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: New Castle Health And Rehabilitation Center **DATE SURVEY COMPLETED:** November 28, 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. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 11/24/24 through 11/28/24. Survey Census: 115 Sample Size: 37 Supplemental Residents: 11		
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.**		

Provider's Signature [signature] Title NHA Date 12/20/24

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	This requirement is not met as evidenced by: Cross refer: F554, F558, F600, F609, F610, F657, F691, F803, F812, and F880.		

Provider's Signature [signature] Title NHA Date 12/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

(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 A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 11/24/24 to 11/26/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 11/24/24 through 11/28/24. Survey Census: 115 Sample Size: 37 Supplemental Residents: 11	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to assess a resident for self-administration of medication for one of one resident (Resident (R) 7) reviewed for self-administration of medication of 37 sample residents. This had the potential to affect resident medication safety at the facility.	F 554	R7 was evaluated for their ability to self-administer medication. R7□s plan of care was updated accordingly. All residents who wish to self-administer medication have the potential to be affected. On 12/18/2024 the Director of	1/7/25

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

Electronically Signed | 12/18/2024

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 554	Continued From page 1 Findings include: Review of R7's "Admission Record" in the "Profile" tab of the electronic medical record (EMR) revealed an admission date of 05/26/23. The "Admission Record" also revealed a diagnosis of chronic obstructive pulmonary disease, cognitive communication deficit, and dementia. Review of R7's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/26/24 and located in the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of three out of 15 which indicated the resident was severely cognitively impaired. Review of a completed "Self-Administration of Meds Assessment" located under the "Observations" tab of the EMR and with observation date of 11/12/24, revealed that the resident made the determination of not wanting to self-administer her own meds and that the facility would deliver meds to the resident. No further evaluation was completed in the assessment. During an observation and interview on 11/24/24 at 11:05 AM, the observation revealed R7 lying in bed awake with a medicine cup containing four to five pills on top of bedside table next to bed. R7 stated, "That's my medicine. I don't know what medicine that is or what it's for, but I was going to take them when I got ready too. I don't know how long they've been there. I just tell them to leave my medicine there and I'll take them when I want." When asked how often she had her medicine brought and left on her table for her R7 responded, "Oh I don't remember if they leave my	F 554	Nursing (DON) and/or designee audited all alert and oriented residents to ensure that those wishing to administer their own medications were evaluated for functional ability. Where necessary the resident□s plan of care was updated. Root Cause Analysis was completed by the Nursing Home Administrator and Director of Nursing to determine the system failure responsible for these alleged deficiencies. The nurse on duty failed to determine whether or not the resident was evaluated for self-administering medications prior to leaving them at the bedside. To prevent the potential for reoccurrence the DON and/or designee re-educated all licensed staff on the resident medication self-administration process with emphasis placed on not leaving medication at bedside unless resident is capable. To monitor and maintain on-going compliance the DON or designee will conduct weekly audits of 5 resident rooms for 4 weeks to verify that medication is not left at the bedside unless the resident is capable of self-administration. If necessary, the medication will be removed, and the responsible person will be re-educated. Following this, weekly audits will be conducted for 3 months with the goal of achieving and maintaining	

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F 554	Continued From page 2 medicine there everyday or not. If they're there, I know they're mine." During an observation and interview on 11/24/24 at 11:10 AM, the Assistant Director of Nursing (ADON) entered R7's room with this surveyor and the medicine cup containing medicine was sitting on top of R7's bedside table next to her. ADON told R7, "I'm going to take these from you and give them back to your nurse because you're not supposed to have them. The nurse will come back with your meds and tell you what they are and give them to you to take." R7 stated, "I don't know what they're for. I don't know why she left them here, but I need to take them." ADON told her, "That's why the nurse is going to come back to your room and give them to you, so that she can tell you what they are for and watch you take them." ADON stated, "We're not supposed to be leaving meds at the bedside. She is cognitive but does have confusion. I don't know what her BIMS is. I'm sure she doesn't have a self-administration of medication assessment done. She's not supposed to have them. I will take these to the nurse and re-educate her." During an interview on 11/24/24 at 11:15 AM, Registered Nurse (RN) 5 stated, "I'm new here, but I'm an old nurse. So, I knew better than to leave meds at the bedside. I'm not sure what her BIMS is. She does have a self-administration of medication assessment done, but we still don't allow anyone to keep meds at bedside because another resident can roll themselves into her room and get those meds. So, we don't allow them to self-administer for safety reasons or other reasons. The meds were Zoloft, Prednisone, and Acetaminophen."	F 554	100% compliance. If compliance falls below the target, the Interdisciplinary Team (IDT) will review the process and implement revisions to ensure sustained compliance. Findings will be presented to the facility's QAPI for continued evaluation and recommendations.	

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F 554	Continued From page 3 During an interview on 11/26/24 at 2:20 PM, the Director of Nursing (DON) stated, "[R7] should never have had meds. Staff know this. R7 isn't capable of self-administering her own meds. She has low BIMS. We educated nursing staff that day and still doing it as they come on shift." During an interview on 11/26/24 at 2:35 PM, the Administrator stated, "[R7] never have been allowed to self-administer her own meds. Our process is to do a self-administration of meds assessment on anyone that expresses their need to, or they're observed capable, get a doctor order for her to be allowed to, care plan it with the appropriate interventions, and then nursing would follow up and make sure she is taking all her meds and if she was still capable. We are providing an in-service on this to make sure nursing is reeducated on that and that this isn't allowed."	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure residents had access to call lights when needing assistance from staff for one of three residents (Resident (R) 73) reviewed for call lights out of 37 sample residents. This failure had the potential to affect resident safety.	F 558	R37□s call button was moved within reach of the resident at time of observation. All residents have the potential to be affected. On 11/26/2024 the DON and/or designee conducted an observation of all	1/7/25

