DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

263 Chapman Road, Suite 200, Cambridge Bldg
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Regal Heights Healthcare & Rehab Ctr

DATE SURVEY COMPLETED: May 1, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced Annual, Complaint and Extended survey was conducted at this facility starting on April 18, 2024 and completed on May 1, 2024. The deficiencies contained in this report are based on observations, interviews and review of clinical records and other documentation as indicated. The facility census on the first day of the survey was 168 residents. The survey sample size was 58.	-Please cross reference to the CMS 2567-L Survey ending May 1, 2024: Responses posted on ePOC. CMS F-tags listed in the left column 2024:
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	F550, F578, F600, F609, F620, F623, F641, F656, F658, F676, F677, F688, F689, F712, F725, F812, and F842.
3201.1.0	**Scope**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed May 1, 2024: F550, F578, F600, F609, F620, F623, F641, F656, F658, F676, F677, F688, F689, F712, F725, F812, and F842.	Date of compliance: 6/11/2024

Provider's Signature Sara J. Thompson, NHA Title Administrator Date 5/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE** **HOCKESSIN, DE 19707**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced annual, complaint and extended survey was conducted at this facility from April 18, 2024 through May 1, 2024. The facility census was 168 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on interview, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint and extended survey was conducted at this facility starting on April 18, 2024 and completed on May 1, 2024. The deficiencies contained in this report are based on observations, interviews and review of clinical records and other documentation as indicated. The facility census on the first day of the survey was 168 residents. The survey sample size was 58. Abbreviations/Definitions: AD - Admission Director; ADON - Assistant Director of Nursing; BIMS - Brief Inventory of Mental Status/assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions). 8-12: Moderately impaired (decisions poor; cues/supervision required). 13-15: Cognitively intact (decisions consistent/reasonable);	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/24/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 CNA - Certified Nurse's Aide; CRM - Corporate Risk Management; DO - Doctor of OSteopathy; DON - Director of Nursing; LPN - Licensed Practical Nurse; MDS - Minimum Data Set/federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; NHA - Nursing Home Administrator; NP - Nurse Practitioner; Peripheral neuropathy - disease affecting nerves often causing weakness, numbness and pain in the hands and feet; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; SW - Social Worker; UM - Unit Manager; Wanderguard - device that is worn on the wrist or ankle to prevent wandering.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and	F 550		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 550	Continued From page 2 promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for two (R154 and R28) out of 40 residents observed the facility failed to ensure the residents right for a dignified existence and privacy was upheld. Findings include: 1. 4/18/24 12:11 PM - During a lunch observation on the Easton unit E43 (LPN) referred to R154 as a "feeder" when removing the resident's lunch tray from the dining care. E43 then stood over R154 while assisting R154 with her meal. E43	F 550	A-For R154 the deficient practice of utilizing the term feeder and standing over R154 while assisting with meal was unable to be corrected at that time of occurrence. For R28 the deficient practice of using privacy curtain during a dressing change was unable to be corrected due to having past the time of occurrence. For R28 the deficient practice of signing and dating a bandage while already on the resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 05/01/2024
NAME OF PROVIDER OR SUPPLIER: **REGAL HEIGHTS HEALTHCARE & REHAB CENTER**		STREET ADDRESS, CITY, STATE, ZIP CODE: **6525 LANCASTER PIKE HOCKESSIN, DE 19707**	

(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 550	Continued From page 3 immediately confirmed the finding. 2. 4/25/24 11:22 AM - 11:58 AM- During a dressing change observation the privacy curtain to R28's room remained opened. Additionally, E44 (RN) placed a bandage on R28's foot and buttocks. After placing the bandage on R28, E44 then signed and dated the bandages while they were already on the resident. E44 immediately confirmed the finding. 5/1/24 at 1:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E28 (CRM) and representatives with the Ombudsman's Office.	F 550	was unable to be corrected due to having past the time of occurrence. B- Residents requiring assistance with feeding and residents needing wound care have the potential to be affected by this deficient practice. C- Staff Educator/designee will educate current nursing staff and new orientees on using dignified terminology when providing feeding assistance and while providing care. Staff Educator/designee will also be in serviced on providing privacy during care. Staff educator/designee will educate licensed staff on the proper labeling of a wound dressing prior to placing on a resident. RCA: Facility failed to ensure the residents right for a dignified existence and privacy was upheld by using the term feeder, standing over instead of sitting next to the resident while assisting with the meal, not providing privacy by pulling the curtain closed during a dressing change and by improperly labeling a bandage while it was already on the resident. Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov E44 was verbally educated on 4/25/24 by the DON regarding the proper way to provide privacy during a dressing change and how to properly label a bandage prior to being placed on a resident. E44 voiced	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 550	Continued From page 4	F 550	understanding at the time. E44 has since had additional documented education for the same event. D- DON /designee will perform daily audits of residents during meals to ensure proper use of terminology and proper seating while assisting residents with meals. Daily audits will be conducted to ensure residents privacy during care and dressing changes. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.	F 578		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 578	Continued From page 5 §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R35) out of four residents reviewed for advance directives, the facility failed to offer R35 the opportunity to formulate an advanced directive. Findings include: R35's clinical record revealed:	F 578	A-For R35 the deficient practice of not offering the opportunity to formulate an advanced directive was corrected by social services on 4/26/24. R35 was asked on 4/26/24 by social service if she wanted to formulate an advanced directive. R35 declined offer.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 578	Continued From page 6 1/29/24 - R35's quarterly MDS assessment documented that she was cognitively intact with a BIMS (Brief Interview of Mental Status) of 15. Review of R35's clinical record lacked evidence that R35 was offered the opportunity to formulate an advanced directive. 4/26/24 at 2 PM - During an interview, E42 (SW) reviewed the facility's process and acknowledged that R35 was not offered the opportunity to formulate a written advanced directive. E42 stated that she would check with R35 right now and offer the opportunity. 5/1/24 at 1:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E28 (CRM) and representatives with the Ombudsman's Office.	F 578	B-Residents residing at this facility who are cognitively intact have the potential to be affected by this deficient practice. C-social worker/designee will educate social services on ensuring residents who are cognitively intact are offered the opportunity to formulate a written advanced directive. Acceptance or declination will be documented in the residents clinical record. RCA: The facility failed to offer a cognitively intact resident the opportunity to formulate an advance directive. R35 was asked on 4/26/24 by social service if she wanted to formulate an advanced directive. R35 declined offer. On admission social service will review admission documents to determine whether a prior advance directive has been completed. If an advance directive was not done a cognitively intact resident will be offered the opportunity to formulate an advance directive. Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov D- Don/designee will perform daily audits new admissions and current residents who are cognitively intact to ensure they were given the opportunity to formulate an advanced directive. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 578	Continued From page 7	F 578	times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 600 SS=E	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 record review and interview, it was determined that for three (R91, R132 and R136) out of five residents reviewed for abuse, the facility failed to ensure that each resident were free from abuse. Findings include: A facility policy dated 2001, revised 4/21, and	F 600	A- Deficient practice was unable to be corrected for R91, R132 and R136 due to having passed the time of occurrence. B- Residents residing at the facility have the potential to be affected by this deficient practice.	6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 8	F 600		

titled, "Abuse, Neglect ...Prevent Program", documented, "Residents have the right to be free from abuse ..."

Review of R136's clinical records revealed:

1. 6/18/22 - R136 was admitted to the facility with diagnoses including right sided weakness, anxiety, and depression. R136's BIMS score was 13 (cognitively intact).

6/21/22 - R136's care plan documented, "Approach calmly and give empathy, support and compassion".

a. 8/18/23 4:30 PM - R136 reported that he felt that E27 (LPN) was disrespectful and rude to him when she told him she was not going to bring his medications out to the front of the building anymore.

4/21/24 10:20 AM - During an interview, R136 stated, "I live at this facility because I can't remember to take my medications at home. I tried to tell the nurse (E27) but she did not want to listen to me". E27's statement (in the facility investigation) documented, " ...It's not my job to look for you outside ...you need to come back in the building for your medications".

4/21/24 11:30 AM - During a telephone interview, E27 stated, "I have to take his medications outside to him, and I told him he had to come inside. He said I was not a real nurse and called me a racist".

b. 4/10/24 8:30 AM - The facility reported to the Division of Long-Term Care Protection an incident involving a resident and staff member. The

C- Staff educator/designee will educate current staff and new orientees on what constitutes and the prevention of abuse, neglect, misappropriation of resident property and exploitation. In serving will include notifying supervisors immediately if they identify any form of abuse.

RCA: The facility failed to ensure that R91, R132, and R136 were free from abuse by not following facilities abuse policy and procedure.

Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov

D- Administrator/designee will review any grievances or allegations of abuse, neglect, exploitation or misappropriation to identify if any forms of abuse have taken place. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 9	F 600		

report documented that R136 became upset E26 (maintenance staff) accused him of pulling the call bell out of the wall. R136 denied pulling the call bell out of the wall but E26 continued to insist that he did. R136 became angry and cursed at E26. E26 cursed back at R136, and R136 then attempted to hit E26. The facility's staff intervened and separated them.

4/21/24 12:30 PM - During an interview R136 stated, "I tried to tell him (E26) that I did not pull the call bell out of the wall, but he kept insisting that I did it. I became angry and, told him, "Fuck you, I did not pull the call bell out of the wall. Why are you accusing me of do it?". R136 stated, "He (E26) said "Fuck you" back to me".

4/21/24 1:30 PM - During a telephone interview E26 stated, "I asked him (R136) if he pulled the call bell out of the wall. He because (sic) angry and started to yell "Fuck you" to me. So I said "Fuck you" back to him. He then tried to hit me but the nurses came in and he didn't get to hit me".

2. Review of R91's clinical records revealed the following:

3/15/19 - R91 was admitted to the facility with diagnoses including dementia.

6/2/21 - R91 was care planned for agitation with verbal abuse related to screaming, cursing and calling out behaviors. Interventions including but not limited to leaving the resident alone, allowing time to calm down and then reapproach.

4/8/22 - R91 was care planned for impaired verbal communication related to cognitive loss

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 and difficulty finding words. Interventions including but not limited to gently approaching resident in a calm, friendly, relaxed manner "with a smile on your face." 6/20/23 - R91's quarterly MDS assessment revealed moderately impaired cognition with behavioral symptoms directed towards others occurring 1-3 days during the review period. R91 required supervision and set up help only with transfers to or from: bed, chair, wheelchair or standing position. In addition, R91 was independent with eating requiring set up help only. 9/8/23 10:40 AM - A facility incident submitted to the State Incident Reporting Center documented that, "Resident [R91] sitting in her wheelchair in doorway of room stated to her CNA (Certified Nurse Assistant) [E4] that she was hungry and did not get her tray (breakfast). CNA stated that he put her breakfast tray in her room. Resident then told him you are lying, he then stated you are lying in an aggressive manner. Nurse immediately intervened and stopped the verbal exchange." 9/8/23 12:53 PM - A progress note by E3 (SW) documented, "Social Services met with [R91] after the argument she had with a staff member (E4). She stated that she is okay. 'I held my ground. I don't lie and I don't steal.' She appears okay and denies any form of distress." 9/8/23 - A facility documentation of E4's verbal statement revealed that R91 stated she was hungry and did not get a breakfast tray. E4 told R91 that she got a tray and she already ate her breakfast...[R91] then stated "...you (E4) are a	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 11	F 600		

liar." E4 then told R91 not to call him a liar... The document further revealed that E4 stated "... I gave you your breakfast and you ate it all. She then called me a liar. I stated to her don't call me a liar... The nurse (E5, RN) came up to me and took me away....".

