STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 complaint survey was conducted at this facility from March 3, 2020 through March 4, 2020. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was seventy-nine (79). The survey sample totaled eleven (11) residents. Abbreviations and Definitions used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; ADON - Assistant Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD - Medical Doctor; NP - Nurse Practitioner; CNA - Certified Nurse's Aide; UM - Unit Manager.	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		4/30/20

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

Electronically Signed | 03/26/2020

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 607	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined that for one (E5) out of ten randomly-sampled employees the facility failed to ensure abuse / neglect training was provided. Findings include: Review of facility policy entitled Resident Abuse Protection Program (implementation 10/19/19) included, under the training/education section, "Upon hire and annually, as well as throughout the year, the facility will provide ongoing education about the sensitive treatment of our residents and the prohibition of abuse, neglect, mistreatment and misappropriation." Review of a State Agency form requesting evidence of the latest abuse / neglect training, completed by the facility, revealed E5 (Custodian) with hire date of 11/22/10, had no abuse / neglect training in 2019. E5's last abuse prohibition training was October, 2018. 3/3/2020 (afternoon) - E1 (NHA) confirmed the finding when providing the completed form to the surveyor. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (QA) on 3/4/2020 during the exit conference beginning at 11:30 AM.	F 607	F607 A. Resident were not negatively impacted by this deficiency. B. All residents have the potential to be impacted by this deficiency. The Staff Trainer will conduct a sweep of all active employees to identify any other staff who have not completed abuse training in the past year. Immediate re-education will be provided. C. Root Cause Analysis revealed that the educational tracking system did not accurately track employees who missed mandatory education due to a prolonged absence from work, therefore allowing employees to return to work with incomplete assignments. The staff Trainer will update his tracking tool to incorporate notification of staff on prolonged leave and their expected return date (if known). Managers and the House Supervisor will be notified of staff members who need training upon return to work. The Staff Trainer will conduct monthly reviews to ensure staff is in compliance with annual abuse training. The data will be reported as part of the Staff Trainers monthly QA reporting plan. Additional abuse training opportunities will be required outside of annual mandatories, utilizing both in-classroom and electronic education. D. The Staff Trainer will provide the Quality Assurance Administrator with	

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F 607	Continued From page 2	F 607	updated tracking sheets by the last day of each month. The QAA or designee will review any staff out of compliance with annual abuse training to determine if they had worked during the reporting period. The audit will continue until the facility achieves 3 consecutive months of staff compliance with annual abuse training unless they were on a leave of absence and had not worked in the past 30 days. E. Copy of the tracking tool and audit sheet are attached.	

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Veterans Home **DATE SURVEY COMPLETED: March 4, 2020**

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 complaint survey was conducted at this facility from March 3, 2020 through March 4, 2020. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was seventy-nine (79). The survey sample totaled eleven (11). **Title 16 Health and Safety** **Delaware Administrative Code**		
3201	**Regulations for Skilled and Intermediate Care 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 March 4, 2020: F607.	A. The resident was not negatively impacted by this deficiency. B. All residents have the potential to be negatively impacted by this deficiency. Unit Managers will conduct a focused review of charting for all residents who have had a fall in the past 30 days to ensure the Nurse's Note documents the incident, the condition upon discovery, and the immediate assessment for injury. C. The Root Cause Analysis revealed that the staff nurses did not complete the required documentation following a resident fall. The staff Trainer or designee will provide a focused re-education for all RNs and LPN's on the facility's fall prevention policy, highlighting the documentation expectations. Nursing Supervisors will report the compliance of completed documentation as part of their Morning Meeting report. D. The Medical Records Tech (MRT) or	3/24/2020
3201.9.0	**Records and Reports**		
3201.9.1.6	**Nursing notes, which shall be recorded by each person providing professional nursing services to the resident, indicating date,**		

Provider's Signature Jena M. Foley, LNHA Title Administrator Date 3/30/2020

NAME OF FACILITY: Delaware Veterans Home **DATE SURVEY COMPLETED: March 4, 2020**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	time, scope of service provided and signature of the provider of the service. Nursing notes shall include care issues, nursing observations, resident change of status and other significant events. **This requirement is not met as evidenced by:** Based on record review and interview it was determined that for one (R7) out of three residents sampled for falls the facility failed to ensure that two falls and the immediate resident assessment was included in the nursing notes. Findings include: The facility policy entitled Fall Prevention / Intervention Program (last reviewed 12/21/2016) included to not move a resident until the resident is assessed by a nurse ... Each fall will be properly documented in the resident's electronic medical record (EMR), in the nurses' notes, and the care plan must be reviewed for fall precautions and interventions. Review of R7's clinical record revealed: 1/13/2020 - Admission to the facility after hospitalization with multiple diagnoses including dementia (brain disorder with memory loss, poor judgement, personality changes and disorientation) and a history of a left knee fusion in the extended position (knee straight and cannot bend). 1/19/2020 - Admission MDS assessment included that R7 had moderately impaired cognition (decisions poor, cues / supervision required) with a BIMS (Brief Interview for Mental Status) score of 11 out of 15. R7 did not walk, needed extensive assistance (resident involved in activity, staff provide weight bearing support) with toileting and total assistance (full staff performance) with trans-	designee will complete a weekly review of any residents who have fallen. The MRT or designee will audit Nurse's Notes for documentation about the incident occurring, the resident's condition upon discovery, and the immediate assessment for injury. The audit will be completed weekly until 4 consecutive weeks of 100% compliance is achieved.	