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F 558	Continued From page 4 Findings include: Review of the quarterly "Minimum Data Set (MDS)" located under the "Resident Assessment Instrument (RAI)" tab of the electronic medical record (EMR) with an Assessment Reference Date (ARD) of 11/04/24 revealed a Brief Interview for Mental Status (BIMS) of nine out of 15 which indicated the resident was moderately cognitively impaired. The resident was admitted on 10/03/22 with diagnoses which included atrioventricular block, muscle weakness, and osteoarthritis. During an observation and interview on 11/24/24 at 2:05 PM, the call light was observed on the opposite side of the bed. The call light was not within R73's reach. When R73 was asked if she needed to call for assistance, how would she call for help. R73 stated was not able to reach the call light. During an observation and interview on 11/24/24 at 2:28 PM the DON said, "The call light should be where she can reach it." The DON proceeded to attach R73's call light to her lapel.	F 558	residents to ensure their call button was in reach at time of review. Where necessary the resident□s call bell was moved. Root Cause Analysis was completed by the Nursing Home Administrator and Director of Nursing to determine the system failure responsible for these alleged deficiencies. It was determined that a lack of ongoing staff education contributed to the undesired outcome. To prevent the potential for reoccurrence the DON and/or designee re-educated all staff on the need to ensure that call buttons remain within reach of the resident at all times. To ensure ongoing compliance, the DON or designee will conduct weekly audits of 5 resident rooms for 4 weeks to verify that call buttons are within the resident's reach. If necessary, the call button will be repositioned, and the responsible person will be re-educated. Following this, weekly audits will be conducted for 3 months with the goal of achieving and maintaining 100% compliance. If compliance falls below the target, the Interdisciplinary Team (IDT) will review the process and implement revisions to ensure sustained compliance. Findings will be presented to the facility's QAPI for ongoing review and recommendations.	

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F 600	Continued From page 5	F 600		
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 observations, interviews, record review, and facility policy review, the facility failed to protect two of four residents right to be free from physical abuse, Resident (R) 218 from physical abuse by R26, and R316 from physical abuse by R42 of 37 sample residents. This failure could lead to the potential of physical abuse towards other residents throughout the facility. Findings include: Review of the facility's policy titled, "Delaware Resident Abuse policy: Abuse, Neglect and Exploitation," revised 09/28/22, indicated, under the section "Policy: This Facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone." The section "Definitions: Abuse - includes actions such as the willful	F 600	An immediate investigation and appropriate follow up was conducted at time of events including R26, R316, and R42. All residents have the potential to be affected. On 12/20/2024 the Social Services Director (SSD) reviewed all resident plans of care for indications of verbal or physical aggression. Where identified the resident□s plan of care was reevaluated to ensure interventions were in place to manage these behaviors. Resident plan of care was updated as necessary. Root Cause Analysis was completed by	1/7/25

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F 600	Continued From page 6 infliction of injury unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. It includes verbal abuse, sexual abuse, physical abuse, mental abuse including abuse facilitated or enabled through the use of technology, misappropriation of resident property, exploitation, involuntary seclusion and injuries of unknown source, physical and chemical restraints. Physical abuse - includes hitting slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment." 1. a. Review of R26's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed an initial admission date of 12/03/21. The "Admission Record" revealed diagnoses of vascular dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R26 was transferred and admitted to a hospital on 11/22/24 for a change in condition due to decreased responsiveness and multiple vomiting episodes. Review of R26's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/03/24, located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of six out of 15 which indicated the resident was severely cognitively impaired. Review of the facilities document titled, "Incident/Accident or Injury of Unknown Origin,"	F 600	the Nursing Home Administrator and Director of Nursing to determine the system failure responsible for these alleged deficiencies. It was determined that a proactive approach to identifying meaningful interventions for resident aggression may have prevented these resident to resident events from occurring. To prevent the potential for reoccurrence the DON and/or designee re-educated all staff on the center□s abuse prohibition policy with emphasis on how to deescalate aggressive resident behaviors should they be observed. To ensure ongoing compliance, the SSD or designee will conduct weekly audits of resident documentation for 5 times weekly to identify any indications of aggressive behavior. If aggressive behavior is noted, the SSD will verify that appropriate and effective interventions are in place. Ineffective plans will be revised, and the MD, RP, and clinical team will be notified. Following this, weekly audits will be conducted for 3 months, with the goal of achieving and sustaining 100% compliance. If compliance consistently falls below the goal, the Interdisciplinary Team (IDT) will review the process and implement necessary revisions to ensure sustained compliance. Findings will be presented to the facility's QAPI for ongoing evaluation and recommendations.	

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F 600	Continued From page 7 revealed a witness statement from CNA3 [Certified Nurse Aide] signed and dated 03/24/24 stated, "While assisting another patient, I heard fighting in an adjacent room. I ran to the room and saw [R26] with both hands around [R218's] throat. [R218] had his cane hitting [R26]. I quickly stepped in and stopped the altercation and asked [R26] to leave the room." Review of R26's "Focused Head to Toe Observation Note" located in the EMR "Progress Notes" tab, dated 03/25/24 at 12:01 AM by Registered Nurse (RN) 3 revealed, "[CNA3] was providing care to a resident when she heard loud voices from resident's shared room. Upon responding, [CNA3] reported observing [R26] standing over his roommate, [R218], with his hands around his neck, squeezing tightly. The roommate, [R218], had grabbed a cane and was waving it in the air in an attempt to defend himself. [CNA3] was able to separate the two and called for [RN3]. Upon responding, [RN3] observed [R26] standing in the hallway looking agitated with reddened face. Upon asking [R26] what happened, [R26] responded, "Yeah I did it. I just snapped. He knows what buttons to push." [R26] would not elaborate further. [R26] was provided with alternate room assignment and is receiving 1:1 observation. Resident now sitting in wheelchair in private room with [CNA3] at bedside maintaining 1:1 surveillance." b. Review of R218's undated "Admission Record" in the "Profile" tab of the EMR revealed latest admission date of 10/01/24 and diagnosis of atrioventricular block, second degree, diastolic (congestive) heart failure, end stage renal disease with dependence on renal dialysis, and adult failure to thrive. R218 was a hospice patient	F 600		