9/8/23 - A facility documentation of E5's verbal statement revealed that E5 pulled E4 away. E5 told E4 that he can't talk to a resident like that and that E5 found E4's acting towards R91 as defensive and aggressive with his (E4) tone.

9/8/24 - A facility documentation of E3's statement revealed, "... I was walking the hallway... to E5's cart, I got to stop because E4 was in the way, by [R91]'s door. I heard [R91] say you are a liar, E4 then yelled back, facing [R91] calling her a liar. They both went back and forth calling each other a liar. E5 then intervened by telling E4 to stop."

4/25/24 1:25 PM - During an interview, E3 stated that she saw and heard E4 in a verbal exchange with R91. E3 went to E5 and advised E5 to let E4 know that he can not talk to the residents in that manner. E3 further confirmed that the incident was substantiated for verbal abuse.

3. R132's clinical record revealed:

5/23/23 - R132 was admitted to the facility with diagnoses that included, but were not limited to,
- Parkinson's Disease (progressive disorder of the nervous system that affects your movement or a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination);
- Chronic Obstructive Pulmonary Disease

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 12	F 600		

(chronic inflammatory lung disease that causes obstructed airflow from the lungs); and
- a history of repeated falls.

5/29/23 - The admission MDS assessment documented that R132 had moderate cognitive impairment (BIMS of 12) and it was very important to choose between a bath/shower. R132 required physical help of one staff person in part of the bathing activity; required supervision of one staff person for locomotion/walking on the unit; and limited assistance of one staff person for dressing.

7/24/23 - On the 3-11 PM shift, a staff to resident altercation occurred between E21 (CNA) and R132. Despite the House Supervisor's (E40) knowledge and involvement, the facility management did not become aware of the incident until two days later, during the 3-11 PM shift stand down meeting on 7/26/23 where another Supervisor reported it to E2 (DON).

It should be noted that there were no nurse's notes documented in R132's clinical record regarding the 7/24/23 evening shift incident that occurred between E21 (CNA) and R132 and follow-up assessments, until a social services note was documented on 7/28/23 at 4:06 PM, four days later.

Review of E21's (CNA) timecard revealed:
- 7/24/23 - E21 clocked in at 4:27 PM and clocked out at 11:01 PM.
- 7/26/23 - E21 clocked in at 3:06 PM and clocked out at 4 PM.

On 7/26/23 during the 3-11 PM shift, the facility's investigation was initiated by E2 (DON) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 13 included the following: - 7/26/23 at 5:15 PM - A documented interview of R132 by E2 (DON) was: "I began this interview by asking him how [name of E21 (CNA)] is doing with his care? Resident stated 'not too good' he then stated I tried to give him another chance but on Monday her (sic) took me into the shower a little after 2015 (8:15 PM) and all he did was turn on the shower and he said to me, I have to do care across the hallway I will be right back. Resident then stated around 2100 (9 PM) I was naked still in the shower over one hour and [name of E21] never came back. Resident stated I had to walk to the shower room door naked open it up and ask for help. Two nice girls covered me up and helped me back into my room. Resident then stated I was talking to one of those girls from inside of my room she was standing outside of my doorway. [Name of E21] then came up to the doorway and she asked him why did you leave (sic) resident in the shower alone. [Name of E21] was standing outside of my room and then came in talking very loud saying you told me to leave the shower. Resident answered said you told you had other people to take care of and would be right back. Resident stated to [name of E21] I was in the shower for about one hour until I came to the door naked and the girls helped me. Resident stated then [name of E21] began yelling about my [family member], and I am still upset with [name of E21] because I heard him talking about my [family member] when he walked past me when I was outside smoking. Her name is [name] and [name of E21] said her name several times when he was on the phone. [Family member name] is not a very common name so I know he was talking about my [family member]. Resident then said	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 14 [name of E21] then said to me why did you told (sic) your [family member] that I did not give you good care when you know that I do. One of the CNA's went to get the supervisor to intervene and remove [name of E21] from the residents room. Supervisor arrived on location and overheard the end of [name of E21] yelling at resident and asked him to leave the residents room. Supervisor stated after asking [name of E21] to leave residents room that she then texted the ADON stating [E21's] assignment needs to be changed resident does not want [name of E21] as his CNA. I asked [name of R132] how was he doing he stated today I'm OK but don't know why it's a problem for [name of E21] to provide care timely and why he gets so upset when I ask him for an explanation." - 7/26/23 (untimed) - E8's (CNA) statement: "7/24/23 Monday... During 3-11 shift [R132] was to receive a shower it was his shower night. [E21] told [R132] he will give him a shower at 8 PM. Later, that night around 8:30/9:00 PM [E21] and [R132] were talking and [R132] was addressing how he was left unattended in the shower and was calling for help and [E39 (CNA)] assisted resident out of shower. [E21] began to get upset with [R132] and began to tell him 'he is lying.' [E21] also stated 'I told you one thing and you are listening to what you wanna hear' 'Nobody is going to give you as many showers as I gave you.' Your chart does not say you are a (sic) everyday shower, so we have to put in the chart your taking a shower everyday so Regal can start charging you for showers.' 'If you (sic) in the shower you don't need assistance because you are listed in the chart as independent.' All [R132's name] proceeded to say was nun (sic) of this is true. Then, I stepped in and told [E21's name] he	F 600		

(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 15 can't talk to residents like that but he proceeded to go on. I stepped away and got the supervisor. She then went into [R132's name] room where he followed [R132's name] to get him out. The supervisor asked [E21] (sic) happen (sic), [E21] stated '[R132's name] was yelling at me' which was incorrect." - 7/26/23 (untimed) - E2 (DON) completed an Employee Performance Improvement/Action Notification for E40 (RN/House Supervisor) that documented "[E40's name] failed to report or notify the DON, Administrator, ADON or designee of a case of suspected verbal abuse timely ... was re-educated on procedure for timely notification and or reporting of suspected cases of Abuse." - 7/27/23 (untimed) - E41 (Nurse) statement: "On 7/26/2023, I came to stand down and the 3-11 (PM) Supervisor advised me that [E21] could not have [R132]. This was due to [E21] yelling at the resident. At the time I was on vacation. I reported the incident immediately to my Director of Nursing." - 7/27/23 (untimed) - E39 (CNA) statement: "On Monday 7/24/23 on 3-11 I walked past the room and asked [R132] if he had his shower. It was around 8:45 PM. Per [R132] '[E21's name] said he was going to give me my shower at 8P (sic) but it was passed 8P (sic) so I am just going to call my (family member).' I went and called the supervisor [E40's name] who then called [E21] on the phone to come complete his ... shower. When [E21] came back in the building he was mad and stated 'someone called me off my break to get a shower.' [E21] gave him the shower around 9P (sic). [E21] put the resident in the shower and left (sic) there. [E21] started yelling for help, I went to	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 16	F 600		

check on him and helped him dry off. I told [E21] he should not have left him alone. [E21] then went in the room agitated and started yelling at [R132], stating 'I am a good CNA. You called and reported me to your (family member) and supervisor. [R132] began yelling back but you could tell he was intimidated. I was going to get [E40's name] but she was already coming up the hallway and told him to come out of the room away from the resident. [E40's name] then spoke to [E21] in the hallway about his behavior to the resident."

- Undated - E40's (RN/House Supervisor) statement: "[E36 (CNA)] and [E39 (CNA)] approached me and said that [E21] was in a resident's room upset. Approached resident room and saw [E21] gathering linens. [E21] was visibly upset making remarks to Resident about how the resident had called his (family member). Statements such as 'I'm sorry you aren't happy with my services.' Spoke with [E21] to come out of resident room and that his assignment needs to be changed."

- 7/27/23 - During a follow up interview with E40 by E2 (DON), E40 stated "[E21] was loud and yelling at the resident and acting out. [E21] was aggressive and that's why I told him to leave the resident's room ... [R132] looked shocked like he was confused just standing there still like... I asked him [R132] if he was OK and resident replied YEAH......".

7/28/23 at 4:06 PM - A social services note documented, "Supportive visit to him in room. At first he noted that he was angry that a service person could be disrespectful to him. He then stated that he is over it. Aware that Management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 17	F 600		

has resolved the issue and that said service person will no longer be in the building."

7/28/23 at 6:40 PM - The facility reported the 7/24/23 staff to resident allegation of emotional abuse incident to the State Agency. However, the facility failed to report the alleged violation within the 2 hour requirement.

8/7/23 - E1 (NHA) documented an Employee Performance Improvement/Action Notification via phone with E21 at 1:30 PM. E21 was being terminated for "...violation of Policy #501, Major Offense #26... On Monday, July 24, 2023, there was an allegation of verbal abuse between [E21] and a resident [R132]... After further investigation, it has been substantiated that verbal abuse occurred...".

4/29/24 at 1:21 PM - During an interview with the Surveyor, E21 (CNA) stated that R132 was independent. On 7/24/23 evening shift, E21 stated that the supervisor gave me an extra shower to do and that he had a heavy workload. E21 stated that R132 was on oxygen and told him to go tend to another person. E21 stated that R132 was supposed to wait on the shower bench. E21 stated that R132 was calling my name, had bunched up the towels and wasn't using his walker. E21 stated that he said to R132 to be careful as he wanted him to hold onto something. E21 stated that "I was just being assertive to the guy (resident)." E21 acknowledge that he speaks too loud, but sometimes residents can't hear. E21 stated that other nursing staff were standing outside the resident's room. E21 stated that two days later (7/26/24) I was called to the office and told that I was too aggressive with my tone.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 18 4/29/24 at 3:32 PM - During an interview with the Surveyor, E39 (CNA) stated that R132 was mad at the situation. E39 stated that E21 (CNA) was avoiding giving him a shower on that day. E39 stated that R132 was supervision for showers and depending on the day and his Parkinson's diagnosis, he may need assistance with his lower extremities. E39 stated that she overhead R132 and E21 and she was going to get the supervisor (E40), but the supervisor walked up on it and heard what was taking place. 4/30/24 at 12:22 PM - During an interview with the Surveyor, E40 (RN/House Supervisor) stated that on 7/24/23 evening shift, she was assigned to a medication cart in the Eastburn Unit due to a nursing calling off late in addition to being the House Supervisor. E40 stated that she arrived after the incident occurred and only heard hearsay. E40 stated that she believed that the CNA (E21) was fired for the incident. E21 stated that the incident report was not filed until a day later. The facility failed to ensure that R132 was free from verbal abuse by a staff person that caused emotional distress for the resident on the 7/24/23 evening shift and failed to immediately implement their facility's abuse policy and procedure. 4/30/24 at 3:34 PM - Finding was reviewed with E1 (NHA), E2 (DON), and E28 (CRM). No further information was provided to the Surveyor. 5/1/24 at 1:30 PM - All findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E28 (CRM) and representative's with the Ombudsman's Office.	F 600		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 609	Continued From page 19	F 609		
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 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 interview and review of facility and other documentation as indicated, it was determined that for one (R132) out of five residents reviewed for abuse, the facility failed to report staff to resident abuse to the State Agency within the two hour requirement. Findings include:	F 609	A- Deficient practice was unable to be corrected for R132 due to having passed the time of occurrence. B- Residents residing at the facility have the potential to be affected by this	6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 609

Continued From page 20

Cross refer to F600, example 3

The facility's policy and procedure entitled "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating," revised September 2022, stated, "... 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials... 2. The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility;... 3. 'Immediately' is defined as: a. within two hours of an allegation involving abuse...".

