

DHSS - DHCQ 263 Chapman Road, Ste 200, Cambridge Bldg. Newark, Delaware 19702 (302) 421-7400

STATE SURVEY REPORT

Page 1 of 1

NAME OF FACILITY: Delaware Hospital for the Chronically III

DATE SURVEY COMPLETED: December 12, 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 with Complaints 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 to be in substantial compliance with 42 CFR 483 subpart B.				
	Survey Dates: 12/09/24 - 12/12/24.				
	Survey Census: 73				
	Sample Size: 21				
	Supplemental Residents: 2				
3201	Regulations for Skilled and Intermediate Care Nursing 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:	3201.1.2 Cross Refer to the CMS 2567-L survey completed December 12,2025: E18,	01/31/25		
	Cross Refer to the CMS 2567-L survey completed December 12,2025: E18, E20, E23, E31, E36.	E20, E23, E31, E36.			
	L31, L30,				

Provider's Signature

Title NHA

Date 0/03/2025

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PRINTED: 01/09/2025 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORR		IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
		085035	B. WING	÷		12	C / 12/2024
NAME OF PROVIDE		HRONICALLY ILL (DHCI)		1	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SUNNYSIDE ROAD 6MYRNA, DE 19977		, I a / a va · ·
	ACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)) BE	(X5) COMPLETION DATE
A Red Surve Mana State Socia on 12 found 483.73 E 018 Proce CFR(s §403. and (v §482. §486.) [(b) Po developolicie plan s assess and the this sereview [annua policie following [(2) or on-dut [facility staff a the em	y was conductively was conducted by the services of Delaware, and Services of Delaware, and Services of Delaware, and Services of Delaware, and Services of Traces of Services	6.54(b)(1), §418.113(b)(6)(ii) 9(2), §460.84(b)(2), 8.73(b)(2), §483.475(b)(2), 85.625(b)(2), §485.920(b)(1),		0000	SEL IGIENCI)		1/31/25
		ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE 01/03/2025

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.