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F 600	Continued From page 8 and transferred to hospital on 10/15/24 at the request of daughter for abdominal breathing and audible gurgling and rales in upper lower lobes. R218 admitted for congestive heart failure and expired during hospitalization." Review of R218's Significant change in status assessment MDS" with an ARD of 08/12/24, located in the EMR "MDS" tab, revealed a BIMS score of three out of 15 which indicated R218 was severely cognitively impaired. Review of R218's "Heath Status Note" located in the EMR "Progress Notes" tab, dated 03/24/24 at 9:56 PM by RN4, revealed "It was brought to my attention by [CNA3] that she witnessed [R218's] roommate on top of him with his hands around his neck attempting to squeeze. [R218] attempted to reach his cane in an attempt to fight back. The aggressive patient, [R26], was immediately removed from the situation and placed in another room on the North side. [R218] was assessed for injury and none was found. This nurse notified the responsible party of the incident with all questions addressed at time of notification." During an interview on 11/26/24 at 12:38 PM Assistant Director of Nursing (ADON) stated, "Right after the incident with [R26] and [R218], we did do abuse and neglect training for a few days after to make sure we got everyone in the facility. Those that were here received the training right away." During an interview on 11/26/24 at 2:20 PM, the Director of Nursing (DON) stated, "The abuse altercation was reported to me. We did an investigation and called it into the state. [R26] did not have any behaviors like that previously and	F 600		

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F 600	Continued From page 9	F 600		

hasn't had any since. It was an isolated incident. Our process is to report abuse to the state immediately, investigate, do necessary interventions, reeducate, and turn our 5-day report into the state."

During an interview on 11/26/24 at 2:35 PM, the Administrator stated, "I wasn't here during the altercation involving [R26] and [R218], but all reports of abuse or neglect would automatically be reported to the state. We make sure residents are safe, notify responsible parties, do interventions and care plan, reeducate staff, do a thorough investigation, and follow up with the 5-day report to the state."

2. a. Review of R42's "Admission Record" located under the "Profile" tab revealed the resident was admitted to the facility on 03/28/17 with diagnosis of Alzheimer's disease, cerebral infarction, and dysphagia.

Review of R42's annual "MDS" with an ARD of 08/19/24 revealed the facility had assessed the resident with a BIMS of 10 out of 15 indicating moderate cognitive impairment.

b. Review of R316's "Face sheet" located under the "Resident" tab of the EMR revealed the resident was admitted to the facility on 08/12/19 with diagnoses to include dementia, anxiety disorder, major depressive disorder, and unspecified lump in the right breast.

Review of R316's quarterly "MDS" located under the "MDS" tab of the EMR with an ARD of 06/10/24 revealed R361 had been assessed to have a BIMS score of 00 out of 15 indicating the resident was severely cognitively impaired.

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(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 600	Continued From page 10 Review of R316's "Progress Note" located under the "Progress Notes" tab of the EMR, dated 08/26/24 at 10:01 PM, entered by Licensed Practical Nurse (LPN) 2, revealed the resident was aimlessly wandering in the hallways throughout the facility, and it was reported that another resident physically assaulted the above written resident. Review of "Progress Note" located under the resident "Progress Notes" tab of the EMR, dated 08/26/24 at 11:00 PM, entered by LPN3, revealed she overheard a resident call for help and found that R42 was sitting in his wheelchair at the feet of another resident who was on the floor in front of him. The resident who had called for help asserted that R42 had been hitting another resident and had pushed her, which had resulted in her fall. The resident on the floor was R316. R42 was asked about it but he denied hitting the resident. R42 was redirected to his room and monitored while staff alerted the doctor, and pertinent personnel. Messages left for on call doctor and R316's Responsible Party (RP). During an interview on 11/25/24 at 4:30 PM, LPN2 stated she was on the 200 Hall on 08/26/24 when LPN3 from the 500 Hall came and told her R42 hit and pulled R316 down to the ground. LPN2 stated she reported the incident to the nurse supervisor on duty and to the DON that night. LPN2 stated she called R316's son and he came into the facility that night and stated he wanted the police called. LPN2 stated the police came and completed a report that night. LPN stated R42 as placed on 1:1 monitoring and R316 required redirection and placed on every 30-minute checks to ensure her safety.	F 600		

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	085039	A. BUILDING _____ B. WING _____	C 11/26/2024

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F 600	Continued From page 11 During an interview on 11/26/24 at 5:45 PM, the DON stated she had been called by LPN2 and made aware of the incident involving R42 and R316. She stated she immediately conducted an investigation, and the Administrator notified the appropriate reporting agencies. The DON stated she and the Administrator were responsible for reporting incidents of abuse to the state agency within 24 hours. She stated all staff were trained on the facility's abuse policy on hire and are provided with additional training anytime there is an incident involving abuse. She stated she expected staff to notify her and the Administrator immediately of any allegations of abuse. The DON stated the nurse on duty should notify the police and begin interviewing all staff involved so a thorough investigation could be conducted immediately. The DON further stated all staff should follow the facility's Resident Abuse policy to ensure the safety of residents. During an interview on 11/26/24 at 6:00 PM with the Administrator she stated she expected staff to follow the facility's Abuse policy to ensure resident safety.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		1/7/25

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F 609	Continued From page 12 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and review of the facility's policy, the facility failed to report allegations of abuse to the appropriate reporting authority for two of four residents (Residents (R) 316 and R216) reviewed for abuse of 37 sample residents. This failure had the potential to affect resident safety at the facility. Findings include: Review of the facility's policy titled, "Delaware Resident Abuse," revised on 09/28/22, revealed facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator would immediately begin an investigation and notify the applicable local and state agencies in accordance with the procedures	F 609	R16, R26, and R218 no longer reside within the facility. All residents in the facility have the potential to be affected. On 12/10/2024 the Nursing Home Administrator (NHA) and/ or designee conducted an audit from date of survey exit to ensure all events requiring reporting to the State Department of Health were reported. If necessary, the event was reported. Root Cause Analysis was completed by the Nursing Home Administrator and Director of Nursing to determine the system failure responsible for these	