Review of the facility's investigation revealed:

7/24/23 - On the 3-11 PM shift, a staff to resident altercation occurred between E21 (CNA) and R132 where multiple staff observed and/or were involved. Despite the House Supervisor's (E40) knowledge and involvement as well as other staff, the facility management did not become aware of the incident until two days later, during the 3-11 PM shift stand down meeting on 7/26/23 where a different Supervisor reported it to E2 (DON).

7/26/23 at 6:40 PM - The State Agency received a report from E2 (DON) that an employee (E21, CNA) caused emotional distress to a resident (R132). The employee was suspended pending investigation.

The facility failed to ensure that staff immediately report alleged violations of abuse to the State

F 609

deficient practice.

C- Staff educator/designee will educate current staff and new orientees on what constitutes abuse and neglect and the timeliness of reporting to the supervisor. Staff educator/designee will educate nursing administration regarding the need to report to the state agency within 2 hours after an alleged violation of abuse, neglect, exploitation or mistreatment is made.

RCA: The facility failed to report an allegation of mistreatment to the state agency in a timely manner. House supervisor failed to recognize this event as one to report in the 2hour time frame. Employee had documented education on 7/26/23 regarding what constitutes abuse and the timeliness of reporting.
The nursing supervisor will contact the DON or Nursing Home Administrator immediately, with any allegations of abuse, neglect, exploitation or misappropriation to ensure proper notification has been completed to the state licensing department.

Additional information and attachments sent to
DHSS_DHCQ_POC@delaware.gov

D-Administrator/designee will review grievances or allegations of abuse, neglect, exploitation or misappropriation for timely reporting. Daily audits will be completed until we consistently reach 100% success over 3 consecutive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 609	Continued From page 21 Agency within the two hour requirement. 4/30/23 at 3:34 PM - During a combined interview with E1 (NHA), E2 (DON) and E28 (CRM), the finding was reviewed. No further information was provided to the Surveyor. 5/1/24 at 1:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E28 (CRM) and representatives of the Ombudsman's Office.	F 609	evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 620 SS=B	Admissions Policy CFR(s): 483.15(a)(1)-(7) §483.15(a) Admissions policy. §483.15(a)(1) The facility must establish and implement an admissions policy. §483.15(a)(2) The facility must- (i) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid; and (ii) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits. (iii) Not request or require residents or potential residents to waive potential facility liability for losses of personal property. §483.15(a)(3) The facility must not request or require a third party guarantee of payment to the facility as a condition of admission or expedited admission, or continued stay in the facility. However, the facility may request and require a	F 620		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 620	Continued From page 22	F 620		

resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

§483.15(a)(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the State plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission or continued stay in the facility. However,-
(i) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the State plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services; and
(ii) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

§483.15(a)(5) States or political subdivisions may apply stricter admissions standards under State or local laws than are specified in this section, to prohibit discrimination against individuals entitled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 620	Continued From page 23 to Medicaid. §483.15(a)(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility. §483.15(a)(7) A nursing facility that is a composite distinct part as defined in §483.5 must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under paragraph (c)(9) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R35) out of four residents reviewed for advanced directives, the facility failed to disclose and provide R35, a cognitively intact resident, with the facility's admission agreement that included, but was not limited to, addressing services, charges, consents, policies, advance directive form and resident rights. Findings include: Cross refer to F578 R35's clinical record revealed: 6/6/22 - R35 was admitted directly from another skilled nursing facility pending facility closure. Review of the R35's clinical record lacked evidence of a signed admission agreement by R35. 4/26/24 at 3:22 PM - In response to the	F 620	A-Facility failed to provide R35 with the facilities admission agreement to sign. On 4/26/24 the admission agreement was completed by R35. B- Residents residing at the facility who are cognitively intact have the potential to be affected by this deficient practice. C-Nursing Home Administrator will educate admissions director on ensuring that residents that are cognitively intact are provided with the facilities admission agreement to sign on admission. RCA: Admissions director failed to provide R35, a cognitively intact resident, with the facilities admission agreement to sign on admission. Process change: Admissions director will ask cognitively intact residents if they	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 620	Continued From page 24 Surveyor's request for R35's admission agreement, E6 (AD) confirmed in an interview that the admission agreement was not done when R35 was admitted on 6/6/22. E6 confirmed that the admission agreement was completed today (4/26/24) with R35 as she was her own representative. 5/1/24 at 1:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E28 (CRM) and representative's with the Ombudsman's Office.	F 620	would like to sign their own admission agreement on admission. If a resident declines we will contact the resident representative to complete the admission packet. Admissions director will offer RR options to complete the agreement. Admissions Director will check the status of completion and document progress and attempts for completing the admission agreement. Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov D-Administrator/designee will perform daily audits on new admissions that are cognitively intact to ensure that they have been provided facilities admission agreement and that they have been signed and returned. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)	F 623		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 623	Continued From page 25 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 623	Continued From page 26 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 623	Continued From page 27 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for four (R12, R169, R176, R177) out of seven residents reviewed for Hospitalization, the facility failed to ensure that all the mandatory contents of the transfer notice when a resident was transferred to the hospital. Findings include: 1. Review of R12's clinical record revealed: 1/24/14 - R12 was admitted to the facility. 12/25/23 - A progress note documented that R12 was transferred to the hospital to be evaluated after hitting her head on the windowsill. 4/29/24 2:20 PM- Review of the Notices for transfer for R12's 12/25/23 transfer revealed a lack of the required content within the notice such as: - an explanation of the right to appeal the transfer or discharge to the State;	F 623	A-Facility failed to provide to ensure that all the transfer notice had all of the mandatory content for R12, R169, R176, and R177. Deficient practice was unable to be corrected for due to having passed the time of occurrence. B- Residents being transferred to the hospital have the potential to be affected by this deficient practice. C-Staff Educator/designee will educate current licensed nurses and new orientees on providing the updated transfer notice when a resident is discharged to the hospital. RCA: Facility failed to provide to ensure that the transfer notice had all of the mandatory content for R12, R169, R176, and R177. The resident transfer form has been updated to include all of the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 623	Continued From page 28 - the name, address and telephone number of the State entity that receives such appeal hearing requests; - the information on how to obtain an appeal form; - the information on obtaining assistance in completing and submitting the appeal hearing request; and - the name, address and telephone number of the representative of the Office of the State Long-term Care Ombudsman. 2. Review of R176's clinical record revealed: 11/27/23 - R176 was admitted to the facility. 1/12/24 - A progress note documented that R76 was transferred to the hospital for a change in mental status at the daughter's insistence. 4/29/24 2:20 PM- Review of the Notices for transfer for R176's 1/12/24 transfer revealed a lack of the required content within the notice such as: - an explanation of the right to appeal the transfer or discharge to the State; - the name, address and telephone number of the State entity that receives such appeal hearing requests; - the information on how to obtain an appeal form; - the information on obtaining assistance in completing and submitting the appeal hearing request; and - the name, address and telephone number of the representative of the Office of the State Long-term Care Ombudsman. 3. Review of R177's clinical record revealed: 11/1/23- R177 was admitted to the facility.	F 623	mandatory contents. Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov D- Administrator/designee will perform daily audits of resident transfer forms to ensure the proper form was utilized. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

F 623 | Continued From page 29 | F 623

11/15/23 3:21 AM - E58 (LPN) documented R177 was sent to the hospital after a fall.

4/29/24 2:20 PM- Review of the Notices for transfer for R177's 11/15/23 transfer revealed a lack of the required content within the notice such as:
- an explanation of the right to appeal the transfer or discharge to the State;
- the name, address and telephone number of the State entity that receives such appeal hearing requests;
- the information on how to obtain an appeal form;
- the information on obtaining assistance in completing and submitting the appeal hearing request; and
- the name, address and telephone number of the representative of the Office of the State Long-term Care Ombudsman.

4/26/24 12:20 PM- During an interview, E6 (Admission Director) confirmed that the facility's Notice of Transfer did not include the appeal information.

4/29/24 11:24 AM - During an interview, E1 (NHA) confirmed that the facility failed to complete appeal and Ombudsman contact information on the current facility's Notice of Transfer form.

4. The following was reviewed in R169's clinical record:

11/7/23 - A progress note documented that R169 was admitted to the hospital.