Provider's Signature Tina M. Tolley, LNHA Title Administrator Date 3/30/2020

NAME OF FACILITY: Delaware Veterans Home **DATE SURVEY COMPLETED: March 4, 2020**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	fer. 1/22/2020 - A care plan for falls related to a history of falls, impaired balance, decreased mobility (moving around), poor leg control and unsteady gait (walking) was developed. Interventions included: non-skid footwear, encourage to ask for assistance and use call bell; bed/chair alarm; keep glasses within reach; assist with ambulation/transferring and toileting; use assistive devices (wheel-chair, reacher). 2/21/2020 (5:11 PM) - NP note documented that R7 "noted with fall x2 (twice) [today]. AM fall occurred as resident attempted to self-transfer. Fall #2 occurred in afternoon, resident initially stated did not know cause of fall then stated ... was trying to get cell phone. Resident has denied majority of neu-rological assessments (questions and physical tests to see if nervous system impaired from bleeding in the brain) for each fall ..." 2/21/2020 (11:28 PM) - The nurses' note documented ... "to get his vital signs (clinical measurements including blood pressure, heart/breathing rate and temperature), per protocol due to multiple falls today." 2/21/2020 - Review of all nursing notes re-vealed no evidence that R7 fell twice, his condition upon discovery or immediate as-sessment for injury. 3/4/2020 (9:36 AM) - During an interview, E6 (UM) confirmed the missing fall documenta-tion including assessment for injury related to R7's two falls on 2/21/2020. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (QA) on 3/4/2020 during the exit conference beginning at 11:30 AM.		

Provider's Signature Tina M. Fiddy, LNHA Title Administrator Date 3/30/2020

NAME OF FACILITY: Delaware Veterans Home **DATE SURVEY COMPLETED: March 4, 2020**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.9.6	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. The method of reporting shall be as directed by the Division.**		
3225.9.8	**Reportable incidents are as follows:**		
3225.9.8.4.2	**Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.** **This requirement is not met as evidenced by:** Based on record review and review of other facility documentation it was determined that for one (R7) out of three residents investigated for falls, the facility failed to timely report a fall with injury requiring transfer to a local hospital for treatment. Findings include: Review of R7's clinical record revealed: 1/13/2020 – R7 was admitted to the facility. 2/26/2020 – A nursing note documented, "Resident was in his wheelchair in the TV room when he fell flat to the floor and hit his forehead sustaining a hematoma (collection of blood under the skin) with a cut to the right temporal area at 6:00 AM ... Resident had a change in mentation (thinking) and repeats one thing over and over ... 911 was called ..." Review of the facility fall investigation documents for R7's 2/26/2020 fall revealed the	A. The resident was not negatively impacted by this deficiency. B. All residents have the potential to be negatively impacted by this deficiency. The House Supervisor or designee will conduct a focused review of all falls related State Incident Reporting for the past 30 days to ensure compliance with the submission timeline. C. Root Cause Analysis revealed that the Supervisor did not submit the incident to Division of Healthcare Quality (DHQ) until the end of her shift. The QA Administrator or designee will provide a visual tool and brief in-service related to DHQ Incident Reporting timelines for the facility's Nursing Leadership. D. The DON or designee will complete a weekly review of any state reported incidents to ensure compliance with timeline restrictions. This audit will be completed weekly until 3 consecutive weeks of compliance are achieved, then the audit will be continued monthly until 1 month compliance is achieved.	5/1/2020

Provider's Signature Jessica M. Fosley, LNHA Title Administrator Date 3/30/2020

NAME OF FACILITY: Delaware Veterans Home **DATE SURVEY COMPLETED: March 4, 2020**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	last half of the fall was witnessed by E6 (RN), E7 (RN) and E8 (LPN) who were at the nursing station. The incident was reported to the State Agency on 2/26/2020 at 7:31 PM, over 13 hours after R7 had a fall with injury needing transfer to the emergency department. Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (QA) on 3/4/2020 during the exit conference beginning at 11:30 AM.		

Provider's Signature Tina M. Frosley, LNHA Title Administrator Date 3/30/2020