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F 609	Continued From page 13 in this policy. 1. Review of R316's "Face sheet" located under the "Resident" tab of the electronic medical record (EMR) revealed the resident was admitted to the facility on 08/12/19 with diagnoses to include dementia, anxiety disorder, major depressive disorder, and unspecified lump in the right breast. Review of R316's quarterly "Minimum Data Set (MDS)" located under the "Resident Assessment Instrument (RAI)" tab with an Assessment Reference Date (ARD) of 06/10/24 revealed R316 had a "Brief Interview for Mental Status (BIMS)" score of 00 out of 15 which indicated the resident was severely cognitively impaired. Review of R316's "Progress Note" located under the "Resident" tab of the EMR, dated 06/19/24 at 10:21 PM and entered by Licensed Practical Nurse (LPN) 1 revealed the resident had purple discolorations to the right and left posterior thighs measuring 4.0 centimeters (cm) by 4.0 cm and 2.0 cm by 2.0 cm long. Upon assessment the resident had no apparent pain with walking in the facility and range of motion was performed with no pain noted. LPN1 notified the Advanced Practice Registered Nurse (APRN), and the resident's son was made aware. A new order was received to monitor the sites of bruising every shift for 14 days. Review of R316's "Progress Note" located under the "Resident" tab of the EMR, dated 06/20/24 and entered by the Director of Nursing (DON) revealed the Interdisciplinary Team (IDT) met to discuss R316's plan of care. The resident was noted with bouts of pacing throughout the halls	F 609	alleged deficiencies. It was determined that the facility was unaware of federal versus state reporting guidelines and follow state department recommendations for the identified events. To prevent the potential for reoccurrence the NHA and/or designee re-educated the DON on state reporting requirements with emphasis on what constitutes a reportable event. To ensure ongoing compliance, the NHA or designee will conduct weekly audits for 4 weeks to review all adverse events and confirm that reportable events were properly reported. If necessary, the event will be reported. Afterward, weekly audits will continue to be conducted for 3 months, with the goal of achieving and sustaining 100% compliance. If compliance consistently falls below the goal, the Interdisciplinary Team (IDT) will review the process and make revisions to ensure sustained compliance. Findings will be presented to the facility's QAPI for continued review and recommendations.	

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F 609	Continued From page 14 ambulating independently with no report or observation of incidents causing trauma. Continued review revealed on 06/19/24 she was observed with bruising to both posterior thighs and upon assessment there were no signs and symptoms of pain or discomfort, and no evidence of abuse noted. New interventions included dressing the resident in long sleeve shirts and pants, protecting the extremities, keeping the skin lubricated, monitoring, and recording any complaints of pain (location, duration, quantity, quality, alleviating factors, aggravating factors). The was no documentation to support the facility reporting the incident to the state agency or the police. During an interview on 11/26/24 at 7:45 AM, DON stated she did not report or investigate the bruising to R316 bilateral posterior thighs because she had determined the root cause of the bruising was from her pants being bunched up behind her legs. During a follow-up interview on 11/26/24 at 5:45 PM, the DON stated she and the Administrator were responsible for reporting incidents of abuse to the state agency within 24 hours. She stated all staff were trained on the facility's abuse policy on hire and were provided with additional training anytime there was an incident involving abuse. She stated she expected staff to notify her and the Administrator immediately of any allegations of abuse to include injuries of unknown origin. The DON stated the nurse on duty should notify the police and begin interviewing all staff involved so a thorough investigation could be conducted immediately. The DON further stated all staff should follow the facility's Resident Abuse policy to ensure the safety of residents.	F 609		

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F 609	Continued From page 15 During an interview on 11/26/24 at 6:00 PM, the Administrator stated she expected staff to follow the facility's abuse policy to ensure resident safety. 2. Review of R216's admission "MDS" with an ARD of 08/21/24 revealed R216 was admitted on 08/16/24 and discharged on 09/07/24. R216's "BIMS" score was three out of 15 which indicated the resident was severely cognitively impaired. Diagnoses included metabolic encelphalopathy, dementia, difficulty walking, weakness, sepsis, type two diabetes, atrial fibrillation, anxiety, and mood disturbance. Review of the "Resident Concern Log" dated 08/22/24 and provided by the facility, revealed Staff reported observing resident (R216) being hit by his wife with a hanger. Review of facility follow-up revealed the wife was spoken to by SS (Social Services) and DON (Director of Nursing). The wife was educated not to hit or yell at the resident. The staff would provide the care resident needs when needed which she was concerned. Resolution of Concerns documented Resident was discharged to hospital on 08/22/24. Concern form was signed by the Administrator with no date. During an interview on 11/26/24 at 3:50 PM, the Administrator stated she was told she did not have to report this allegation of abuse. The Administrator provided a copy of the resident concern form, dated 08/22/24, which reported an allegation of abuse of R216 by his wife.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)	F 610		1/7/25

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F 610	Continued From page 16 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure a thorough investigation was completed related to an allegation of physical abuse for one of four residents (Resident (R) 216) reviewed for abuse of 37 sample residents. This failure created the potential for R216 to experience further abuse. Findings include: Review of the facility's policy titled, "Abuse, Neglect, Mistreatment, Exploitation of Resident Property," dated 09/28/22, read in part, "The Facility will not tolerate abuse, neglect, mistreatment, exploitation, of residents, and misappropriation of resident property by anyone. It is the facility's responsibility to investigate all allegations, suspicions and incidents of abuse,	F 610	R216 no longer resides within the facility. All residents have the potential to be affected. On 12/10/2024 the NHA and/or designee conducted an audit from date of survey exit to ensure that all suspected abuse events were appropriately investigated. If necessary an investigation was completed. Root Cause: Root Cause Analysis was completed by the Nursing Home Administrator and Director of Nursing to determine the system failure responsible for these alleged deficiencies. It was determined that the facility did not	