11/21/23 - A progress note and MDS entry documented that R169 was admitted to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 623	Continued From page 30 hospital. 4/26/24 11:15 AM - Review of R169's Notice of Transfers on 11/7/23 and 11/21/23 revealed a lack of the required information on the contents of the notice such as: - An explanation of the right to appeal the transfer or discharge to the State; - The name, address (mail and email), and telephone number of the State entity which receives such appeal hearing requests; - Information on how to obtain an appeal form; - Information on obtaining assistance in completing and submitting the appeal hearing request; and - The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care ombudsman. 4/26/24 12:20 PM - During an interview, E6 (Admission Director) stated that the facility's Notice of Transfer form does not include the appeal information. 4/29/24 11:24 AM - In an interview, E1 (NHA) confirmed that the facility did not have the complete appeal and ombudsman contact information in the Notice of Transfer forms currently being sent out to the resident/family representative during a resident transfer/discharge to the hospital. 5/1/24 at 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E28 (CRM) and representatives from the Ombudsman's Office.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 641	Continued From page 31 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R130) out of six residents sampled for nutrition and one (R146) out of seven residents sampled for hospitalization, the facility failed to ensure accuracy of the MDS assessments for each resident. Findings include: 1. R130's clinical record revealed: 12/11/23 - R130's physician ordered diet was mechanical soft texture. 4/16/24 - R130's quarterly MDS assessment was not accurately coded to reflect his mechanical diet. 4/24/24 at 10:01 AM - During an interview, finding was confirmed with E48 (RNAC). 2. R146's clinical record revealed: 2/23/23 (revised) - R146 was care planned for requiring hemodialysis for a diagnosis of end stage renal disorder with an approach that specified the offsite location and the treatment days: Tuesday, Thursday and Saturday. 2/16/24 - R146's quarterly MDS assessment was not accurately coded to reflect his required ongoing dialysis treatment under Section O - Special Treatments, Procedures, and Programs. 5/1/24 at 10:42 AM - During an interview, finding	F 641	A-For R130 and R146 facility failed to ensure accuracy of the MDS assessment. R130 and R146 MDS□s have been modified. B- Residents being transferred to the hospital have the potential to be affected by this deficient practice. C- Director of Clinical Reimbursement/designee will educate RNAC□s on ensuring accuracy of residents MDS assessments. RCA: For R130 the RNAC□s did not accurately code resident's diet and R146 the RNAC's did not accurately code to reflect residents need for dialysis. R130 and R146 MDS's have been modified. Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov D- Director of Clinical Reimbursement/designee will conduct and audit for all current dialysis residents to ensure that they are coded correctly on the MDS. Director of Clinical Reimbursement will conduct and audit for all residents with a mechanically altered diet are coded correctly on the MDS. Audits will continue for the next 2 MDS cycles. Audits will continue another	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 641	Continued From page 32 was confirmed with E48 (RNAC). 5/1/24 at 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E28 (CRM) and representatives from the Ombudsman's Office.	F 641	Quarter after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and	F 656		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 656	Continued From page 33 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R29) out of three residents reviewed for dental services the facility failed to develop a care plan to address the resident's missing teeth. Additionally, for one (R169) out of three residents reviewed for behavior, the facility failed to develop a person centered care plan to address R169's new medical diagnoses of depression and anxiety disorder. Findings include: 1. 12/5/23 - An admission MDS assessment documented R29 had obvious cavity or broken natural teeth. During initial pool screening on 4/18/24 at 12:18 PM, R29 was observed to have missing teeth. During an interview on 4/19/24 at 10:43 AM, FM1 stated, "He is losing teeth like crazy and I am worried about that".	F 656	A-R29 care plan was updated to include missing teeth. R169 no longer resides at the facility. B- Residents who have a need for a person centered care plan have the potential to be affected by this deficient practice. C- Staff educator/designee will educate current licensed staff and new orientees to ensure residents on admission and subsequently with dental concerns and new diagnoses have their care plans updated accordingly. RCA: Facility failed to recognize the need to update R29's care plan for missing teeth and R169□s care plan for new diagnosis. R29 care plan was updated to include missing teeth. R169 no longer resides at the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ____ B. WING ____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 656	Continued From page 34 4/20/24 - Review of R29's clinical record lacked evidence of a care plan that addressed the resident's broken teeth. During an interview on 4/24/24 at 12:33 PM, E17 (RN) and unit manager confirmed a care plan for R29's missing teeth had not been created but that one would be created immediately. 2. Review of R169's clinical records revealed the following: 11/8/23 - R169 was readmitted to the facility. 11/9/23 - R169's list of diagnoses included depression and anxiety disorder. 11/14/23 - R169's physician's order for lorazepam (for anxiety) 0.5 mg, 1 tablet by mouth every 12 hours as needed for 14 days was discontinued on 11/16/23. 11/16/23 - R169 had a new physician's order for lorazepam 0.5 mg, 1 tablet by mouth every 8 hours as needed for 14 days. 4/25/24 11:42 AM - A further review of R169's records revealed a lack of evidence that the facility developed a person centered care plan to address R169's new medical diagnoses of depression and anxiety disorder. 5/1/24 at 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E28 (CRM) and representatives from the Ombudsman's Office.	F 656	Residents requiring dental services care plans have been updated to reflect any changes or concerns. Residents with new diagnosis of depression and anxiety disorder will have a person centered care plan developed. Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov D--Don/designee will audit dental consults for the past 60 days to ensure that all care plans have been developed to reflect any dental concerns. DON/designee will audit current residents with a diagnosis of depression/anxiety have a person centered care plan in place. Daily audits of admissions and residents with any new diagnosis will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 658	Continued From page 35 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interviews, it was determined that for four (R170, R174, R176, R177) out of six residents reviewed for accidents, the facility failed to provide services that meet professional standards of quality by having Licensed Practical Nurses (LPN) complete admission assessments and admission progress notes. Findings include: A review of the 2023 State of Delaware Board of Nursing RN, LPN, and NA/UAP (Nurse Assistant/Unlicensed Assistive Personnel) Duties Task list revealed that Registered Nurses are supposed to do Admission Assessments. 1. A review of R170's clinical record revealed: 8/9/23 2:00 PM - R170 was admitted to the facility. A review of the clinical record revealed the following 8/9/23 facility admission assessments conducted by E33 (LPN): - Admission Assessment Evaluation form - An admission progress note for R170's facility admission assessment - A Braden Scale for Predicting Pressure Ulcer Risk assessment. 2. 9/4/23 - R174 was admitted to the facility. A review of the clinical record revealed the	F 658	A- Deficient practice was unable to be corrected for R170, R174, R176, and R177 due to having passed the time of occurrence. B-New admissions admitted to the facility had the potential to be affected by this deficient practice. C-Staff educator/designee will educate current licensed staff and new orientees on the Delaware board of nursing duties task list to include that only registered nurses are to complete all admission assessments and admission progress notes. RCA: For R170, R174, R176, R177, LPN□s had performed various admissions assessments and admission progress notes. New process has been initiated to include that only registered nurses are to complete all initial admission assessments and admission progress notes. Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 658	Continued From page 36 following 9/4/23 facility admission assessments conducted by E68 (LPN): Admission evaluation, AIMS (Abnormal Involuntary Movement Scale) evaluation, Bladder and Bowel Continence evaluation, Braden (scale for predicting pressure ulcer risk) evaluation, Elopement evaluation, Fall Risk evaluation and Skilled Nurse admission note. Of note, E40 (RN) completed the Side Rail/Restraint evaluation and E47 (RN) completed the Skin Only evaluation. 3. 11/27/23 - R176 was admitted to the facility. A review of the clinical record revealed the following 11/27/23 facility admission assessments conducted by E64 (LPN): Admission evaluation, AIMS evaluation, Bladder and Bowel Continence evaluation, Braden evaluation, Elopement evaluation, Fall Risk evaluation, Side Rail/ Restraint evaluation, Smoking Screen evaluation and Skilled Nurse admission note. Of note, E19 (RN) did complete the Skin Only evaluation. 4. 11/1/23 - R177 was admitted to the facility. A review of the clinical record revealed the following 11/1/23 facility admission assessments conducted by E63 (LPN): Admission Assessment evaluation form and Skin Only Evaluation. A review of the clinical record revealed the following 11/1/23 facility admission assessments conducted by E64 (LPN): AIMS evaluation, Bladder and Bowel Continence evaluation, Braden evaluation, Elopement evaluation, Pain	F 658	D- Don/designee will perform daily audits of new admissions assessments and admission notes to ensure that a registered nurse completed the assessments and progress notes. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 658 Continued From page 37 F 658

Interview, Side Rail/ Restraint evaluation and Smoking Screen evaluation.

A review of the clinical record revealed the following 11/1/23 facility admission assessments conducted by E65 (LPN): Fall Risk evaluation and Skilled Nurse admission note.

4/25/24 8:07 AM - During an interview about the facility's admission process, E2 (DON) stated, "We use a checklist. The admitting nurse does the assessments. We (DON, ADON) check and enter the orders and have them in que so the admitting nurse can focus on the assessments. The admitting nurse does the assessments, there are many."

E2 provided the surveyor with a copy of the facility admission checklist. The checklist documented the following admission assessments: Admission evaluation, AIMS evaluation (if on anti-psychotic), Bladder and Bowel assessment, Braden evaluation, Fall Risk evaluation, Skin Only evaluation, Weekly Skin evaluation (entered based on shower schedule), Smoking Screen evaluation, Side Rail/ Restraint evaluation, Self-Administration of Medications evaluation, Skilled Nurse admission note, Pain Interview tool and Lift/Transfer evaluation.

4/30/24 1:05 PM - During an interview, E14 (LPN) stated, "Yes, the LPNs do the various admission assessments such as fall risk, elopement and Braden evaluations."

4/30/24 1:12 PM - During an interview, E65 (LPN) stated, "LPNs do admission evaluations and assessments when a new admission comes in."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 658	Continued From page 38 5/1/24 at 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E28 (CRM) and representatives from the Ombudsman's Office.	F 658		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 676	Continued From page 39 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R35) out of six residents reviewed for communication-sensory, the facility failed to ensure nursing staff provided communication assistive devices. Findings include: R35's clinical record revealed: 6/16/22 (revised) - R35 was care planned for impaired verbal communication related to dsyarthria (speech disorder caused by muscle weakness or control problems in the mouth, face or throat) and she can write on paper with a pen. One intervention was to provide paper and pen for the resident to communicate with. 1/29/24 - The quarterly MDS assessment documented that R35 has no speech, but she has the ability to express her ideas/wants and to understand others. R35 was cognitively intact and used a walker. On 2/1/24, according to the Prehospital Care Report documented by the Basic Life Safety (BLS) crew: - at 11:27 AM - 911 was called by the facility for medical transport to the ER for R35's pain; - at 11:41 AM - "Upon arrival the patient was found sitting outside of (name of facility) with staff. Staff advised the patient began to have abdominal pain since this morning. Staff advised the patient is unable to speak and communicates	F 676	A-For R35 facility failed to provide resident with her communication device, paper and pen, while waiting for transfer to the hospital. B-Residents who require communicative devices have the potential to be affected by this deficient practice. C-Staff Educator/designee will current educate current license staff and new orientees on ensuring a tool of communication is readily available for those who require a special communicative device. RCA: R35 had communication device (pen and paper) with her outside while waiting for ambulance to arrive to transfer to the hospital. R35 agreed to return to the vestibule with staff to await hospital transfer. As she was returning back to the facility the ambulance arrived and resident immediately went toward the ambulance leaving her walker behind with her communication device (pen and paper). Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov D- Don/designee will perform daily audits of those residents requiring specialized	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 676	Continued From page 40 by writing on a notepad. The patient did not have a notepad on her and staff advised that they did not provide her with one... BLS provided the patient with pen and paper for communication purposes...". 4/18/24 at 1:12 PM - During an interview with the Surveyor, R35 confirmed that the ambulance staff had to provide her with paper and pen on 2/1/24 so she could answer their questions about her pain. 4/30/24 - A typed statement from E8 (RN) documented, "2/1/24 resident wanted to be sent to ED for evaluation. She sat outside the facility and refused to come back inside. This writer stood outside with her the entire time. Resident was able to communicate to this writer by using writing pad she always has with her. I was able to convince her to come inside the lobby to wait for transport. She agreed, and when entering the building transport arrived. Resident left walker in lobby of building with her notepad and pen on walker seat. While this writer giving emergency transport report on the situation resident got on their stretcher and refused to get up. This writer made transport aware that resident was non verbal and communicated by writing. They then pulled out paper and pen to give resident to communicate with them while they interviewed her before taking her to the ED. Residents (sic) walker with note pad and pen were taken back to the unit by this writer...". 5/1/24 at 9:11 AM - During an interview, E60 (Receptionist) stated that she recalled the 2/1/24 incident with R35, where she was outside waiting. When asked did R35 come back inside the first door to the vestibule, she stated that she did not	F 676	communication devices to ensure that they are within reach of resident and able to communicate at all times. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 676	Continued From page 41 see R35 come back inside the first door to the vestibule. E60 stated that she can see the front vestibule by surveillance camera. This Surveyor observed the surveillance of the front vestibule from the receptionist desk. 5/1/24 at 9:52 AM - During an interview, C1 (BLS crew member) stated that R35 was sitting on the bench. BLS asked the staff person if they had pen and paper and the staff person said no when they were trying to communicate with the resident. C1 stated that the staff person went back inside to find a pen and came back out with no pen or paper. BLS had to give the resident pen and paper to communicate. 5/1/24 at 1:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E28 (CRM) and representative's with the Ombudsman's Office.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R53 and R120) out of six residents reviewed for ADLs (activities of daily living), the facility failed to ensure each resident was provided toileting care per each resident's care plan. Findings include: 1. R53's clinical record revealed:	F 677	A-For R53 and R120 facility failed to ensure each resident was provided toileting care per each residents care plan. Deficient practice was unable to be corrected due to having past the time of occurrence. B- Residents needing assistance with toileting have the potential to be affected	6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 677	Continued From page 42 11/17/23 - R53 was admitted to the facility with diagnoses that included, but were not limited to, cancer, heart failure, depression, Post Traumatic Stress Disorder (disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event that can last from months or years, with triggers that can bring back the memories of the trauma accompanied by intense emotional and physical reactions) and diabetes. 12/1/23 - R53 was care planned for incontinence of bowel and bladder with interventions that included, but were not limited to: - check resident every two hours and PRN (as needed); - incontinence care after each incontinent episode; - toilet after meals - urinal and bedpan (date initiated 12/6/23); and - use absorbent products as needed. 1/23/24 - The admission MDS assessment documented that R53 was cognitively intact, always incontinent for bowel and bladder and dependent for toileting hygiene. a. On 2/14/24 day shift, R53 went to a morning appointment and returned to the facility at 12:12 PM. R53's family member had to call the facility's Administrator to ask how long it takes for R53 to be changed. The facility's investigation by E2 (DON) revealed: - Surveillance video was reviewed. "It appeared that resident (name of R53) was placed into his room at 1212 (PM). [E67] who was his CNA did not go into resident's room until around 1225 (12:25 PM) when he was called to change [R53's]	F 677	by this deficient practice. C-Staff educator/designee will educate current staff and new orientees on process change in regards to the following: when resident is returned from an outside appointment that communication is given to the staff member who will be taking over care of this resident to ensure residents care needs are met according to residents care plan. Staff educator/designee will educate current staff and new orientees on answering all residents call bells in a timely fashion regardless of assignment and if a staff member responds to a call bell and is unable to address the resident's needs they will leave the call bell on and convey need to the appropriate person. RCA: Facility failed to ensure care and services for toileting was provided for R53 and R120. Systemic change includes the following: When resident is returned from an outside appointment that communication is given to the staff member who will be taking over care of this resident to ensure residents care needs are met according to residents care plan. If a staff member responds to a call bell and is unable to address the resident's needs they will leave the call bell on and convey need to the appropriate person.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 677	Continued From page 43 roommate who was sitting in the hallway. [E67] was observed after changing [R53's] roommate walking around unit with his ear buds on and had his phone in his hand. 1335 (1:35 PM) (name of E67] checked [R53's] roommate who was sitting in the hall... At 1409 (2:07 PM) [E67] was once again called to change [R53's] roommate after changing him he took him back into the hallway. [E67] had not rendered any care to [R53] during my observation on video from 1212 until he left the building sometime around 1500 (3 PM)... [R53's family member] had called the administrator stating how long it takes someone to change [R53]. It was around 1515 (3:15 PM) when I went on the unit to investigate and [E67] had already left for the day. [R53] was then changed for the first time since he returned from his appointment around 1212 (PM). Care Plan Changes: Resident will be toileted before and after meals. System Changes: (blank)." 4/30/24 at 2:50 PM - During an interview with the Surveyor, E66 (CNA) stated that she was the assigned CNA to escort R53 to his morning appointment. E66 stated that the 11 PM - 7 AM shift had R53 ready for his 8 AM pickup and they returned to the facility around 12 Noon. E66 stated that R53 told her that he was wet. E66 stated that she told the nurse at the nurse's station that R53 was back and handed the papers from the appointment. E66 stated that she told R53's assigned CNA, who was in the dining room, that R53 was back from his appointment. When asked if she told anyone that R53 was wet, E66 said no, she just assumed they know he needed to be changed because he was gone all morning and needed lunch. While the facility's investigation addressed the	F 677	Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov D- Don/designee will perform daily random observations of resident returning from an outside appointment to ensure communication is given to the staff member who will be taking over care of resident. Don/designee will perform daily random observations of call bells being answered in a timely fashion. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ____ B. WING ____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 677	Continued From page 44 lack of care provided by one CNA that resulted in termination, there was no evidence provided to the Surveyor that the facility initiated systemic changes with respect to nursing staff in response to this incident. b. On 4/8/24 evening shift, R53 triggered his call light twice and was not provided with timely toileting care per the following interviews. This was uncovered during a related facility investigation of another resident's complaint of lack of toileting care on the same hallway. 4/18/24 at 3:14 PM - During an interview between the Surveyor and R53, R53 was asked if he gets the care and service he needs without having to wait a long time, R53 replied that he needs incontinence care because he tends to pee a lot. R53 stated that a recent incident occurred right around change of shift where he triggered his call light and staff turned the call light off and did not return. R53 stated that he was incontinent and he laid in it. 4/30/24 at 10:59 AM - During an interview with the Surveyor, E59 (CNA) stated that she was assigned to R53 on 4/8/24 evening shift. E59 stated that R53 will ring his call bell when he needs to be changed. E59 stated that she had a medical condition and she sits when charting. E59 stated one nurse was on the computer at the nurse's station and the other computer was not working. E59 stated that she told her nurse [E32] that she was going over to the Eastburn Unit to do her charting. E59 stated that all her resident care was done and no call bells were on at the time. E59 stated that she came back on the unit after 11 PM when another CNA [E61], who was working a double shift (3 PM through 7 AM), told	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 677	Continued From page 45	F 677		