01/03/2025

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		ISTRUCTION	COMPLETED	
		085035	B. WING				12/2024
	PROVIDER OR SUPPLIER	RONICALLY ILL (DHCI)		100 SU	r address, city, state, zip code NNYSIDE ROAD NA, DE 19977		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 018	*[For PRTFs at §44/ICF/IIDs at §483.47 Policies and proced location of on-duty sthe [PRTF's, LTC, I'and after an emergisheltered residents emergency, the [PF must document the the receiving facility *[For Inpatient Hosp Policies and proced (ii) Safe evacuation includes consideratineeds of evacuees; transportation; iden location(s) and primicommunication with assistance. (v) A system to trace employees' on-duty employees relocated during the must document the the receiving facility *[For CMHCs at §44] procedures. (2) Saf which includes constreatment needs of responsibilities; trarevacuation location means of communicassistance.	1.184(b), LTC at §483.73(b), '5(b), PACE at §460.84(b):] lures. (2) A system to track the staff and sheltered residents in CF/IID or PACE] care during ency. If on-duty staff and are relocated during the RTF's, LTC, ICF/IID or PACE] specific name and location of or other location. Dice at §418.113(b)(6):] lures. from the hospice, which ion of care and treatment staff responsibilities; tification of evacuation hary and alternate means of a external sources of k the location of hospice and sheltered patients in the ag an emergency. If the or sheltered patients are seemergency, the hospice specific name and location of or other location. 85.920(b):] Policies and see evacuation from the CMHC, sideration of care and	EC	18			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		E SURVEY PLETED
		085035	B. WING		1	C 12/2024
	PROVIDER OR SUPPLIER	HRONICALLY ILL (DHCI)		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNNYSIDE ROAD SMYRNA, DE 19977	1 127	12/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 018	donor information, potential and actual secures and maintal *[For ESRD at § 49 procedures. (2) Safacility, which include needs of the patient This REQUIREMENT by: Based on interview	ystem of medical preserves potential and actual protects confidentiality of I donor information, and ains the availability of records. 4.62(b):] Policies and ie evacuation from the dialysis les staff responsibilities, and its. NT is not met as evidenced is and facility policy review, the	E 018	A. The facility failed to develop a p	policy	
	for an adequate tra staff as part of its e failure could cause information and res located in the event. Findings include: Review of the facilit Hospital for the Chroperations Plan," d'Resident Tracking transported to a detaccording to EMS to number for tracking have a copy of a contracking Form and for the purpose of the Discharge Unit will Resident Tracking Formatics and the EMS Transported to the purpose of the Discharge Unit will Resident Tracking Formatics and the EMS Transported to the EMS Tra	elop a policy and procedure cking system for residents and mergency plan. This facility a breach in protected health idents not being able to be of an emergency. y's policy titled, "Delaware onically III Emergency ated 08/21/24, revealed Each resident who is being stination site is triaged riage protocols and triage tag acking the resident. The maintain a HICS 255 Master form. As residents are tition from the individual will be entered into the HICS sportation Unit Leader will sing the tag number assigned nographics information for all		and procedure for an adequate trac system for residents and staff as paits emergency plan. The facility reviand updated its emergency prepare policies and procedures to include a system to track the location of on-d staff, sheltered residents in the facility and specific name and location the receiving facility during an emer (Attachment #1). All supervisors an managers will be trained on the upopolicies and procedures regarding the tracking system by the Risk Manager Training Administrator II, or designed 01/31/2025. B. All residents in the facility have potential to be affected by this deficing practice. The facility revised and up its emergency preparedness policies procedures to include a tracking system in the facility's care during emergency. All supervisors and ma will be trained on the updated policing procedures regarding the tracking services.	art of ised edness a uty lity's on of rgency d dated the er, ee by the sient dated es and stem in ed g an nagers es and	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l , ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		085035	B. WING			12/1) 12/2024
	PROVIDER OR SUPPLIER	HRONICALLY ILL (DHCI)		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SUNNYSIDE ROAD		