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F 610	Continued From page 17 neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source. The facility staff must immediately report all such allegations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately being an investigation and notify the applicable local and state agencies in accordance with the procedures and policy." Review of R216's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/21/24 revealed R216 was admitted on 08/16/24 and discharged on 09/07/24. R216's "Brief Interview for Mental Status (BIMS)" score was three out of 15 which indicated the resident was severely cognitively impaired. Diagnoses included metabolic encelphalopathy, dementia, difficulty walking, weakness, sepsis, type two diabetes, atrial fibrillation, anxiety, and mood disturbance. Review of the "Resident Concern Log" dated 08/22/24 and provided by the facility, revealed staff reported observing resident (R216) being hit by his wife with a hanger. Review of facility follow-up revealed the wife was spoken to by SS (Social Services) and DON (Director of Nursing). The wife was educated not to hit or yell at the resident. The staff would provide the care resident needs when needed where she was concerned. Resolution of Concerns documented Resident was discharged to hospital on 08/22/24. Concern form was signed by the Administrator with no date. During an interview on 11/26/24 at 3:50 PM, the Administrator stated she was told she did not have to report this allegation of abuse. The	F 610	immediately recognize the event as a circumstance of abuse and perceived the issue as a marital disagreement. To prevent the potential for reoccurrence the NHA and/or designee re-educated all staff on the abuse prohibition policy with emphasis on the need to conduct a thorough investigation if abuse is suspected. To ensure ongoing compliance, the NHA or designee will conduct weekly audits for 4 weeks to review all adverse events and verify that episodes of suspected abuse were thoroughly investigated. Following this, weekly audits will be conducted for 3 months with the goal of achieving and sustaining 100% compliance. If compliance consistently falls below the goal, the Interdisciplinary Team (IDT) will review the process and make revisions to ensure sustained compliance. Findings will be presented to the facility's QAPI for ongoing review and recommendations.	

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F 610	Continued From page 18 Administrator provided a copy of the resident concern form, dated 08/22/24, which reported an allegation of abuse of R216 by his wife. The facility failed to provide a copy of an investigation of the allegation of abuse related to R216.	F 610		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview,	F 657	R89□s care plan was updated to reflect	1/7/25

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F 657	Continued From page 19 and facility policy review, the facility failed to ensure the care plan was updated to reflect the use of a palm guard to address contractures for one of two residents (Resident (R) 89) reviewed for contractures of 37 sample residents. This failure placed R89 at risk for inconsistent use of the palm guards which could lead to pain and skin breakdown related to hand contractures. Findings include: Review of the facility's policy titled, "Splint Issuance Policy," dated 03/11/22, revealed "Patient splint schedule will be communicated to the multidisciplinary team and documented in the care plan." Review of the facility's policy titled, "Comprehensive Care Planning Policy," dated 03/02/21, revealed "The MDS [Minimum Data Set] Coordinator develops the current care plan ...by addressing all unresolved problems from the previous care plan and/or noting on the care plan all new problems, approaches and target dates as they are identified in the: (1) current Resident Assessment (annual or quarterly MDS), (2) the CAAs [Care Area Assessments], (3) Medical Record, (4) Resident Contact, and (5) Staff input." Review of R89's "Face Sheet" tab of the electronic medical record (EMR) revealed he was admitted to the facility on 11/07/22 with diagnoses including traumatic subdural hemorrhage (condition that occurs when a head injury causes blood to pool between the brain and its covering) and left- and right-hand contractures. Review of R89's quarterly "MDS" with an	F 657	the palm guard. All residents requiring adaptive equipment have the potential to be affected. On 11/25/2024 the DON and/or designee conducted an audit to ensure that adaptive equipment was reflected on the resident□s plan of care. If necessary the care plan was updated. Root Cause: Root Cause Analysis was completed by the Nursing Home Administrator and Director of Nursing to determine the system failure responsible for these alleged deficiencies. It was determined that the facility may have prevented a missed care plan intervention when the device was recommended by the Therapy Department. To prevent the potential for reoccurrence the DON and/or designee educated licensed staff on adaptive equipment with emphasis on ensuring that it is care planned when recommended by the Therapy Department. To monitor and maintain on-going compliance the DON or designee will conduct weekly audits for 4 weeks of all new admissions and any residents discharged from therapy caseload to ensure that appropriate care planning is in place. If necessary, the care plan will be updated, and the responsible person will	

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F 657	Continued From page 20 Assessment Reference Date (ARD) of 09/04/24 and located under the "RAI [Resident Assessment Instrument]" tab of the EMR, revealed the "Brief Interview for Mental Status (BIMS)" score was zero out of 15 which indicated R89 was severely cognitively impaired. He did not exhibit mood or behavioral symptoms. R89 had an impaired range of motion in both upper and lower extremities. During observations on 11/24/24 at 10:35 AM and 12:18 PM, R89 was observed lying in bed. Both of his hands were contracted into fists and the resident was unable to open his hands. There were no splints or devices in his hands. There were two palm guards on the nightstand next to the bed. During an observation on 11/24/24 at 2:26 PM, R89 was observed seated in his reclining wheelchair in his room with both hands contracted into fists. There were no splints or devices in his hands. There were two palm guards on the nightstand next to the bed. During observations on 11/25/24 12:08 PM and 3:50 PM, R89 was observed seated in his reclining wheelchair in his room. There were palm guards in both hands. Review of R89's "Physiatry Record of Consultation," dated 08/09/24 and located in the "Documents" tab of the EMR, revealed "Botulinum toxin injections for spasticity r/t [related to] TBI [traumatic brain injury], continue PROM [passive range of motion], bil [bilateral] palm protectors." Review of R89's EMR under the "Orders" tab	F 657	be re-educated. Following this, weekly audits will be conducted for 3 months, with the goal of achieving and maintaining 100% compliance. If compliance consistently falls below the goal, the Interdisciplinary Team (IDT) will review the process and implement revisions to ensure sustained compliance. Findings will be presented to the facility's QAPI for continued review and recommendations.	

