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: Regency Healthcare & Rehab Center
July 17, 2024

DATE SURVEY COMPLETED:

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from July 10, 2024, through July 17, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents as indicated. The facility census on the first day of the survey was eighty-seven (87). The survey sample totaled seventeen (17) residents. **Regulations for Skilled and Intermediate Care Facilities** **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 completed July 17, 2024: cross refer: F600 and F641.	Please refer to the CMS 2567 survey completed 7/17/24: F600 and F641	8/1/24

Provider's Signature Bruce Mawby Title NHA Date 8/1/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	C 07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

(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 An unannounced annual and complaint survey was conducted at this facility from July 10, 2024, through July 17, 2024. The facility census was eighty-seven (87) on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from July 10, 2024, through July 17, 2024. The deficiencies contained in this report are based on observations, interview, record review and review of other facility documents as indicated. The facility census on the first day of the survey was eighty-seven (87). The survey sample totaled seventeen (17) residents. This requirement is not met as evidenced by: Abbreviations/definitions used in this report are as follows: CNA- certified nursing assistant; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse; SW - Social Worker;	F 000		

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

Electronically Signed | 08/01/2024

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 000	Continued From page 1 Minimum Data Set (MDS) - Standardized assessment forms used in nursing homes;	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R95) out of nine sampled residents reviewed for abuse, the facility failed to protect R95 from verbal abuse. Findings include: Review of R95's closed clinical record revealed: 11/23/22 - R95 was admitted to the facility. 5/25/23 - R95 had a care plan for physical and verbal aggression. Interventions included but not limited to "listen to resident and try to calm". 8/24/23 - R95 had a care plan for verbal aggression to staff, yelling and threatening to	F 600	A. The deficient practice of preventing a resident from verbal abuse was unable to be corrected for R95 due to having passed the time of occurrence. R95 no longer remains at the facility. There is no opportunity to correct the deficiency. B. All residents have the potential to be affected by this deficient practice. C. The root cause analysis indicates that facility did not protect resident from receiving verbal abuse and did not immediately initiate in-servicing thereafter for entire house as a result of recognizing the verbal altercation amongst contracted staff towards a resident. The DON or designee will conduct	8/7/24

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F 600	Continued From page 2 have staff fired and interfering with care and disruptive behavior in the dining hall. Interventions included "listen to resident and try to calm". 5/15/24 3:10 PM - A facility incident report submitted to the State agency documented that R95 was in the dining room awaiting dinner service. R95 got frustrated when he felt that E6 was ignoring him and yelled (fuck). E6 then cursed R95 and yelled at him. 5/15/24 - A written statement by E5 (RN) documented, "At approximately 1715 (5:15 PM), I heard a screaming from the dining room. I saw [E6] at the entrance of the dining room upset and saying motherfucking way. I went in and saw [R95] and [E6] going back and forth using curse words. [R95] kept repeating 'I ain't no bitch you are.' [E6] said 'the fuck, you don't talk to me that way' and went into the kitchen. I asked [R95] what happened and he said that that they did not have the meal ticket for him and he kept calling her 15 - 20 times but she keeps walking from table to table ignoring him. When he got frustrate (sic) and slammed his phone on the table saying 'fuck', she said to him 'you don't fucking talk to me like that.' When she got to the kitchen doorway, she said ' you got me fucked up you dumbass bitch' ..." 5/15/24 - A written statement by E10 (CNA) documented, "While I was in the dining room [R95] and [E6] had an altercation. [R95]'s (meal) ticket wasn't down there with the rest of the tickets...[R95] kept calling [E6] name (sic) but she didn't answer him so he yelled out 'fuck' then [E6] starting (sic) say stuff like 'I don' know who yall think yall be talking to' then...start arguing more	F 600	resident interviews regarding feeling safe and able to report verbal abuse. If any resident interviewed has issues, a full investigation is to immediately ensue thereafter. Staff Development or designee will in-service all staff on de-escalation, abuse/neglect and reporting, customer service, and resident rights. 1) Reinforce staff to report immediately change in behavior from residents baseline with anticipation for potential escalated behaviors. DON or designee will review any concerns daily in Clinical meeting. D. The DON or designee will interview residents regarding feeling safe and able to report verbal abuse: 1) Daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	

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F 600	Continued From page 3 and calling each other names like 'Bitches'. 5/15/24 - A written statement by E11 (CNA) documented, "...[R95] had a loud verbal outburst when his question was not instantly answered. [E6] then raised her voice in retaliation to tell [R95] to 'not speak to her in that way' (sic) and she was helping someone else and would answer him when she was done. They then went back and forth yelling." 5/15/24 - A review on Employee Corrective Action (ECA) revealed that E6 was discharged from the contract company for poor performance, insubordination and rule violations. 5/21/24 8:14 AM - A progress note by E12 (SW) documented, "...follow up with [R95] about incident that happened last week in (sic) dining room and it was reported no issues. Psych services was offered but resident refused..." Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 7/17/24 beginning at approximately 2:00 PM.	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R40) out of one resident reviewed for hearing and visioin the facility failed to ensure the MDS was accurate for one (R40). Findings include:	F 641	A. R40 continues to reside at the facility. The MDS for hearing and vision was corrected to accurately reflect residents' needs. B. Residents who require a hearing aid or	8/7/24

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F 641	Continued From page 4 A review of R40's clinical record revealed: 5/2/23 - Resident was admitted to the facility. 5/2/23 - An inventory list included hearing aid and charger on admission. 5/7/24 - An annual MDS documented "Hearing aid or other hearing appliance used." The response was recorded as "No". 5/15/24 - A review of R40's care plan states that R40 "is at risk for impaired communication. [R40] is very hard of hearing." 7/16/24 11:33 AM - During an interview with E8 (RNAC) it was confirmed that the MDS for hearing was wrong. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 7/17/24 at approximately 2:00 PM.	F 641	hearing appliance has the potential to be affected by this same deficient practice. C. The root cause analysis indicates that the MDS was incorrectly coded by Social Services by not having a hearing appliance based on the Social Services evaluation. Facility failed to completely review clinical documentation, including inventory list in addition to clarifying the care plan that did indeed reflect a hearing appliance. RNAC will in-service Social Services to accurately complete Section B of MDS. D. RNAC will audit Social Services for accuracy of section B: 1) Once for all residents once until 100% success is achieved for entire house; 2) MDS completed for every resident over a 92 day period is reviewed for correct coding until 100% success is measured. Results of such audits to ensure correct coding of Section B for all residents will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	