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

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

STATE SURVEY REPORT

NAME OF FACILITY: Wilmington Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: June 3, 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. 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.		
3201	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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		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 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	6/12/2024

Provider's Signature Renee Boyer Title LNHA Date 6/11/2024

NAME OF FACILITY: Wilmington Nursing & Rehabilitation Center **DATE SURVEY COMPLETED: June 3, 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 will verify weekly skin checks are	6/12/2024

Provider's Signature *Renee Boyer* Title LNHA Date 6/11/2024

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		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 and then monthly x 4 months until 100% compliance is met Date of Compliance: 6/12/24	

Provider's Signature Renee Boyer Title LNHA Date 6/11/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING _____ B. WING _____	R-C 06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS 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. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurses Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RDCS - Regional Director of Clinical Operations; RN - Registered Nurse; UM - Unit Manager; VPO - Vice President of Operations; Blindness (Legal) - severe vision impairment; Cornea - outer clear layer of the eye; Glaucoma - a disease of the eye which can cause blindness; Sacrum - large triangular bone at the base of the spine; Ulcer - a break in the skin or membrane.	{F 000}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	{F 684}		6/12/24

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

Electronically Signed | 06/11/2024

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 684}	Continued From page 1 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for one (R9) out of four residents reviewed for quality of care, the facility failed to ensure that the resident received treatment and care in accordance with professional standards of practice when the facility failed to schedule a timely follow up eye physician appointment for R9. Findings include: Review of R9's clinical record revealed: 5/17/24 5:00 PM - R9 was admitted to the facility directly from a hospital stay for the treatment of an infected corneal (eye) ulcer on his left eye; R9 had multiple diagnoses including glaucoma and legal blindness. R9's 5/17/24 hospital discharge summary, uploaded in the Electronic medical record (Emr) on 5/17/24, included instructions for the R9 to have a follow up appointment with a hospital ophthalmologist (eye care physician) within one week of hospital discharge. 5/17/24 10:35 PM - A physician order was written by E4 (Medical Director) for R9 to have an ophthalmology follow up appointment within one week. 5/31/24 11:00 AM - A review of the Electronic medical record (Emr) revealed the lack of an ophthalmology appointment within one week for	{F 684}	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 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	

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{F 684}	Continued From page 2 R9. 5/31/24 1:30 PM - During an interview, E13 (Unit Clerk) confirmed that R9 did not have an ophthalmology appointment scheduled yet, and that she and E4 (Medical Director) had discussed that morning, the timely need for R9 to have a ophthalmology appointment scheduled. 5/31/24 3:00 PM - During an interview, R9 stated that he has occasional pain from his left eye, and that he is anxious to see the hospital ophthalmologist to know the healing status of his left eye. 5/31/24 3:05 PM - A progress note was written by E13 that R9 was scheduled for an ophthalmology appointment on 6/11/24 at 2:30 PM. 6/3/24 10:45 AM - During an interview, E3 (ADON) confirmed that a physician order was written by E4 for R9 to have an ophthalmology appointment within one week of his 5/17/24 admission and that the appointment date was not made until 5/31/24, more than two weeks after his facility admission. The facility failed to have a process in place to schedule a time sensitive eye care appointment for R9 upon his admission to the facility. 6/3/24 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E12 (RDCS) and E14 (VPO).	{F 684}	UM/DON. DON/SDC or designee have educated the appointment schedulers (unit clerk, admission staff), ADON and unit manager on the 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	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		6/12/24

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F 686	Continued From page 3 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: F686 - Based on observation, interviews, and record review, it was determined that for one (R10) out of one resident reviewed for the treatment/services to prevent/heal pressures, the facility failed to initiate treatment and monitoring when R10 was readmitted on 4/13/24 with a sacral pressure ulcer. Findings include: A facility policy dated 1/29/24, and titled, "Wounds/Skin Impairments", documented, " ...The skin observation tool will be completed by a licensed nurse at least every seven (7) days, detailing any wound/skin impairments. Notify provider with updates and/or changes to the skin impairments, obtain new orders as necessary, provide treatments as ordered ...". Review of R10's clinical records revealed: 4/13/24 2:16 PM - R10 was readmitted to the facility from the hospital with past medical diagnoses including cerebrovascular disease affecting the left dominant side and muscle weakness. R10's readmission skin assessment	F 686	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 will verify weekly skin checks are completed and documented appropriately in the chart. DON/SDC or designee have	

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F 686	Continued From page 4 documented, " ...Open area to sacrum (large triangular bone at base of spine)". 6/3/24 10:00 AM - R10 was observed lying in her bed on her right side. R10 stated, "My butt hurts". 6/3/24 10:15 AM - A review of R10's medical records revealed that the facility lacked evidence that the skin assessments for 4/17/24, and 4/24/24 were completed. The skin assessment for 5/1/24 documented, "No pressure ulcer". The facility lacked evidence that the sacral ulcer was resolved. R10's skin checks in the Electronic medical records (Emr) for the next four (4) weeks were not documented in the clinical records. 6/3/24 11:30 AM - A review R10's treatment records from 4/13/24 through 6/2/24 failed to show evidence of a wound care treatment for the sacral ulcer for a total of fifty-one (51) days. 6/3/24 12:20 PM - The surveyor was present for R10's skin check, and an open area on her sacrum was observed. E7 (LPN) stated, "The aide told me yesterday that the resident had an open area on her bottom and I put some cream on it". E7 confirmed that a wound care treatment was not initiated and the wound was not documented on R10's medical records. 6/3/24 1:30 PM - During an interview, R6 (LPN) and E7 stated that they were aware that the weekly skin checks included a description of the residents' skin and notification of the doctor if any skin issues were observed. The facility failed to asess and provide treatment to a pressure ulcer.	F 686	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 and then monthly x 4 months until 100% compliance is met Date of Compliance: 6/12/24	

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F 686	Continued From page 5 6/3/24 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E12 (RDCS) and E14 (VPO).	F 686		