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F 657	Continued From page 21 revealed no physician order for the use of palm guards. Review of R89's "Care Plan," dated 03/24/24 and located under the "RAI" tab, revealed "Problem: Increasing and/or maintaining ROM [range of motion]. Prevention or reduction of contracture and deformity. Alteration in musculoskeletal status r/t reduced ROM to all extremities." The approaches included providing passive range of motion exercises daily for 15 minutes, encouraging the resident to participate in the program, providing therapy consults as needed, and assessing pain. The "Care Plan" did not address the use of palm protectors. Review of R89's undated "Profile," provided by the facility, revealed it did not include information regarding the use of palm protectors. During an interview on 11/26/24 at 3:25 PM, Certified Nurse Aide (CNA) 2 stated R89 should have his palm protectors in at all times, every day. When asked how she knew they were to be used, CNA2 stated she would look on the resident "Profile," which told her all the needs of the resident. During an interview on 11/26/24 3:29 PM, the Clinical Reimbursement Coordinator (CR) stated when a resident used splints or palm protectors, this was communicated to her via therapy staff so she could put in an order and include its use on the "Care Plan," and "Profile." The CR stated she had not received any communication regarding splints or palm protectors for R89 and he was not on the list of current device use. The CR stated she would check with therapy for current recommendations, as she did not have any	F 657		

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NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

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F 657	Continued From page 22 information. The CR stated the use of palm guards for R89 was not included in his "Orders," "Care Plan," or "Profile." During an interview of 11/26/24 at approximately 5:00 PM, the CR stated therapy recommended use of the palm protectors at all times and added she would put in the order and include this information on the "Care Plan" and "Profile."	F 657		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure proper nephrostomy tube care for one of three residents (Resident (R) 367) reviewed for ostomy care of 37 sample residents. This failure has potential to cause residents to have urine back flow and cause blockage and infection. Findings include: Review of the "Face Sheet" located under the "Face Sheet" tab of the electronic medical record (EMR) revealed the resident was admitted on 11/19/24 with diagnoses which included dysphagia, gastric ulcer disease, immobility, incontinence, colostomy, and sepsis.	F 691	R367 nephrostomy bag was clipped below the kidney height at time of observation. All residents requiring nephrostomies have the potential to be affected. On 11/26/2024 the DON and/or designee conducted an audit to determine if urine collection bag placement fell below kidney level. If necessary the bag was moved. Root Cause: Root Cause Analysis was completed by the Nursing Home Administrator and Director of Nursing to	1/7/25

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F 691	Continued From page 23 Review of R367's EMR "Orders" tab revealed an order, dated 11/21/24, "Monitor output from nephrostomy." During an observation and interview on 11/24/24 at 12:24 PM, R367 was unable to speak. R367's unidentified Family Member (FM) 1 was visiting her and sat at the bedside. FM1 stated R367 was admitted for kidney stone that was not passing at the hospital. She stated they put in a stint for R367, but it (kidney stone) had not passed yet. At 12:30 PM, the resident nephrostomy bag was observed in R367's bed near her arm and was not covered. The urine was yellow and clear. During an observation and interview on 11/24/24 at 12:30 PM, the Assistant Director of Nursing (ADON) entered R367's room. The ADON stated she was not the nurse for R367 but could answer a question regarding R374's nephrostomy bag. The ADON said, the urine bag should be hanging at the level of the bed. The ADON gloved up and proceeded to hang the bag from the bed rail below the resident's waist but noticed that a clip was needed to hang the nephrostomy bag. ADON returned to the resident's room with a clip and hung the nephrostomy bag from the bed rail. During an interview on 11/24/24 at 5:40 PM, the Director of Nursing (DON) stated that residents with nephrostomy bags should have the bag placed below the resident's waist. She expected the nurses to hang the nephrostomy bag on resident's bed side frame, so it hung lower than resident's waist. DON stated this would ensure the urine drained properly.	F 691	determine the system failure responsible for these alleged deficiencies. It was determined that certified staff required additional training on nephrostomy bag placement requirements. To prevent the potential for reoccurrence the DON and/or designee re-educated all licensed and certified staff on the need to ensure that urine collection devices are maintained below kidney height to ensure optimal drainage occurs. To monitor and maintain on-going compliance the DON or designee will conduct weekly audits for 4 weeks of 5 residents with nephrostomies to verify that urine collection devices are positioned below kidney level. If necessary, the collection device will be repositioned, and the responsible person will be re-educated. Following this, weekly audits will be conducted for 3 months with the goal of achieving and sustaining 100% compliance. If compliance consistently falls below the goal, the Interdisciplinary Team (IDT) will review the process and make revisions to ensure sustained compliance. Findings will be presented to the facility's QAPI for continued review and recommendations	
F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed	F 803		1/7/25

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F 803	Continued From page 24 CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and interview, the facility failed to ensure all pureed foods on the menu were served to the seven residents who received pureed diets out of a total census of 115 residents. This failure placed the residents on pureed diets at risk for hunger, dissatisfaction with meals, unplanned weight loss, and malnutrition.	F 803	No adverse findings related to incorrect meal delivery for all pureed diet residents. All residents requiring pureed food have the potential to be affected. On 12/20/2024 the Food Service Director (FSD) and/or designee observed meal trays on both units (North and South) to determine if all menu items were present,	