her that R53's call bell had been ringing a long time. E59 said that she asked E61 (CNA) 'why couldn't you take care of it?' E59 stated that E61 (CNA) cussed at her and stated that she was going to report her. E59 stated that it was after her shift and left. E59 said that she was suspended for a week and then terminated. When asked by the Surveyor if the facility was short staffed on this shift, E59 stated no.

4/30/24 at 11:43 AM - During an interview with the Surveyor, E61 (CNA) stated that she was assigned a 1:1 with another resident on the 3 PM - 11 PM shift on 4/8/24. E61 stated that she answered R53's call light when it was triggered. R53 stated he was wet and she turned off his call light and said she would find his CNA (E59). E61 stated that she asked E62 (Nurse) and another CNA where E59 was and determined that E59 was over at Eastburn Unit charting. E61 said that someone was sent over to let E59 know that R53 needs care. E61 stated that R53 triggered his call light again and E62 (Nurse) answered it. E59 stated that she believed the call bell was ringing from approximately 10:30 PM to 11 PM. E59 did not return back to the unit until after 11 PM. E61 stated that E59 did not provide care to R53. E61 stated that she provided care to R53 at 11:15 PM and stated that his bed was wet. When asked if the facility was short staffed on that shift, E61 stated no.

4/30/24 at 1:30 PM - During an interview, E2 (DON) provided the Surveyor with a copy of the facility's investigation for another resident's complaint in the same hallway where incontinence care was not provided by the same CNA (E59) at the end of evening shift on 4/8/24. E2 stated that R53 was interviewed as part of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 677	Continued From page 46 investigation and it was determined that R53 was not provided with incontinence care on 4/8/24 evening shift. The facility's investigation by E2 (DON) revealed: - the facility's five day follow-up to the 4/8/24 incident submitted to the State Survey Agency on 4/15/24 revealed the following: "... Result of Investigation: Summary... CNA [name of E59] was suspended and termination pending for the following: Excessive amount of time off the unit and tasks not completed... Were changes made to the Care Plan? No. Were system changes put into place? No." - the facility's Employee Performance Improvement/Action Notification form, on 4/16/24, documented that E59 was terminated for multiple violations that occurred on 4/8/24, including E59 "... was not on the nursing unit for an extended period... did not make final rounds at the end of her shift, returned to unit to get belongings and left." While the facility's investigation addressed the lack of care provided by one CNA that resulted in termination, there was no evidence provided to the Surveyor that the facility initiated systemic changes to ensure that nursing staff are responding to call lights timely and, if necessary, providing care to residents. 2. Cross refer to F725 R120's clinical record revealed: 12/1/22 - R120 was admitted to the facility with diagnosis of vascular dementia (a general term describing problems with reasoning, planning, judgment, memory and other thought processes	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 677	Continued From page 47 caused by brain damage from impaired blood flow to your brain). 12/1/22 - R120 was care planned for incontinence of bowel and bladder with the following interventions: - check resident every two hours and PRN (as needed); - incontinence care after each incontinent episode; - offer toileting before/after meals and at bed time (initiated 1/8/23, revised 8/2/23); - toilet at regular intervals if able; and - use absorbent products as needed. 11/10/23 - The annual MDS assessment documented R120 as cognitively impaired (BIMS=9); required partial/moderate assistance for toileting hygiene; independent for toilet transfer; and occasionally incontinent of bladder and frequently incontinent of bowel. 12/17/23 at 2:59 PM - Review of the CNA documentation survey report revealed that E36 (CNA) documented that R120 was independent with no setup help for toilet use. Review of the R120's progress notes lacked evidence of any nurse's notes documented on 12/17/23 day shift. 4/30/23 at 10:23 AM - During an interview with the Surveyor, E36 stated that she was the assigned CNA on 12/17/23 (Sunday) day shift. E36 stated that the unit was short staffed that day, only three CNAs when usually it was four. E36 stated that when this happens, the resident workload goes from eight residents to 10-12 residents. E36 explained that the CNAs try to get	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 677	Continued From page 48 up the residents that need to be out of bed for breakfast. E36 stated that she was familiar with R120 as he has dementia. E36 stated that her routine with care was to work her way up the hallway from the entrance to the back. E36 stated that R120's family member arrived that day approximately 9:15 AM - 9:30 AM and saw R120 was soaking wet. E36 stated that she didn't get to him yet. E36 stated that she provided care to two residents then the breakfast trays came so she stopped care and provided feeding assistance then resume care after breakfast. E36 stated that she was two residents away from R120 when R120's family member arrived. E36 stated that when she saw R120's family member, she got R120 showered, changed and the changed the bed linens. E36 stated that she wasn't avoiding R120, but that she didn't get to him yet. E36 stated that R120's family member expressed frustration, not personally at her, but that this had been occurring multiple times where he needs care. 4/30/24 at 8:51 AM - The Surveyor requested the 12/17/23 incident report with respect to R120's lack of incontinence care. In response, the facility provided a facility reported incident to the State Survey Agency where R120's multiple care issues were discussed during a care conference on 2/7/24 with R120's family member. The 12/17/23 date was documented in this report but it was regarding another issue, not about the incontinence care issue. The facility documented that they discussed with R120's family member to bring care issues immediately to the Supervisor's attention so the issue can be addressed. 5/1/24 at 1:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _______ B. WING _______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 677	Continued From page 49 (DON), E28 (CRM) and representative's with the Ombudsman's Office.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it has been determined that for one (R41) out of one resident reviewed for range of motion and mobility, the facility failed to provide appropriate services, equipment and assistance to maintain function and mobility or prevent further decrease in range of motion to R41's left wrist and hand. Findings include: Review of R41's clinical record revealed: 3/14/24 - R41 was readmitted to the facility with diagnoses including but not limited to stroke, left	F 688	A- -R41 orthotic device was applied to left wrist and hand. B- Residents residing at the facility who require orthotic devices have the potential to be affected by this deficient practice. C Staff Educator/designee will educate current staff and new orientees on ensuring that residents orthotic devices are applied as ordered and will document residents declination in residents health record.	6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 688	Continued From page 50 side weakness and contractures. 2/9/23 - A review of the facility contracture measurement comparison evaluation revealed R41 has severe contractures to the left wrist and left hand. 2/2/24 - A review of the facility contracture measurment comparison evaluation revealed R41 has severe contractures to the left wrist and left hand. 3/13/24 3:00 PM - A treatment order for R41 documented adaptive equipment left hand/wrist orthotic to be donned for five hours as tolerated, with skin checks performed every shift for hand therapy. 4/18/24 11:01 AM - R41 was observed in bed and did not have a left hand/wrist orthotic on. The Surveyor asked R41 if she had a splint to wear on the left hand/wrist, R41 said, "I have a drawer full." 4/19/24 12:57 PM - Another observation revealed R41 was not wearing a left hand/wrist orthotic. 4/23/24 11:36 AM - During an interview and observation (E17) LPN confirmed R41 is supposed to wear the left hand/wrist orthotic 5 hours a day as tolerated every shift. In addition E17 asked R41 if anyone offered to put the orthotic on, [R41] said, "No, not until you asked me." 4/23/24 12:12 PM - An interview with E18 (CNA) confirmed that R41's left hand/wrist orthotic was not on. Additonally E18 stated, "I would need to look at R41's care plan to know how long the	F 688	RCA: Facility failed to ensure R41 orthotic device was in place per order. Facility sweep of residents ordered orthotic devices has been completed to ensure all residents that require orthotic devices are in place and care planned. Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov D- Don/designee will perform daily audits of residents with orthotic devices to ensure they are applied per physicians orders. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations.¿ Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 688	Continued From page 51 orthotic should be worn." 4/30/24 1:12 PM - During an interview E34 (Rehab. D) confirmed R41 had left side weakness from a stroke and contractures to the left wrist and hand. In addition, E34 revealed, "the orthotic is to prevent worsening of contractures." 5/1/24 at 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E28 (CRM) and representatives from the Ombudsman's Office.	F 688		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and review of clinical records and other documentation as indicated, it was determined that for five (R12, R63, R165, R169 and R170) out of nine residents reviewed for accidents, the facility failed to ensure that the residents' environment were free from accident hazards and the residents received adequate supervision. - R170 eloped on 8/16/23 at approximately 6:40 AM and was found outside the facility. Due to the facility's corrective measures completed on 8/31/23, the facility was notified that R170's elopement was an Immediate Jeopardy (IJ) past non-compliance.	F 689	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 689	Continued From page 52 - R169 was able to retrieve a pair of sharp utility scissors from a treatment cart on 11/21/23 at 10:45 AM. Due to the facility's corrective measures completed on 11/28/23, the facility was notified that R169's incident was an Immediate Jeopardy past non-compliance. - R165 fell from an elevated bed while receiving incontinence care on 11/22/23 and sustained multiple right rib fractures and a back fracture. Due to the facility's corrective measures completed on 11/28/23, the facility was notified that R165's incident was a harm past non-compliance. - R12 was rolled into the windowsill during care with resultant facial hematoma on 12/25/23. Due to the facility's corrective measures completed on 1/1/24, the facility was notified that R12's incident was a harm past non-compliance. - R63 was served a hot tea beverage on 11/30/23 with breakfast at an inappropriate temperature as she sustained a first degree burn to her stomach and second degree burn to her upper right thigh. Additionally, the facility failed to ensure that E35 (LPN), the assigned nurse, followed the facility's policy and procedure when R63 had a change of condition (burns). Due to the facility's corrective measures completed on 12/5/23, the facility was notified that R63's incident was a harm past non-compliance. Findings include: 1. Review of R170's record revealed: The facility's Wandering and Elopements Policy, revised April 2024, Policy Interpretation and Implementation... "A wandering/elopement assessment is completed as well as an obtained wandering/elopement hx (history) if able."	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 689	Continued From page 53	F 689		

