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 Veterans Home

DATE SURVEY COMPLETED: June 8, 2021

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 COVID-19 Focused Infection Control Survey and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection from June 4, 2021 to June 8, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census on the first day of the survey was fifty-five (55). The survey sample totaled ten (10).		
3201	**Regulations for Skilled and Intermediate Care Facilities**	Cross reference F-886.	
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 June 8, 2021: F886.		

Provider's Signature [signature] Title Administrator Date 6/29/21

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 06/08/2021

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 COVID-19 Focused Infection Control Survey and Complaint Survey was conducted by the State of Delaware Division of Health Care Quality office of Long Term Care Resident Protection from June 4, 2021 to June 8, 2021. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other documentation as indicated. The facility census on the first day of the survey was 55. The survey sample totaled ten (10). Abbreviations/Definitions used in this report are as follows: NHA - Nursing Home Administrator; CNA - Certified Nursing Assistant; DON - Director of Nursing; CDC - Centers for Disease Control and Prevention; CMS - Centers for Medicare & Medicaid Services; COVID-19/Coronavirus - a respiratory illness that can be spread person to person; COVID Testing - a test for COVID-19/Coronavirus.	F 000		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:	F 886		8/6/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/29/2021

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.

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 06/08/2021

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 886	Continued From page 1 §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the	F 886		

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 06/08/2021

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 886	Continued From page 2 transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to conduct the required COVID-19 testing every seven days for one (E5) out of three employees sampled. Findings include: 8/26/20 - A CMS memorandum (QSO-20-38-NH) established Long-Term Care (LTC) Facility Testing Requirements for Staff and Residents...Specifically, facilities are required to test residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19 based on parameters set forth by the HHS (Health and Human Services) Secretary...The minimum frequency of routine testing of LTC facility staff shall be based on county positivity rates, State and county officials have a right to direct LTC facilities to test at higher frequency based on other factors." 2/25/21 -The Division of Public Health (DPH) Testing Guidance for Long-Term Care Facilities required weekly COVID-19 testing of facility staff based on county positivity rates.	F 886	Date: __6/24/2021_ Deficiency Noncompliance with employee COVID – 19 testing per facility universal testing policy and as required by the positivity rate and DPH guideline F– Tag # F886 Department: __Nursing______________ Question Plan of Correction 1. What Corrective action(s) will be accomplished for those employee(s) found to have been affected by the deficient practice? Review of the testing data, work schedules and documentation provided by E1(NHA) revealed that employee E5(CNA) worked from 2/26/2021 though 3/13/2021 without being tested for COVID -19. E5(CNA) tested positive for COVID 19 with a POC test which was confirmed with PCR test. Employee E5 tested positive on 3/14/2021	

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 06/08/2021

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 886	Continued From page 3 Review of testing data, work schedules and documentation provided by E1 (NHA) revealed the following discrepancy in testing: - E5 (CNA) worked from 2/26/21 through 3/13/21 without being tested for COVID-19. - E5 (CNA) tested positive for COVID-19 with a POC (Point of Care) test which was confirmed with a PCR (Polymerase Chain Reaction) test. 6/8/21 9:30 AM - During an interview, E1 (NHA) confirmed that the facility failed to conduct the required testing for E5 (CNA) during the two weeks prior to her testing positive on 3/14/21. 6/8/21 11:15 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (CRN) during the Exit Conference.	F 886	and could not test for the next 90 days. Employee E5(CNA) is currently compliant with testing requirements. 2. How will you identify other employees having the potential to be affected by the same deficient practice and what corrective action will be taken? Weekly tracking of staff from all departments, to include nursing, administration, food services, operations, activities, and contractors with extended contact of residents was completed to ensure compliance with current testing guidelines. During the initial review of the weekly tracking it was identified that, within the nursing department 3 staff members, two of which are weekend casual seasonal staff did not have documented weekly testing, the remaining departments and staff were compliant. Those who were found to be out of compliance were required to test prior to working their next scheduled shift and had negative test results. 3. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? RCA: The current process in place was incomplete. The process was lacking an adequate follow up procedure to ensure employee compliance with testing guidelines as set by DPH guideline and the current positivity rates. There were not clear role responsibilities set forth to ensure proper oversight and compliance with testing guidelines. In adequate staff education of current policy and procedure. As well as an inadequate process to alert staff of what testing	

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 06/08/2021

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 886	Continued From page 4	F 886	process was in place at different times. Finally, there was not a process in place to ensure weekend testing was completed timely. The Manager from each department, to include nursing, administration, food services, operations, and activities and the staff who directly report to them have been clearly identified, including clarifying a manager for the casual seasonal staff. The process for notifying casual seasonal staff of the need to test when they sign up for shifts was updated. A process to ensure all staff know of changing in testing process was also put in place. Weekly testing is tracked, a list of employees who need to test for the week is sent out to their managers starting on Wednesday each week, which they return prior to the weekend, confirming completion of testing, to ensuring compliance. Staff Trainer or designee will educate all active employees from all departments on the Universal testing policy by June 30, 2021. The QA nurse has educated all managers from each department, to include nursing, administration, food services, operations, and activities, on the updated process to ensure COVID- 19 testing is completed as required by the positivity rate and the DPH guidelines. A town hall was held where education on the testing policy was reinforced. Any noncompliance of testing will be reported to the administrator immediately. Noncompliance will result in removal from schedule until compliant and progressive	

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 06/08/2021

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 886	Continued From page 5	F 886	disciplinary action. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. What quality assurance program will be put into place? QA administer/QA nurse/designee will conduct random audits, utilizing an electronic randomizer to ensure an equal subset of the entire staff, from all departments is represented. From this randomized selection, 20 different employee's will be audited for compliance. Audits will be conducted weekly x 4 weeks and report any noncompliance to the administrator. Audits will continue of 20 per month, as stated previously, x 2 months, reporting any noncompliance to the administrator. Findings of the audits will continue to be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 5. The date the corrective action will be completed Friday August 6, 2021	