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F 803	Continued From page 25 Findings include: Review of the undated "Diet Counts (Census)," provided by the facility, revealed there were seven residents who received a pureed diet. Review of the undated "Fall Winter 24125 Diet Guide Sheet," provided by the facility, revealed lunch meal for a pureed diet on 11/26/24 consisted of pureed roast beef, pureed creamed spinach, pureed egg noodles, pureed bread, and pureed spice cake. During observations of meal service in the kitchen on 11/26/24 beginning at 11:44 AM, there were no pureed noodles or pureed bread observed on the tray line. All seven residents who received a pureed diet were served a meal of only pureed roast beef, pureed creamed spinach, and pureed cake. During an interview on 11/26/24 at 11:59 AM, the Dietary Manager (DM) confirmed there were no pureed noodles or pureed bread on the tray line or on the plates prepared for residents on puree diets. The DM stated Cook (CK) 1 had prepared the pureed foods. During an interview on 11/26/24 at 12:00 PM, CK1 stated he had not prepared any pureed noodles or pureed bread for the lunch meal and had served only pureed meat, pureed spinach, and pureed cake to the residents on pureed diets. During an interview on 11/26/24 at 12:00 PM, the DM stated he needed to provide additional training for CK1 since he was new to the position and typically did not work the breakfast and lunch shift. The DM stated the pureed noodles, and	F 803	and pureed. If an issue was identified the tray was replaced. Root Cause Analysis was completed by the Dietary Manager, Nursing Home Administrator and Registered Dietician to determine the system failure responsible for these alleged deficiencies. It was determined that staffing changes, lack of auditing accountability and staff education all contributed to the undesired outcomes. To prevent the potential for reoccurrence the FSD educated all staff on the need to confirm tray accuracy against the resident□s meals ticket before delivering the tray. Staff also educated on what to do if the meal is not correct. To monitor and maintain ongoing compliance the FSD or designee will conduct weekly audits for 4 weeks, reviewing 10 meal trays for residents requiring pureed diets to ensure that all menu items are included. If necessary, the tray will be replaced, and the responsible party will be re-educated. Following this, weekly audits will be conducted for 3 months with the goal of achieving and sustaining 100% compliance. If compliance consistently falls below the goal, the Interdisciplinary Team (IDT) will review the process and make revisions to ensure sustained compliance. Findings will be presented to	

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F 803	Continued From page 26 bread should have been prepared and served according to the menu.	F 803	the regional QAPI for continued review and recommendations.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure foods were labeled, dated, sealed, and stored according to professional standards for food service safety in one of one kitchen. This failure had the potential to cause the spread of foodborne illness to all 115 census residents. Findings include: Review of the facility's policy titled, "Equipment Cleaning and Sanitation Policy," dated 08/25/20,	F 812	All food items in the dry storage, walk-in refrigerator, and food preparation area that were improperly stored or unsealed were discarded at time of observation. All residents have the potential to be affected. On 12/20/2024 the FSD conducted an audit of all stored food items to ensure they were correctly labeled, dated, and stored. Where necessary the items were discarded and replaced.	1/7/25

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F 812	Continued From page 27 revealed "The food and nutrition services staff will maintain a clean and sanitary environment in food service areas." The policy did not address food storage policies and procedures. During initial observations of the kitchen on 11/24/24 beginning at 8:47 AM, the following was observed: -In the dry storage, there was a box with a plastic bag inside containing powdered thickener. The bag was sealed at the top; however, there was a large hole ripped in the bag. Pieces of debris and food wrappers were observed inside the box. There was no date to indicate when the package had been opened. -In the dry storage, there was a package of prepared tart crusts that was left open and unsealed. The crust was directly exposed at the top of the package. -In the dry storage, there was a large bag of panko breadcrumbs that were folded at the top but not sealed. -In the dry storage, there was a can of applesauce on the fourth shelf of the can rack that had a large dent near the top seal. -In the walk-in refrigerator, there were packages of croissants, sliced provolone cheese, and sliced ham that were left open and unsealed. -In the food preparation area, there were two squirt bottles of yellow liquid that were not labeled or dated. Cook (CK) 2 stated the squirt bottles contained oil and were not labeled or dated. -In the food preparation area, there were two boxes of corn starch that were opened and not sealed. CK2 stated the boxes were opened and unsealed. During follow-up observation of the kitchen with the Dietary Manager (DM) on 11/26/24 beginning	F 812	Root Cause Analysis was completed by the Dietary Manager, Nursing Home Administrator and Registered Dietician to determine the system failure responsible for these alleged deficiencies. It was determined that staffing changes, lack of auditing accountability and staff education all contributed to the undesired outcomes. To prevent the potential for recurrence the FSD educated all dietary staff on food storage process with emphasis on labeling and dating. To ensure ongoing compliance, the FSD or designee will conduct audits 5 days a week for 4 weeks of the dry storage area, walk-in refrigerator, and walk-in freezer to ensure that storage expectations are being met. If necessary, improperly stored food items will be discarded, replaced, and the responsible party will be re-educated. Following this, weekly audits will be conducted for 3 months with the goal of achieving and maintaining 100% compliance. If compliance consistently falls below the goal, the Interdisciplinary Team (IDT) will review the process and implement revisions to ensure sustained compliance. Findings will be presented to the facility's QAPI for continued review and recommendations.	

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F 812	Continued From page 28 at 12:18 PM, the following were observed: -In the dry storage, there was a box containing an open, undated bag of thickener. The DM confirmed the bag was left open and unsealed and did not contain an open date. He stated he would throw out the thickener. -In the dry storage, there was a tart crust package left open and unsealed. The DM confirmed the package was left open and unsealed and stated he would throw it out. -In the dry storage, there was a bag of panko breadcrumbs folded and unsealed. The DM confirmed the bag was not sealed and stated he would seal it in a plastic bag. -In the dry storage, there was a dented can of applesauce on the fourth shelf of the can rack. The DM stated the dented cans were to be stored on the top shelf of the can rack to be returned to the supplier. He stated the dented can of applesauce should not have been in the middle of the rack for use. The DM stated all foods were to be sealed and contain labels and dates as to when they were opened.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		1/7/25

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F 880	Continued From page 29 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 30 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of the facility's policy, the facility failed to ensure personal protective equipment (PPE) was utilized properly with proper hand hygiene during wound care for one of one resident (Resident (R) 92) reviewed for transmission-based or enhanced barrier precautions of 37 sample residents. This failure had the potential to contribute to the spread of infection among staff and residents. Findings include: Review of the facility's policy titled, "Infection Prevention and Control Program," revised 05/11/23, revealed employees participated in performance improvement activities related to infection prevention (i.e., improved hand hygiene, respiratory hygiene/cough etiquette protocols, use of PPE) and participated in performance improvement activities by promoting enhanced hand hygiene. Review of the facility's policy titled,	F 880	R92 demonstrated no adverse results. The participating nurse was immediately re-educated on appropriate personal protective equipment (PPE) utilization and hand hygiene during wound care. All residents requiring wound care have the potential to be affected. On 12/17/2024 the DON and/or designee observed wound rounds to ensure appropriate PPE utilization was maintained. If necessary, the treatment was stopped, and the nurse re-educated, before the treatment was resumed. Root Cause Analysis was completed by the Nursing Home Administrator and Director of Nursing to determine the system failure responsible for these alleged deficiencies. It was determined that there was inconsistent adherence to infection control protocols, and	