Review of R170's clinical record revealed the presence of the following progress notes and physician's orders from the previous facility that R170 was in prior to his 8/9/23 facility admission. The documents indicated that R170 had been a resident of the previous facility from 8/2/23 - 8/9/23. The notes and orders were scanned into the facility's Emr (electronic medical record) on 8/9/23 by E6 (AD):

- A Physician Order Summary Report that included an 8/2/23 order for R170 to have a Wanderguard; to check placement and function every shift.
- An 8/2/23 Elopement Risk assessment that scored R170 at 2, at risk for elopement, related to his history of elopement at home, wandering in the facility and his verbal desire to return to his home.
- An 8/2/23 nursing progress note which revealed that R170's elopement risk was a 2, and that R170 had a Wanderguard placed on his right ankle.
- An 8/3/23 physician progress note that documented that R170 was under elopement precautions.

8/9/23 2:00 PM - R170 was admitted to the facility with diagnoses including dementia, mood disturbance and anxiety. The facility's new resident admission process included an assessment for a facility elopement risk and R170 was assessed as zero risk of elopement. A 3:09 PM progress note was written by E33 (LPN) revealed that R170 was admitted to the facility after being at another nursing home in the same city.

8/16/23 9:20 AM - A progress note was written by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 689	Continued From page 54 E24 (RN) that "R170 eloped to parking lot... on 8/16/23 at 6:50 AM secondary to wandering related to advanced dementia." 4/25/23 9:30 AM - During an interview, E2 (DON) stated that R170 was able to elope from the facility through a locked window in the dining room, and that the resident apparently pushed the window until he broke the window locks, raised the window, removed the screen and then climbed out the window. R170 landed on a grassy area and walked to a cement path area which was on the side of the parking lot, which was next to a vehicular traffic road. A staff member who was arriving to work saw the resident on the pathway. 4/25/23 10:45 AM - During an interview, E16 (CNA) stated that on 8/16/23 when she was arriving to work at approximately 6:45 AM that she saw R170 walking on the walking pathway at the side of the facility. E16 stated that she did not know the resident so she wasn't sure if he was a facility resident and that she came in the building and asked E25 (RN) for assistance to verify the identity of R170. E16 stated that R170 was frustrated at the time and he wanted to go home. 4/30/24 10:30 AM - During an interview, E2 (DON) confirmed the presence of the previous facility's documents related to R170 previous facility stay and which had been scanned into the facility Emr on 8/9/23 by E6 (AD). E2 confirmed that R170 had a physician order for a Wanderguard, elopement precautions and the progress notes that described R170's elopement precautions, and all of which had previously been scanned into the facility's Emr. E2 stated that she was unaware of the elopement precautions that	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 689	Continued From page 55	F 689		

previous facility had R170 under.

4/30/23 1:42 PM - E1 (NHA) submitted to the Surveyor documentation of the corrective action plan with correction completed 8/31/23 at 7:00 AM.

Immediate actions taken:

- R170 was immediately moved to the facility's secured dementia unit, with one-to-one supervision and with a Wanderguard in place.
- Facility wide Elopement Assessments accuracy was verified by E29 (ADON) 8/16/23.
- Elopement Drills were conducted on 8/16/23, 8/17/23 and 8/30/23.
- QAPI ad hoc meeting to review the elopement was held on 8/18/23.
- Maintenance conducted a sweep of all windows to ensure the window locks were in place.
- All staff elopement education began on 8/16/23 and was completed 8/31/23.
- All resident name bracelets were audited to ensure that the bracelets were on the residents.
- The elopement book that contained the residents identified as an elopement risk was reviewed and updated.

Ongoing Actions:

- QAPI review of the elopement incident at the September and October 2023 meetings.
- All new admissions will have notes reviewed and elopement assessments checked by the ADON/designee.
- Elopement book was audited weekly and then monthly for three months after the 8/16/23 elopement. Ongoing, E2 will review and update the elopement book with changes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 689	Continued From page 56	F 689		

4/30/24 1:42 PM - Received from E1 the corrective action plan that was fully corrected, signed, dated and timed for 8/31/23 at 7:00 AM.

5/1/24 8:00 AM - An Immediate Jeopardy past non-compliance was called and reviewed with the facility leadership, including E1 (NHA), E2 (DON) and E28 (CRM).

No immediate action required related to facility correction and no further occurrences after the incident on 8/16/23. This was verified by interviews with staff about elopement education, spot inspection for window locks and inspection of the elopement book.

2. Review of R169's clinical record revealed:

The facility's policy on Security of Medication/Treatment Cart (revised June 2023) documented, "The medication/treatment cart shall be secured during medication/treatment passes... 1. The nurse must secure the... cart during the medication/treatment pass to prevent unauthorized entry... 3... The cart must be locked before the nurse enters the resident's room. 4... carts must be securely locked at all times when out of the nurse's view. 5. When the... cart is not being used, it must be locked."

11/2/23 - R169 was admitted to the facility with a wound on the right lower extremity.

11/3/23 - A care plan was initiated for R169's agitation with verbal abuse exhibiting behaviors of cursing and use of derogatory language towards staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 689	Continued From page 57 11/6/23 - R169 was also care planned for alteration in thought process related to episodes of confusion and anxiety. 11/6/23 9:28 PM - A nurse's progress note documented, "Resident [R169] making suicidal statements to son. Resident stated that he wants to find a gun and 'end it all' ... Son does not want resident sent to hospital. On call provider notified - provider made aware of son's wish to not send him. Provider ordered q (every) 15 (sic) checks until tomorrow, stat (immediately) psych consultation....Q (every) 15 minute checks initiated." 11/7/23 - R169's admission MDS assessment revealed an intact cognition, having fluctuating behaviors of difficulty focusing attention and easily distractible with verbal behavioral symptoms directed towards others. R169 required supervision or hand touch assistance with mobility. 11/8/23 - R169 was hospitalized on 11/7/24 and was readmitted to the facility with new diagnoses including, but not limited to, depression and anxiety disorder. 11/16/23 - R169's physician's order for lorazepam (for anxiety) 0.5 mg (milligram), 1 tablet by mouth every 12 hours as needed for 14 days was changed to every 8 hours as needed for 14 days. 11/21/23 10:45 AM - A facility incident submitted to the State Incident Reporting Center documented that, "Resident while in his wheelchair approached wound cart took out a pair of scissors and told staff he was going to hurt himself. He then began to cut at the bandage on	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 689	Continued From page 58	F 689		

his lower leg. When staff approached him to take away scissors he began to swing them around stating to staff he would harm himself. Scissors were successfully removed from his person. Wound team had used the cart during wound rounds. Resident sent to (hospital) for evaluation and behavior."

11/21/23 11:05 AM - A nurse's progress note revealed, "Resident became combative with staff physically and verbally... Resident then went into the wound care cart, grabbed scissors and attempted to harm himself. Resident then smacked a nurse on her leg twice and attempted to bite unit clerk. NP (Nurse Practitioner) made aware... pick up resident to take (hospital)."

11/21/23 - A written statement by E8 (Wound Nurse/UM) documented, "During wound rounds on 11/21/23, I went to treatment cart to obtain scissors, and found none. I obtained a pair of bandage shears from the lower cart nurse (sic) and proceeded to complete dressing changes for residents seen on wound rounds. After rounds completed I returned supplies to treatment cart and thought I locked cart, I did not...".

11/21/23 - A written statement by E9 (LPN) documented, "I was sitting at the nursing station starting to chart. I heard the treatment cart doors opening and closing. I got up and stated, '[R169] please stop opening those.' As I got closer to him I noticed [R169] had a pair of scissors from the treatment cart he had started cutting his leg bandage off. I immediately intervened and I tried to get the scissors from him. When I tried the first time he threw his hands back and almost hit me in the head with the sharp end of the scissors. I lightly held his wrists with my palms so he couldn't

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 689	Continued From page 59	F 689		

hurt me or himself. I yelled for E10 (Unit Clerk) to come help me and take the scissors away from him. As E10 came over (sic) [R169] stated 'he wanted to die'. Once [R169] was safe and away from the scissors and the treatment cart, I had him sit next to me at the nurses station. [R169] proceeded to be disruptive and violent. He started to hit me in the legs and tried to grab my computer. We removed him for my safety and place (sic) him where he couldn't hurt me or anyone else or himself."

11/21/23 - A written statement by E10 (Unit Clerk) documented, "I was sitting at my desk when me and the nurse heard the resident [R169] slamming the drawers open & (and) close on the wound cart, the nurse got up and went over and he had scissors in his hand. She went to grab them because he was cutting his wound bandage and said he was going to hurt himself (sic) as she went to grab he would not let her and was swinging the scissors. I came over to help her and I was able to get the scissors. Afterwards he was very rude to the staff he wouldn't stay calm he tried to hit the nurse multiple times as she had him sit with her, he said, 'Ima (sic) get serious now' and then grabbed at her computer trying to knock it down (sic) he was calm for just a minute then rolled over by the wound cart again and the key attached to the oxygen tank near the wound cart he grabbed and had it around his hand pulling... I tried to get it from me (sic) and on multiple occasions he tried to bite me saying 'I'm going to bite you stop!' I called over the unit manager for help...".