				S	MYRNA, DE 19977		
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E 018	Continued From paresidents, both those who are being triage tag number electronic centralization. As soon as posteaving the health of current photo identification system and the Assistant Hosp Manager, they desidentification system are revealed each unit containing resident diagnoses, code sidentification was attached to the resident of the residen	se who were discharged and ag evacuated along with the are to be entered into the ed database within one hour sible. of the resident are facility. DHCI will maintain diffication cards for each of on 12/11/24, at 1:31 PM with dital Director (AHD) and Risk cribed their emergency m. Continued interview maintained emergency kits as recorded on two tags, one ident's clothing, and another off. However, when questioned es and procedures, both the AHD confirmed that the edness plan lacked specific	E 0		by the Risk Manager, Training Administrator II, or designee. C. The root cause of this deficient practice is a knowledge deficit relat the requirement that the facility mu a system to track the location of staresidents in the facility's care during emergency. All supervisors and managers will be trained by the Ris Manager, Training Administrator II, designee regarding the updated poand procedures to ensure the accutracking of staff and residents during after an emergency. This includes implementing the use of HICS 255 Evaluation Tracking Form (Attachment #2), HICS 260 Patient Evacuation/Transfer Tracking Form (Attachment #3), and Staff Tracking (Attachment #4) to document real-movement and location during emergency.	ted to st have aff and g an sk or dicies and master nent nent nent me ergency	
	During an interview the Hospital Admin Assistant Hospital acknowledged the procedures for tracking, daily, and staff assignments atracking, they used reports to document those in the buildin hospitalized. While shelter in place, the recognized the needs	on 12/12/24, at 10:46 AM with istrator, Risk Manager, and Director (AHD), the AHD absence of formal policies and sking. They currently rely on weekly schedules to monitor and adjustments. For resident unit rosters and daily census at resident locations, including g, on leave of absence, or their primary strategy was to be Hospital Administrator and to revise their entire process are comprehensive method sidents and staff.			situations. In addition, the Risk Marwill conduct quarterly evacuation drills/trainings, shelter in place, and the tracking forms after each drill/tror actual emergency event to ensure accuracy and adherence to the tracprotocol. D. To ensure compliance, the Continuous Quality Improvement N (CQI RN III) will complete monthly of the tracking forms and evacuation drill(s)/training(s) using the Emerge Preparedness (EP) Audit Tool (Attachment #5) for three (3) consemonths with 100 percent compliance has been	I review raining recking	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		085035	B. WING			С
NAMEOE	PROVIDER OR SUPPLIER	003033	D. WING		12/	12/2024
I WAIVIL OI	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)				100 SUNNYSIDE ROAD SMYRNA, DE 19977		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 020 SS=D	Policies for Evac. ar CFR(s): 483.73(b)(3 §403.748(b)(3), §41	nd Primary/Alt. Comm. 3) 6.54(b)(2), §418.113(b)(6)(ii),	E 02	achieved, then, the Continuous Qualimprovement Nurse (CQI RN III) was complete quarterly audits of the transforms and evacuation drill(s) for the consecutive quarters with 100 percompliance. The results of these a will be reviewed at the quarterly QAS steering Committee meetings. If it determined that 100 percent complis achieved for three (3) consecutive quarters, then, the facility will conclude that we have successfully addressed deficient practice.	rill cking ree (3) cent udits API is liance re ude	1/31/25
	§441.184(b)(3), §46 §483.73(b)(3), §483 §485.542(b)(3), §489 [(b) Policies and pro- develop and implem policies and procedured plan set forth in para- and the communical this section. The policies and update [annually for LTC fact policies and procedured plan set forth in para- and the communical this section. The policies and update [annually for LTC fact policies and procedured plan set forth in clusters and procedured plan set for the policies and plan set for the	0.84(b)(3), §482.15(b)(3), .475(b)(3), §485.68(b)(1), .5.625(b)(3), §485.727(b)(1), 1.12(b)(1), §494.62(b)(2) cedures. The [facilities] must tent emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of icies and procedures must be eed at least every 2 years cilities]. At a minimum, the ures must address the				