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F 880	Continued From page 31 "Transmission-Based Precautions and Isolation," revised 04/15/24, revealed Enhanced Barrier Precautions (EBP) - EBP were intended to prevent the transmission of multi-drug-resistant organisms (MDROs) via contaminated hands and clothing of healthcare workers to high-risk residents. EBP were indicated for high contact care activities for residents with chronic wounds and indwelling devices (such as central lines, urinary catheters, and trachs) and for all those colonized or infected with a MDRO currently targeted by the CDC (Centers for Disease Control and Prevention). Further review revealed PPE recommended included: a. Gloves - whenever touching the resident's intact skin or surfaces and articles near the resident. b. Gowns - whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment near the resident. Review of R92's "Face sheet" located under the "Resident" tab of the electronic medical record (EMR) revealed the facility admitted the resident on 04/27/24 with diagnoses to include pressure ulcer of right hip, stage four, unspecified protein-calorie malnutrition, and schizoaffective disorder. Review of R92's quarterly "Minimum Data Set (MDS)" located under the "Resident Assessment Instrument (RAI)" tab of the EMR with an Assessment Reference Date (ARD) of 09/17/27 revealed the facility assessed the resident as having a "Brief Interview for Mental Status (BIMS)" score of nine out of 15 which indicated the resident was moderately cognitively impaired. Review of R92's "Orders," dated 10/22/24 and	F 880	inconsistent monitoring which led to undesirable outcomes. To prevent the potential for reoccurrence the DON and/or designee re-educated all licensed staff on wound treatments with emphasis PPE utilization and hand hygiene. To monitor and maintain on-going compliance the DON or designee will conduct weekly audits for 4 weeks of 2 wound treatments to verify that infection control standards are being maintained. If necessary, the treatment will be stopped, and the nurse will be re-educated before resuming the treatment. Following this, weekly audits will be conducted for 3 months with the goal of achieving and sustaining 100% compliance. If compliance consistently falls below the goal, the Interdisciplinary Team (IDT) will review the process and make revisions to ensure sustained compliance. Findings will be presented to the facility□s QAPI for ongoing review and recommendations.	

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F 880	Continued From page 32 located under the "Resident" tab of the EMR, revealed cleanse left hip wound with Normal Saline Solution (NSS), Pat dry, apply silver alginate and dry dressing. Review of R92's "Care Plan," dated 05/02/24 and located under the "RAI" tab of the EMR, revealed he was on Enhanced Barrier Precautions (EBP) due to the resident requiring a feeding tube related to dysphagia. During observation of R92's wound care on 11/26/24 at 5:11 PM, Registered Nurse (RN) 2 entered R92's room with EBP and wound care supplies in her hand. She placed the EBP supplies on R92's dresser located at the bedside and the wound care supplies on the residents rolling bedside table. She donned (put on) a gown and gloves without washing or sanitizing her hands, opened a small bottle of normal saline solution (NSS), took her ink pen, and labeled and dated the NSS bottle and then dated and initialed the wound dressing. She then opened a bag of 4x4 gauze pads, picked up the bottle of NSS, and poured the solution onto the 4x4 gauze pads, all without washing or sanitizing hands, or changing gloves. She then reached up and pulled the string turning on the overbed light. RN2 then pulled back R92's bed linens, removed the adhesive strips from his adult brief, rolled the resident to his right side, and removed the old dressing from his left hip. RN2 picked up the wet NSS 4x4 gauze and cleansed the left hip wound and threw the wet gauze in the nearby trash can. She then picked up a clean dry 4x4 gauze and patted the left hip wound dry and applied the new dated and initial dressing laying on the rolling bedside table. RN2 removed her gloves, threw them in the nearby trash can, and put on a clean pair of	F 880		

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F 880	Continued From page 33 gloves and performed peri care to R92 and applied a clean dry adult brief. RN2 did not wash or sanitize her hands when donning or doffing (taking off) her gloves and did not change her gloves at any point when touching the overbed light string, removing the bed linens, removing the adult brief, or prior to performing wound care. During an interview on 11/26/24 at 5:20 PM, RN2 stated R92 was on EBP because he had wounds and a Peg Tube. She stated the proper procedure for residents on EBP was to don PPE in the room if staff were going to be providing direct care to the residents. She further stated PPE did not have to be put on outside the room prior to entering the room. Per interview, she stated it was OK to wear the same gloves when changing the dressing because she was not going back and forth between different wounds. She stated she should have washed and sanitized hands and changed gloves when having contact with the ink pen, light switch, bed linens, adult brief, and when she removed the old dressing. During an interview on 11/26/24 at 5:33 PM, the Infection Preventionist (IP) stated all staff were trained in EBP and infection control practices and she expected staff to follow the infection control and EBP policies for the safety of the resident and staff and to prevent the spread of infection from one resident to another and to protect staff from potential infections. During an interview on 11/26/24 at 5:45 PM, the Director of Nursing (DON) stated she expected staff to follow the facility's infection control policy to ensure resident safety and to prevent the spread of infection. She expected staff to wear	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW CASTLE HEALTH AND REHABILITATION CENTER	32 BUENA VISTA DRIVE NEW CASTLE, DE 19720

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F 880	Continued From page 34 the appropriate PPE and to wash and sanitize hands per policy. During an interview on 11/26/24 at 6:00 PM, the Administrator stated she expected staff to follow the facility's infection control policy to ensure residents and staff safety and to prevent the spread of infection throughout the facility.	F 880		