4/25/24 1:00 PM - In an interview, E10 confirmed that she removed the scissors away from R169, who was very agitated at that time. E10 further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 689	Continued From page 60	F 689		

stated, "He tried to bite me as I took the scissor away. I don't know what type of scissors it was but the ends were sharp... He was sent out to the hospital after that incident and he did not return anymore."

4/26/24 11:30 AM - A spot check of the five treatment carts, four oxygen carts and nine medication carts across the five units revealed all carts were locked.

4/26/24 3:20 PM through 3:34 PM - An interview with the following nursing staff E11, E12, E13, E8, E14 and E15 revealed that staff were educated to keep all of the medication and treatment carts locked at all times when not in use and in view.

4/26/24 3:36 PM - In a separate interview, E8 (RN/Wound Nurse) clarified that she used a regular utility scissor and not a bandage scissor. E8 stated, "There was no bandage scissor on the treatment cart. I used a regular scissor and that was the same scissor that [R169) took out from the drawer."

4/29/23 10:54 AM - E1 (NHA) submitted to the Surveyor an acceptable documentation of a signed and dated corrective action plan that was fully corrected on 11/28/23. The facility's corrective actions at the time of the incident included:
- Investigation found that the treatment cart was left unlocked and resident was able to open it and obtain a pair of non-safety scissors.
- Scissors were removed and the resident was unharmed. The resident was sent out for psychosocial evaluation.
- Staff education immediately initiated on 11/21/23 along with auditing of treatment carts being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING ______	(X3) DATE SURVEY COMPLETED C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 689	Continued From page 61 locked. Safety scissors were placed in all treatment carts. - Completed education as of 11/28/23. - Audits documented compliance as of 11/28/23. - Facility was in substantial compliance as of 11/28/23. - The facility continued to audit and maintained compliance. 4/29/24 2:54 PM - An IJ was called and reviewed with the facility leadership, including E1 (NHA), E2 (DON) and E28 (CRM). During this conference, both E1 and E2 confirmed that there had been no other incidents of residents opening unlocked medication and treatment carts after the 11/21/23 incident. No immediate action required related to no further occurrences after the incident on 11/21/23 and past non-compliance. This was verified by spot inspection of medication/treatment carts, review of facility documents and interview with facility staff and residents. 3. Review of R165's clinical record revealed: 11/17/16 - R165 was admitted to the facility with diagnoses including, but not limited to, dementia and heart failure. 1/5/23 - R165's medical record documented E52's (MD) order: "Transfer Status: assist of 2, Bed Mobility: assist of 1, Ambulation 1 person assist with RW (rolling walker) with wheelchair following." 11/22/23 4:30 AM- R165 fell from an elevated bed while receiving incontinence care by E53 (former CNA).	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ____ B. WING ____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 689	Continued From page 62	F 689		

11/22/23 7:07 AM - E54 (Emergency Department MD) documented in the ED (Emergency Department) Physician Record, "... History of Present Illness... patient's bed was elevated and they [staff] were changing her when she was rolled and unfortunately fell out of the bed... Secondary Survey- Head: hematoma to the right parietal region... CT (computed tomography) scan chest/abdomen/pelvis shows evidence of acute displaced rib fractures on the right side including ribs 4,6,7 and 9. Also has progressive loss of height of L3 (lumbar vertebrae 3) when compared to prior imaging... Trauma evaluated the patient and will admit to their service...".

11/25/23 12:53 PM - R165 was discharged back to the facility after a three day admission following her fall with resultant right rib fractures.

4/26/24 7:36 AM - During an interview, E25 (RN) stated, "I was called and told R165 had fallen. I went to her room and found her sitting on her butt with her legs in a V shape kind of in the air... I thought she [R165] hurt her right hip because she complained of pain when I palpated her right hip area but she ended up having right rib fractures...".

4/26/24 11:07 AM - During a telephone interview, E53 (former CNA) stated, "I was changing her [R165] and she had poop all over. I was turning her away from me towards the door... there was no scoop mattress or side rail. There was another CNA on the floor but she was a one person assist for bed mobility. She rolled out of the bed and onto the floor. I went and got the nurse. They sent her to the hospital."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 689	Continued From page 63	F 689		

4/30/24 1:25 PM - During an interview, E1 (NHA) stated that the facility immediately started to educate the staff on the proper method of turning and repositioning residents that morning of the incident. She said that she would provide the documentation of the facility's efforts to correct this situation.

4/30/24 - Review of all documentation of the corrective action plan completed on 11/28/23 included:
- Timely reporting to State Agency;
- Education regarding bed mobility for all nursing staff providing direct care to residents;
- Initiated competencies on turning and repositioning residents;
- Initiated a perimeter mattress on R165's bed upon her return from the hospital;
- Facility investigation of the incident; and
- Observations of bed mobility care with audits that documented compliance.

This was verified by the Surveyor with observations of resident repositioning as well as multiple staff interviews about the content of the turning and repositioning inservice/education.

4. Review of R12's clinical record revealed:

Eliquis (Apixiban) is an anticoagulant medication used to prevent serious blood clots from forming due to a certain irregular heartbeat (Atrial fibrillation). Source: Drugs.com 2024

1/24/14 - R12 was admitted to the facility with diagnoses including, but not limited to, dementia and atrial fibrillation.

10/26/22 - E55 (NP) ordered, "Eliquis tablet 2.5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 689	Continued From page 64 mg (milligram) - give one tablet by mouth two times a day for A fib (Atrial fibrillation)." 7/19/23 - R12's medical record documented E52 (MD) ordering: "Updated Transfer Status: transfer and bed mobility- assist of 1, Ambulation with PT (Physical therapy) only." 11/17/23 - R12's quarterly Minimum Data Set (MDS) assessment documented her Brief Inventory of Mental Status (BIMS) score of three, which reflected severe cognitive impairment. 12/25/23 2:45 PM - A progress note documented that while receiving care by E56 (CNA), R12 was rolled to her side and her head struck the windowsill. 12/25/23 4:06 PM - E57 (DO) documented in the ED (Emergency Department) Physician Record, "... patient was at her skilled nursing facility, nursing staff was rolling her in bed. Her bed is up against a wall/window, and they accidentally rolled her against the windowsill when she hit her head. She developed a large hematoma over her left forehead...". 12/25/23 8:32 PM - R12 discharged from the ED back to the facility. 4/30/24 12:07 PM - During an interview, E14 (LPN) stated that R12 no longer was able to interact with the staff in a meaningful way. "She just grunts and makes noises." 4/30/24 1:25 PM - During an interview, E1 (NHA) stated that the facility recognized immediately that this incident involved staff rolling a resident in an inappropriate manner and began to re-educate	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 689	Continued From page 65	F 689		

the staff.

4/30/23 - Review of all documentation of the corrective action plan completed on 1/1/24 included:
- Timely reporting to State Agency;
- Additional education regarding bed mobility for all nursing staff providing direct care to residents;
- Facility investigation of the incident; and
- Observations of bed mobility care with audits that documented compliance.

This was verified by the Surveyor with observations of resident repositioning as well as multiple staff interviews about the content of the turning and repositioning inservice/education. The Surveyor also reviewed the competency sheets for the bedside staff, which involved observations by management.

5. Review of R63's clinical record revealed:

3/23/23 - R63 was admitted to the facility with hemiplegia and hemiparesis following a stroke affecting the right dominant side.

9/20/23 - R63's quarterly MDS assessment documented that she was cognitively intact and required supervision and setup help only for eating.

12/1/23 - A physician's note documented that R63 was seen and evaluated for "...spilled tea to right thigh and lower abdomen... Right thigh with intact blister, + (positive) erythema (redness), mild swelling, no tenderness or drainage. Right lower abdomen with mild erythema, no blisters, swelling or open wound... Burn of abdominal wall, first degree... Burn of thigh, second degree... Monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 689	Continued From page 66	F 689		

for signs of pain or discomfort, or infection. Apply Silvadene cream... Tylenol... for pain... Peripheral neuropathy. Discussed with patient concerns with drinking hot beverages and she is unable to feel when she dropped hot liquids. Reiterated with patient the need to have a two handle cup for all hot beverages and this includes any beverages that family or friends may bring in from the outside...".

12/1/23 - The facility's investigation documented the following timeline:

- at 10 AM, E2 (DON) was notified by NP of R63's burn/blisters from a hot water spill. NP and Wound Nurse assessed resident and treatment ordered.

- at 10:30 AM, R63 stated during an interview that "on 11/30/23 she spilled the hot water from her breakfast tray onto herself. She stated that when she picked up the cup that her hand gave out and it spilled. Resident admitted that she did not tell any staff members of the incident. During care on 12/1/23 at approximately 6am resident said that the C.N.A. [E37] discovered the blisters to her right thigh while she was getting her up."

Additional interviews on 12/1/23 revealed:
- "Nurse [E38] from 12/2/23 7-3 shift was interviewed and stated that the burn/blister area on the resident was passed along to her during shift to shift report to have the NP assess the resident. Stated that the 11-7 nurse had contacted the family regarding the findings."

- "Nurse [E35] from 11/30/23 11-7 shift was called and multiple messages left to return urgently. Supervisor for 11-7 shift was not made aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 689	Continued From page 67 the resident having a blister on her right upper thigh area. Update: nurse returned DON call later that day 12/1/23. Nurse stated after aide notified her of changes to residents skin she assessed and notified MD/NP and emergency contact. Emergency contact told the nurse that her mother spilled a hot beverage and the skin changes may be a result of her mother spilling the hot beverage on herself. She then reported to the oncoming nurse of skin changes and MD/NP will follow up." (It should be noted that E35 did not call the on-call provider at the time, but documented R63's burn/blisters in the MD/NP book to follow up.) - at 11 AM, interviews of multiple nursing staff assigned to provide care for R63 on 11/30/23 day and evening shifts revealed that R63 did not tell anyone that she spilled her tea nor did anyone see any skin issues during care. - "On 12/1/23, Therapy was notified of the need for 2 handled lidded cups for hot beverages with meals. Cups ordered with meals and supplied to the kitchen for use. Therapy will evaluate for hand strengthening." - "On 12/1/23 at approximately 12 pm, the kitchen manager was notified of incident with resident burn/blisters. Water coming from the coffee machine was tempted and showed to be 170 degrees. Maintenance director contacted manufacturer of coffee machine and was able to lower the temperature. Dietary staff was instructed that the temperature of coffee or hot water has to be served at 150 degrees or lower. Dietary manager immediately initiated new process of temping hot beverages at start of meal service and taking temp of hot beverage of each	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 689	Continued From page 68 cart prior to service to ensure temps at 150 degrees or below. Education for dietary staff was initiated on 12/1/23 on new process for taking temperatures of hot beverages prior to service." - "On 12/1/23, staff educator initiated education with nursing staff on the importance of notifying the Supervisor of burn/blister for proper resident assessment and investigation." - On 12/1/23 at 1:30 PM, facility reported R63's incident to the State Agency. - The facility identified and noted during the investigation that the "Nurse [E35] who first assessed R63 was given a write up and education was conducted on proper process to follow when there is an observed change in a resident's condition. Plan to review the nurse's documentation to ensure proper documentation and following the facility's policy and procedure." 12/5/23 - E2 (DON) completed an Employee Performance Improvement/Action Notification for E35 (LPN) for Violation of Policy #501-1 "Failure to report incident or change in resident condition to Supervisor. Failure to provide notification of a residents change in condition to the N.P. and or On Call Service. Failure to document note in chart and obtain treatment orders. Failure to initiate incident report." The corrective actions were: "[Name of E35] will receive training on the proper procedure for reporting and documentation change in resident condition and notification of supervisor and or Nurse Practitioner... will be audited by supervisor to review documentation in order to insure following proper procedure for documenting."	F 689		