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		C C		
		085035	B. WING				12/2024
	OVIDER OR SUPPLIER	IRONICALLY ILL (DHCI)		100 SUNN	DDRESS, CITY, STATE, ZIP CODE NYSIDE ROAD A, DE 19977		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
ena** \$500000000000000000000000000000000000	means of communicassistance. [For RNHCIs at §4 §416.54(b)(2) and For the safe evacuation from the safe evacuation of the safe evacuation of the safe evacuation of the safe evacuation with the safe evacuation and safe evacuation from the safe evacuation from the safe evacuation from the safe evacuation from the safe responsibilities and this REQUIREMENT of the safe on interview acility failed to estator managing resides	(s); and primary and alternate cation with external sources of 03.748(b)(3) and ASCs at REHs at §485.542(b)(3):] m the [RNHCI or ASC or es the following: care needs of evacuees. ties.	EO	A. T and p who r emer	The facility failed to establish porocedures for managing residues to evacuate during gencies. The facility revised atted its emergency preparedne	dents and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		085035	B. WING		C 12/1	2/2024
	PROVIDER OR SUPPLIER	HRONICALLY ILL (DHCI)		STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNNYSIDE ROAD SMYRNA, DE 19977		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 020	Findings include: Review of the facilit Hospital for the Chr Operations Plan," depurpose of this Emprovide a facility-wire response to a disast limit the effects of the for planned measure minimize damage. The response during a contract the evacuation of its facility to a nearby distance. The plan restablishes a recover to its normal operated buring an interview Assistant Hospital Empression of the evacuation of its normal operated buring an interview Assistant Hospital Empression. When specific the expectation of the experience combehavior. When specific these regulatory recombends in 42 CFR Risk Manager confirmed in 42 CFR Risk Manager confirmed in the ADA confirmed in	by policy titled, "Delaware onically III Emergency ated 08/21/24, revealed, "The ergency Operation Plan is to de comprehensive emergency of the event. The plan seeks to the disaster. The plan provides es to preserve life and The plan provides for disaster emergency, to include a residents and staff within the facility or safe facility at further provides for assistance and ery system to return the facility ions." on 12/11/24 at 1:31 PM, the Director (AHD) and Risk maying no knowledge of espite acknowledging the residents with dementia who infusion and exhibit combative ecifically asked about the Long may Preparedness Procedures 483.73, both the ADA and remed they were unaware of	EO	consideration of care and treatment for evacuees (Attachment #1). This includes staff responsibilities, transportation, identification of evacuoation, and primary and alternate of communication with external social assistance for a safe evacuation. A nursing staff will be trained on de-escalation techniques by the Ris Manager, Training Administrator II, designee by 01/31/2025. B. All residents in the facility have potential to be affected by this deficing practice. The facility revised and up its emergency preparedness policing procedures to include consideration care and treatment needs for reside staff responsibilities, transportation, identification of evacuation location primary and alternate means of communication with external source assistance. Additionally, the revision includes policies and procedures for managing residents who refuse to evacuate during emergencies. All in staff will be trained on de-escalation techniques to include how to provid encouragement and support to thos residents who are finding it difficult refuse to evacuate the facility. C. The root cause of this deficient practice is a knowledge deficit relate the requirement that the facility muse established policies and procedures managing residents who refuse to evacuate during emergencies. The revised and undated its emergency	cuation means urces of all sk or the cient odated es and n of ents, and es of n ursing n e se or ed to st have s for facility	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		085035	B. WING				12/2024
NAME OF I	PROVIDER OR SUPPLIER	000000			TREET ADDRESS, CITY, STATE, ZIP CODE	121	12/2024
		RONICALLY ILL (DHCI)		10	00 SUNNYSIDE ROAD MYRNA, DE 19977		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 020	Continued From pa	ge 7	EC	020	preparedness policies and procedul include consideration of care and treatment needs for evacuees. This includes staff responsibilities, transportation, identification of evacuocation, and primary and alternate of communication with external sour assistance. All nursing staff will be on how to facilitate safe evacuation residents who refuse to leave the factor of training database to ensure de-escalation training is completed the EP Audit Tool (Attachment #5) of three (3) consecutive months with the percent compliance. If 100 percent compliance has been achieved, the Continuous Quality Improvement N (CQI RN III) will complete quarterly of the tracking form for three (3) consecutive quarters with 100 percent compliance. The results of these acts will be reviewed at the quarterly QA Steering Committee meetings. If it is determined that 100 percent complising achieved for three (3) consecutive quarters, then, the facility will conclutative have successfully addressed deficient practice.	cuation means rces of trained for acility. urse reviews using for 1000 en, the audits ent udits PI siance e ude	
E 023 SS=D	Policies/Procedures CFR(s): 483.73(b)(for Medical Documentation	ΕO	23	denoient practice.		1/31/25
	§441.184(b)(5), §46	16.54(b)(4), §418.113(b)(3), 60.84(b)(6), §482.15(b)(5), 6.475(b)(5), §484.102(b)(4),					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		085035	B. WING			1	C 12/2024
	PROVIDER OR SUPPLIER	HRONICALLY ILL (DHCI)		100	REET ADDRESS, CITY, STATE, ZIP CODE 0 SUNNYSIDE ROAD MYRNA, DE 19977		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 023	§485.68(b)(3), §485	5.542(b)(5), §485.625(b)(5), 85.920(b)(4), §486.360(b)(2),	ΕC	23			
	develop and implent policies and proceed plan set forth in part assessment at part and the communicathis section. The pube reviewed and up [annually for LTC fat	pocedures. The [facilities] must ment emergency preparedness lures, based on the emergency agraph (a) of this section, risk agraph (a)(1) of this section, ation plan at paragraph (c) of policies and procedures must addated at least every 2 years acilities]. At a minimum, the ures must address the					
	protects confidentia	system of medical preserves patient information, lity of patient information, and iins availability of records.					
	§485.542(b):] Polici system of care doct following: (i) Preserves patien (ii) Protects confide	03.748(b) and REHs at es and procedures. (5) A umentation that does the tinformation. Initiality of patient information. Saintains the availability of					
