R10 was read sacral pressure ulces a facility policy date "Wounds/Skin ImpaThe skin observation licensed nurse at ledetailing any wound provider with update impairments, obtain provide treatments. Review of R10's clir 4/13/24 2:16 PM - Facility from the hos	sure ulcers. rehensive assessment of a must ensure thates care, consistent with rds of practice, to prevent does not develop pressure dividual's clinical condition they were unavoidable; and ressure ulcers receives at and services, consistent andards of practice, to event infection and prevent veloping. IT is not met as evidenced doservation, interviews, and as determined that for one sident reviewed for the confident pressures, the attended that the treatment and monitoring limitted on 4/13/24 with a ter. Findings include: dd 1/29/24, and titled, irments", documented, "interviewed for the sident reviewed for the start eatment and monitoring limitted on 4/13/24 with a ter. Findings include: dd 1/29/24, and titled, irments", documented, "interviewed for the same as the every seven (7) days, skin impairments. Notify the sand/or changes to the skin new orders as necessary, as ordered". hical records revealed: 10 was readmitted to the bottal with past medical	F 686	F686 A. R10 still resides at the facility. No made aware of area on 6/3/24 and order obtained for treatment to area B. All residents who have skin impal have the potential to be affected. All current residents had a head-to-toe check completed. Any new identifies impairments were reported to the pland treatment obtained if applicable C. Root cause analysis showed that nursing staff failed to complete the check observation tool and just initiate the Tar noting it as completed relate lack of knowledge that the observation needed to be completed as well addition, nursing staff who identified skin impairment failed to notify the provider and obtain an order for treatment. A new process has been implemented where the wound nursing the state of the state	new a. a. airment II a skin d skin rovider e. t skin aled ed to iion II. In d the	
	affecting the left dor	cerebrovascular disease ninant side and muscle admission skin assessment		verify weekly skin checks are comp and documented appropriately in the chart. DON/SDC or designee have		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		085028	B. WING		R-C 06/03/2024				
NAME OF PROVIDER OR SUPPLIER WILMINGTON NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 700 FOULK ROAD WILMINGTON, DE 19803					
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE			
	documented, " Optriangular bone at b 6/3/24 10:00 AM - F bed on her right side 6/3/24 10:15 AM - A records revealed that that the skin assess 4/24/24 were compl for 5/1/24 document facility lacked evider resolved. R10's skin medical records (En were not documente 6/3/24 11:30 AM - A records from 4/13/24 show evidence of a v sacral ulcer for a total 6/3/24 12:20 PM - TI R10's skin check, an sacrum was observe aide told me yesterd open area on her bot on it". E7 confirmed to was not initiated and documented on R10' 6/3/24 1:30 PM - Dur and E7 stated that th weekly skin checks in residents' skin and no skin issues were obs	pen area to sacrum (large ase of spine)". R10 was observed lying in here. R10 stated, "My butt hurts". A review of R10's medical at the facility lacked evidence ments for 4/17/24, and eted. The skin assessment ted, "No pressure ulcer". The nace that the sacral ulcer was checks in the Electronic for for the next four (4) weeks ed in the clinical records. Review R10's treatment through 6/2/24 failed to wound care treatment for the eal of fifty-one (51) days. The surveyor was present for an open area on here all of fifty the east the resident had an another than and I put some cream that a wound care treatment the wound was not as medical records. Ting an interview, R6 (LPN) ey were aware that the notuded a description of the obtification of the doctor if any	F 6	educated nursing staff on completion of the skin obse and notification of the provide new area has been identified educate ADON and UM that admission skin checks will be UM or designee to verify accensure any treatments were place. D. NHA, DON or designee weekly skin checks to ensure observation tools were compakin impairments have treated aily x 4 weeks until 100% then monthly x 4 months untercompliance met. NHA, DON or designee will admission skin checks to veand ensure treatments are in 4 weeks until 100% compliant then weekly x 4 until 100% comet and then monthly x 4 mo	g completed, rvation tool, der when a d. DON will to new per eviewed by curacy and e put into will audit re skin pleted and any ment in place net, then a met, and til 100% audit new rify accuracy in place daily xince is met, compliance is ponths until				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		085028	B. WING		R-C		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			06/03/2024	
WILMINGTON NURSING & REHABILITATION CENTER				700 FOULK ROAD WILMINGTON, DE 19803			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			IX (EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 686	Continued From pa 6/3/24 2:30 PM - Fi (NHA), E2 (DON), B E14 (VPO).	ge 5 ndings were reviewed with E1 E3 (ADON), E12 (RDCS) and	F6	586			