(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 689	Continued From page 69 12/5/24 at 4 PM - E8 (RN/UM) documented that she educated E35 (LPN) of the proper documentation/notification of a resident's change in condition, which was signed and dated by both nurses. Based on the immediate actions taken after R63's incident, reviewed by the Surveyor and confirmation of no further incidents, the facility returned to substantial compliance as of 12/5/23 at 4 PM. 5/1/24 1:30 PM - All findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E28 (CRM) and representative's of the Ombudsman's Office.	F 689		
F 712 SS=E	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in	F 712		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 712	Continued From page 70 accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R12, R165, R174) out of five reviewed for Accidents, the facility failed to ensure that the physician conducted the required visits. Findings include: 1. Review of R12's clinical record revealed: 1/24/14 - R12 was admitted to the facility, with diagnoses including but not limited to, dementia and atrial fibrillation. 6/20/23 - R12 was examined by E52 (MD). 1/20/24 - R12 was examined by E52 (MD). R12 went 213 days between physician visits instead of the 120 days as required.. 2. Review of R174's clinical record revealed: 9/4/23 - R174 was admitted to the facility. 9/6/23 - R174 was examined by E52 (MD). 12/7/23 - R174 was examined by E52 (MD). R174 went 92 days between physician visits. During the first 90 days of an admission to a skilled nursing facility, by regulation a patient should be examined every 30 days. 3. Review of R176's clinical record revealed: 11/27/23 - R176 was admitted to the facility.	F 712	A-Facility failed to ensure R12, R165, and R174 were seen by a physician during the required timeframes. Deficient practice was unable to be corrected due to having past the time of occurrence. B-Residents residing at this facility have the potential to be affected by this deficient practice. C-Nursing Home Administrator/Medical Director will educate practitioners on frequency of physician visits. A resident must be seen by a physician at least once every 30 days for first 90 days after admission and at least once every 60 days thereafter. RCA: Facility failed to ensure that residents R12, R165, and R174 were seen by a physician during the required timeframes. Nursing Home administrator and Medical director are currently collaborating on a monitoring system to ensure that physician visits are not missed. Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov D- Administrator/designee will perform daily audits of frequency of physician visit for residents residing at the facility to ensure residents are seen by a physician	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 712	Continued From page 71 11/28/23 - R176 was examined by E52 (MD). R176 was not seen by a physician during December 2023. During the first 90 days of an admission to a skilled nursing facility, by regulation a patient should be examined every 30 days. 1/12/24- R176 was discharged from the facility. 5/1/24 at 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E28 (CRM) and representatives from the Ombudsman's Office.	F 712	in accordance to the required time frame. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of	F 725		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 725	Continued From page 72 this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R120) out of six residents reviewed for ADLs, the facility failed to ensure there was sufficient staff on 12/17/23 day shift to provide toileting care in accordance with the resident's care plan. Findings include: Cross refer to F677, example 2 R120's clinical record revealed: 12/1/22 - R120 was care planned for incontinence of bowel and bladder with the following interventions: - check resident every two hours and PRN; - incontinence care after each incontinent episode; - offer toileting before/after meals and at bed time (initiated 1/8/23, revised 8/2/23); - toilet at regular intervals if able; and - use absorbent products as needed. 4/30/23 at 10:23 AM - During an interview with the Surveyor, E36 stated that she was the assigned CNA on 12/17/23 (Sunday) day shift. E36 stated that the Unit was short staffed that day, only three CNAs when usually it was four. E36 stated that when this happens, the resident workload goes from eight residents to 10-12	F 725	A- Facility failed to ensure there was sufficient staff on 12/17/23 day shift on the Christina Unit to provide toileting care for R120 in accordance with the residents care plan. Deficient practice was unable to be corrected due to having past the time of occurrence. B- Residents needing assistance with toileting have the potential to be affected by this deficient practice. C-Staff educator/designee will educate current nursing staff and new orientees on prioritizing care needs at start of shift prior to care by viewing residents Kardex to ensure that residents care needs are met. Staff educator/designee will also educate on coordinating employee breaks to ensure that there is adequate staffing coverage on the unit to provide resident care as needed. RCA: E36 failed to prioritize residents care needs at the start of shift. After further investigation and interviews with staff it was determined that on 12/17/23 day shift that there were four C.N.A□s assigned and working on the unit that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 725	Continued From page 73 residents. E36 explained that the CNAs try to get up the residents that need to be out of bed for breakfast. E36 stated that she was familiar with R120 as he has dementia. E36 stated that her routine with care was to work her way up the hallway from the entrance to the back. E36 stated that R120's family member arrived that day approximately 9:15 AM - 9:30 AM and saw R120 was soaking wet. E36 stated that she didn't get to him yet. E36 stated that she provided care to two residents then the breakfast trays came so she stopped care and provided feeding assistance then resume care after breakfast. E36 stated that she was two residents away from R120 when R120's family member arrived. E36 stated that when she saw R120's family member, she got R120 showered, changed and the changed the bed linens. E36 stated that she wasn't avoiding R120, but that she didn't get to him yet. E36 stated that R120's family member expressed frustration, not personally at her, but that this had been occurring multiple times where he needs care. 5/1/24 at 1:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E28 (CRM) and representative's with the Ombudsman's Office.	F 725	R120 resides, reviewed employee time cards, unit assignment sheet and the daily schedule. Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov D- Don/designee will perform daily audits of residents incontinence care to ensure care needs have been met according to residents care plan and/or residents satisfaction. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 812 SS=E	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	F 812		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ____ B. WING ____	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 812	Continued From page 74 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 and interview, it was determined that for four out of five unit's nourishment areas the facility failed to ensure unit refrigerator food items were dated and labeled. Findings include: The facility policy on "Food brought by family/visitors" last updated March 2024 indicated, "Food bought in by family/visitors that is left with the resident to consume later is labeled, resident name and date." The following observations were made during unit refrigerator tours: - 4/24/24 11:08 AM - The Christina unit refrigerator contained one undated, unlabeled garden salad. Finding immediately confirmed by E10 unit clerk. - 4/24/24 11:10 AM - The Eastburn unit freezer/refrigerator contained an undated and unlabeled bag of frozen food, a tea bag, and a bowl of cold cereal. E46 (RN) immediately confirmed the finding. - 4/26/24 1:54 PM - The Bancroft unit refrigerator contained an unlabled and undated pint of fresh	F 812	A-Facility failed to ensure unit refrigerator food items were dated and labeled properly. Facility sweep of unit refrigerators was conducted and food items not labeled and dated were discarded. B-Residents residing at the facility have the potential to be affected by this deficient practice. C-Staff Educator/designee will educate current staff and new orientees on ensuring unit refrigerator food items are properly labeled and dated. Items that are out of date will be discarded. RCA: Facility staff failed to ensure resident food was properly labeled and dated in unit refrigerators to ensure food items that were old were discarded. Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 812	Continued From page 75 strawberries and a Tupperware inside a Ziploc bag. E45 (RN) immediately confirmed the finding. - 4/26/24 1:58 PM - The Hammond unit refrigerator contained three undated, unlabeled frozen beverages. E19 (RN) immediately confirmed the finding. 5/1/24 at 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E28 (CRM) and representatives from the Ombudsman's Office.	F 812	D- Don/designee will perform daily audits of unit refrigerator units to ensure food items are dated and labeled properly. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete;	F 842		6/11/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 842	Continued From page 76 (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments;	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 842	Continued From page 77 (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined for one (R134) out of four residents reviewed for communication sensory and for one (R51) out of one residents reviewed for smoking the facility failed to ensure resident records were complete and accurate. Findings include: 1. 11/18/22- R134 had cataract surgery. 1/27/24 - An order for protective eye shield as resident allows every shift for cataract surgery was discontinued. 3/12/24-3/15/24 - R134 was hospitalized and returned then readmitted to the facility. 3/16/24 - The order was resumed for R134 to receive a protective eye shield as resident allows every shift for cataract surgery. R143 was not scheduled to receive another cataract surgery. March 2024 - Review of TAR for R134 revealed the protective eye shield was documented as given to the resident. April 2024 - Review of TAR for R134 revealed the protective eye shield was documented as given to the resident.	F 842	A-For R134 and R51 facility failed to ensure resident records were complete and accurate. For R134 the protective eye shield order was discontinued 4/25/24. For R51 the smoking evaluation was updated on 5/2/24. B- Residents residing at the facility who are being readmitted back from the hospital have the potential to be affected by this deficient practice. Residents residing at the facility who smoke have the potential to be affected by this deficient practice. C-Staff Educator/designee will educate current Nurse management on reviewing readmission orders for any changes in medication and/or treatments. Staff educator/designee will educate licensed staff on how to perform an accurate smoking evaluation. RCA: The facility failed to review readmission orders for any changes in medication and/or treatments to ensure R134 eye shield was discontinued and R51 had an accurate smoking evaluation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE HOCKESSIN, DE 19707**

(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 842	Continued From page 78	F 842		

During an interview on 4/25/24 at 11:12 AM, E17 (RN) confirmed the error and stated, "The order was discontinued in January. The day of readmission they must have accidentally added it back." E17 then confirmed that staff had been signing the order for protective eye covering as completed and stated, "it shouldn't have been signed".

During an interview on 4/25/24 at 12:43 PM, E43 (LPN) stated, "There's an order for a protective eye covering but he doesn't like it. He doesn't wear it so we still sign it off." E43 was unable to show the R134's eye patch or describe it. E43 then confirmed she had never seen it.

During an interview on 4/26/24 at 12:43 PM, R134 confirmed the date of cataract surgery as, and that protective eye covering was no longer needed and not worn by the resident "in months".

2. Review of R51's clinical record revealed:

7/20/23 - R51 was admitted to the facility with diagnoses including, but not limited to diabetes, hypertension and chronic obstructive pulmonary disease.

1/15/24 - Review of the facility smoking screen evaluation for R51 documented "no, that the resident does not smoke."

2/8/24 - Review of R51's care plan for smoking documented... "1. Resident is at risk for injury related to smoking... 2. Resident will require supervision while outside smoking... 3. Resident will smoke at designated smoking times and locations."

For R134 the protective eye shield order was discontinued 4/25/24. For R51 the smoking evaluation was updated on 5/2/24.

Additional information and attachments sent to DHSS_DHCQ_POC@delaware.gov

D- Don/designee will perform daily audits to ensure residents who are readmitted that their readmitted orders are accurate and reflected accurately on MAR/TAR . DON/designee will perform daily audits to ensure all residents who want to smoke have an accurate smoking evaluation. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING ______ B. WING ______	C 05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 842	Continued From page 79 4/9/24 - Review of the facility smoking evaluation for R51 documented, "no, that the resident does not smoke." 4/18/24 2:19 PM - R51 was observed smoking outside. 4/23/24 11:15 AM - During an interview E17 (LPN) confirmed R51's smoking screen evaluation for 1/15/24 and 4/9/24 documented R51 does not smoke. E17 stated, "[R51] is definetly a smoker." 5/1/24 10:50 AM - Findings were confirmed with E1 (NHA) and E2 (DON). 5/1/24 at 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E28 (CRM) and representatives from the Ombudsman's Office.	F 842		