	procedures. (2) A s documentation that donor information, p potential and actual secures and mainta	5.360(b):] Policies and system of medical preserves potential and actual protects confidentiality of donor information, and sins the availability of records.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		085035	B. WING				C 12/2024
	PROVIDER OR SUPPLIER	HRONICALLY ILL (DHCI)		10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SUNNYSIDE ROAD MYRNA, DE 19977		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 023	Based on interview facility failed to esta for a medical docur preserve and proteinformation while el and accessible. This compromise protect 73 residents during Findings include: Review of the facility Hospital for the Chroperations Plan, of "Resident Tracking transported to a detaccording to EMS to number for tracking have a copy of a contracking Form and for the purpose of to Discharge Unit will Resident Tracking I discharged. informates ident's HICS 260 255. The EMS Transtrack the resident upon the resident upon the purpose of the purp	vs and facility policy review, the ablish policies and procedures mentation system that would ct confidential patient assuring records remain secure s deficiency could ted health information for all	EQ	023	A. The facility failed to establish p and procedures for a medical documentation system that would preserve and protect confidential pinformation while ensuring the recoremain secure and accessible. The revised and updated its emergency preparedness policies and procedu (Attachment #1) to include a combilock system that is HIPAA compliar protect confidentiality of patient information, and secure and mainta availability of records. All nursing sibe trained on the procedures to proaccess of medical records while transporting during evacuation by the Manager, Training Administrator II, designee by 01/31/2025. B. All residents in the facility have potential to be affected by this deficient practice. The facility revised and up its emergency preparedness policie procedures to include a method to preserve patient information, protect confidentiality of patient information secure and maintain availability of records. All nursing staff will be trait the updated policies and procedure include the use of a combination lo HIPAA Compliant Bag by the Risk Manager, Training Administrator II, designee. C. The root cause of this deficient practice is a knowledge deficit relation that the facility faile establish policies and procedures for medical documentation system that the facility faile establish policies and procedures for medical documentation system that	atient ords e facility or a fa	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
		085035	B. WING _			C 12/2024
NAME OF PROVIDER OR SUPPLIER DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)				STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNNYSIDE ROAD SMYRNA, DE 19977	121	1212024
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
E 023	Manager described system: each unit in containing resident diagnoses, code starthis information was attached to the resiretained by nursing formal policies and Manager and AHD specific policy for seresident records dumentioned they coured they coured they coured they coured the contingency placeme inaccessible response. During an interview the Hospital Adminitial Assistant Hospital Explained they rely web-based system with internet connect When questioned a event computers and Administrator acknowledges.	their emergency identification naintained emergency kits is names, unit numbers, atuses, and diet requirements. It is provided on two tags, one dent's clothing, and another staff. When questioned about procedures, both the Risk acknowledged there was no ecuring and maintaining ring emergencies. The AHD and access information through cloud system, but when asked blans if Point Click Care le, the AHD provided no on 12/12/24, at 10:46 AM with strator, Risk Manager, and Director (AHD), the AHD on Point Click Care (PCC), a accessible from any location ctivity or hotspot access. bout contingency plans in the e unavailable, the Hospital by wedged this was an area	E 02:	preserve and protect resident information while ensuring records remain sect accessible during an emergency. A nursing staff will be trained on the pand procedures for a medical documentation system to include the procedures on the use of a combin lock HIPAA Compliant Bag during a emergency by the Risk Manager, TAdministrator II, or designee. D. To ensure compliance, the Continuous Quality Improvement N (CQI RN III) will complete monthly of each residents combination lock HIPAA Compliant Bag to ensure earesident's medical information is update, secure, and available using the Audit Tool (Attachment #5) for three consecutive months with 100 percent compliance. If 100 percent compliance if 100 percent compliance achieved, then, the Continuality Improvement Nurse (CQI R will complete quarterly audits to ensure each resident's medical information to date, secure, and available for the consecutive quarters with 100 percent compliance. The results of these activity equarters with 100 percent compliance. The results of these activity equarters are will be reviewed at the quarterly QA Steering Committee meetings. If it determined that 100 percent complise achieved for three (3) consecutive quarters, then, the facility will concludate we have successfully addressed deficient practice.	ure and all policies ne ation an irraining durse audits exchance nuous N III) sure nie (3) ent udits all irrae (3) ent udits all irrae eude ed this	1/31/25
SS=F	CFR(s): 483.73(c)(2		E 031			1/31/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
						12/2024	
NAME OF PROVIDER OR SUPPLIER DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)			STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNNYSIDE ROAD SMYRNA, DE 19977				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)) BE	(X5) COMPLETION DATE
E 031	§403.748(c)(2), §418,441.184(c)(2), §483.73(c)(2), §485.485.68(c)(2), §485.485.727(c)(2), §494.12(c)(2), §494.1	6.54(c)(2), §418.113(c)(2), 60.84(c)(2), §482.15(c)(2), 6.475(c)(2), §484.102(c)(2), 6.542(c)(2), §485.625(c)(2), 6.5920(c)(2), §486.360(c)(2), 6.62(c)(2). Inst develop and maintain an indicess communication plan rederal, State and local laws red and updated at least every rederal transfer and include all of the interpretation for the following: ibal, regional, and local dness staff. If assistance. In at §483.73(c):] (2) Contact following: ibal, regional, and local dness staff. It is sing and Certification Agency is State Long-Term Care of assistance. 83.475(c):] (2) Contact following: ibal, regional, and local dness staff. It is sing and certification Agency is state Long-Term Care of assistance.	EC	031	A. The facility failed to maintain a		

AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G		E SURVEY
	085035 B. WING			С	
	085035	B. WING _		12/	12/2024
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
DELAWARE HOSPITAL F/T CH	RONICALLY ILL (DHCI)		100 SUNNYSIDE ROAD		
	NOMICALLI ILL (BITOI)		SMYRNA, DE 19977		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
with required authoriessential contact infectibal, regional, and I preparedness staff, Certification Agency, Term Care Ombudsi assistance. This defieffective communicate potentially affecting a Findings include: Review of the facility Hospital for the Chrooperations Plan," date purpose of this Emeroprovide a facility-wide response to a disaste limit the effects of the for planned measure minimize damage. The response during a distance of the evacuation of its facility to a nearby facili	attain a communications plan ities. The plan lacked ormation for federal, state, local emergency the State Licensing and the Office of the State Long man, and other sources of iciency could impede ation during emergencies, all 73 residents. If policy titled, "Delaware onically III Emergency ated 08/21/24 revealed, "The regency Operation Plan is to be comprehensive emergency er event. The plan seeks to be disaster. The plan provides the plan provides for saster emergency, to include the plan provides for saster end the plan the cility or safe facility at further rovides for assistance and the yestem to return the facility	E 03	communication plan which la essential contact information State, tribal, regional, local e preparedness staff, and other assistance. The facility revisupdated its emergency prepapolicies and procedures to in essential contact information #1). Incident Command Systemembers will be in-serviced revised emergency contact in the Risk Manager or designed 01/31/2025. B. All residents in the facility potential to be affected by this practice. The facility revised its emergency preparedness procedures to include the revised emergency preparedness procedures to include the revised information (Attachment #1). Command System (ICS) men in-serviced on the updated communication plan by the Ror designee. C. The root cause of this depractice is a knowledge deficit the requirement that the facility maintain a communication plan equired authorities to include contact information. Incident System (ICS) members will be regarding the essential containformation for Federal, State regional, local emergency prestaff, and other required sour assistance during emergencing assistance during emergencing assistance during emergencing the essential contains assistance during emergencing assistance during emergencing assistance during emergencing the essential contains assistance during emergencing assis	of for Federal, mergency er sources of ed and aredness iclude (Attachment em (ICS) on the information by the by the same deficient and updated policies and vised ential contact Incident inbers will be the isk Manager ficient it related to ty must en with the essential Command e in-serviced ct in tribal, eparedness ces of	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
						С	
		085035	B. WING			12/	12/2024
NAME OF F	PROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
DELAWA	RE HOSPITAL F/T CH	RONICALLY ILL (DHCI)			00 SUNNYSIDE ROAD MYRNA, DE 19977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTIO PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
E 031	Continued From pa list for officials.	ge 13	E 0	31	the Risk Manager will ensure that the essential contact information is discand current at each monthly Safety	cussed	
E 036	EP Training and Te	sting	ΕO	36	D. To ensure compliance, the Continuous Quality Improvement N (CQI RN III) will complete monthly of the Safety Committee Meeting of the essential contact information the EP Audit Tool (Attachment #5) three (3) consecutive months with percent compliance. If 100 percent compliance has been achieved, the Continuous Quality Improvement N (CQI RN III) will complete quarterly of the Safety Committee Meeting of three (3) consecutive quarters we percent compliance. The results of audits will be reviewed at the quarter QAPI Steering Committee meeting is determined that 100 percent compliance is achieved for three (3) consecutive quarters, then, the facconclude that we have successfully addressed this deficient practice.	reviews ninutes eness using for 100 en, the lurse audits ninutes with 100 these erly s. If it	1/31/25
SS=F	CFR(s): 483.73(d)						
	§483.475(d), §484.	84(d), §482.15(d), §483.73(d), 102(d), §485.68(d), 625(d), §485.727(d),					
	*[For RNCHIs at §4	.03.748, ASCs at §416.54,					

PRINTED: 01/09/2025 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING. 085035 12/12/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNNYSIDE ROAD DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI) **SMYRNA, DE 19977** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 036 Continued From page 14 E 036 Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:1 (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at

*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

least every 2 years.

*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: LBRS11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>		E CONSTRUCTION	COMPLETED	
		085035	B. WING			12/12/2024	
NAME OF PROVIDER OR SUPPLIER DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)				10	TREET ADDRESS, CITY, STATE, ZIP CODE 00 SUNNYSIDE ROAD MYRNA, DE 19977		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 036	testing program muleast every 2 years. requirements for every 483.470(i). *[For ESRD Facilitiestesting, and orientation program emergency plan services section, risk assess this section, policie (b) of this section, aparagraph (c) of this and orientation program emergency plan services (b) of this section, aparagraph (c) of this and orientation program that require updated at every 2. This REQUIREMED by: Based on the interminant the facility failed to emergency prepare program that require updates. This deficit residents, along with at an increased risk situations. Findings include: Review of the facilith Hospital for the Choperations Plan, operations Plan, operations Plan, operations et a disast limit the effects of the for planned measure.	es at §494.62(d):] Training, tion. The dialysis facility must an emergency ing, testing and patient at forth in paragraph (a) of this sment at paragraph (a)(1) of s and procedures at paragraph and the communication plan at s section. The training, testing gram must be evaluated and	ΕO	936	A. The facility failed to develop ar maintain an emergency prepared training and testing program that reannual review and updates. The fawill develop and implement a comprehensive training program for staff, contractors, and volunteers of emergency preparedness requirem. The facility Risk Manager will conditive quarterly testing exercises based of facility Hazard Vulnerability Analysis staff will be trained on emergency preparedness by the Risk Manager Training Administrator II or designed 01/31/2025. B. All residents, staff, and visitors facility have the potential to be afferthis deficient practice. The facility with develop and implement a comprehence and residue to the staff of th	ess equired cility or all n nents. uct n the s. All f, ee by in the cted by vill	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
		085035	B. WING				C 12/2024	
NAME OF PROVIDER OR SUPPLIER DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)			-	STREET ADDRESS, CITY, STATE, ZIP CODE 100 SUNNYSIDE ROAD SMYRNA, DE 19977				
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E 036	response during a control the evacuation of its facility to a nearby for distance. The plan establishes a recover to its normal operate. During an interview Hospital Administration in dicated that while did not have a comprogram in place. See the evacuation of th	disaster emergency, to include is residents and staff within the facility or safe facility at further provides for assistance and ery system to return the facility	EC	036	training and testing program for all contractors, and volunteers on emergency response protocols, and evacuation and communication pla during emergencies. All staff will be trained on emergency preparedness the Risk Manager, Training Adminis II, or designee. C. The root cause of this deficient practice is a knowledge deficit relative requirement that the facility must develop and maintain an emergency preparedness training and testing program that require annual review updates. All staff will be trained on facility emergency preparedness artesting program to include the facility Hazard Vulnerability Analysis by the Manager, Training Administrator II of designee. The Risk Manager or deswill review emergency preparedness relates to the facility Hazard Vulnera Analysis quarterly at the Residents Council meetings. The Risk Manag designee will schedule and conduct quarterly emergency preparedness drills/trainings to test the readiness and the facility's emergency system. D. To ensure compliance, the Continuous Quality Improvement N (CQI RN III) will complete quarterly of the emergency preparedness trained testing program using the EP A Tool (Attachment #5) to ensure staff readiness for compliance in emergency situations for three (3) consecutive	ergency ade d ns es by strator ed to st est est est est est est est est est		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		085035	B. WING			l	C 12/2024
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E 036	Continued From pa	ge 17	EC	036	quarters with 100 percent complian. The results of these audits will be reviewed at the quarterly QAPI Ster. Committee meetings. If it is determ that 100 percent compliance is ach for three (3) consecutive quarters, the facility will conclude that we have successfully addressed this deficient practice.	ering ined ieved :hen, /e	74
F 000	conducted by Healt LLC on behalf of the Department of Healt Division of Health C	th Complaints survey was hcare Management Solutions, e State of Delaware, lth and Social Services, care Quality. The facility was tantial compliance with 42	FC	0000			