STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD WILMINGTON, DE 19803

(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 849	Continued From page 94	F 849		

9/25/24 at 11:00 AM - An observation of C1 (Hospice RN) at R26's bedside with R26's family member and C7 (Chaplain). Immediately following, the Surveyor interviewed C1 and asked if hospice would prohibit debridement of a wound. C1 replied no, being on hospice does not prevent debridement. The Surveyor asked C1 to observe R26's hospice binder in the nurse's station. C1 confirmed that there was no contact information for hospice on the front cover nor inside. After reviewing the hospice binder contents, C1 confirmed that there was no current recertification, no current care plan and no current list of medications. When asked if the hospice nurse assessed R26's sacral pressure ulcer, C1 could not answer, and she requested the nurse's notes to be sent over to the facility. C1 stated that the hospice contact was the Social Worker and documentation should be being sent to her so she can place it in the hospice binder.

In response to the Surveyor's request with the facility management, the Hospice Provider provided the Hospice documentation for R26, which included:

9/25/24 Hospice IDG Comprehensive Assessment and Plan of Care Update Report - " ... Current Meeting Summary...
Hospice Physician [documented]... plan of care reviewed... I attest that I have reviewed the medication profile...
[C2, RN documented]... Describe what has occurred during the last two weeks... Is there any improvement or worsening in wound(s) condition, or any new wounds? (checked) No wounds present...
[included in the Meeting Summary was] Medication List... Tylenol... Amlodipine... Aspirin...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	**700 FOULK ROAD WILMINGTON, DE 19803**

(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 849	Continued From page 95 Colace... Ensure... Furosemide... Icy Hot Patch... Iron... Miralax... Morphine... Senna...". Review of R26's current medications on her September 2024 eMAR in the facility were: Tylenol for pain, Active Liquid Protein for wound healing, Morphine as needed for pain, Milk of Magnesia, Bisacodyl suppository and an enema as needed for constipation. R26 was no longer on Amlodipine, Aspirin, Colace, Furosemide, Icy Hot Patch, Iron, Miralax or Senna. The 9/25/24 IDG Report inaccurately documented R26 on seven medications that she was no longer taking. 9/30/24 at approximately 3:30 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON). No further information was provided to the Surveyor. 10/2/24 at 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 849		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		11/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD WILMINGTON, DE 19803

(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 880	Continued From page 96	F 880		

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	**700 FOULK ROAD WILMINGTON, DE 19803**

(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 880	Continued From page 97 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined that for four (R533, R105, R12 and R26) out of four residents reviewed for infection control, the facility failed to establish and maintain an infection control program using enhanced barrier precautions. R12, R105 and R533 had indwelling feeding tubes which met the criteria for Enhanced Barrier Precautions (EBP). Findings include: As per CDC (Centers for Disease Control and Prevention) definition (6/28/24), Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices).	F 880	F880: Infection Prevention and Control F880 1. Upon discovery, enhanced barrier precautions were put in place immediately on identified residents. R533 and R105 no longer reside in the facility. 2. Residents who meet the guidelines related to EBP use to prevent spread of infection. The Director of Nursing/designee will audit all residents with chronic wounds and/or indwelling medical devices to ensure EBP are in place and staff is compliant with use of PPEs. 3. Staff Development Coordinator immediately educated staff on criteria for EBP, guidelines for implementing EBP, and use of PPEs. Criteria for implementing EBP will be presented during orientation for all nursing personnel. SDC will use the table provided by CDC: Implementing Contact	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ____ B. WING ____	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD WILMINGTON, DE 19803

(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 880

Continued From page 98

1. Review of 533 clinical record revealed:

9/10/24 - R533 was admitted to the facility after being hospitalized; R533 had a PEG tube inserted into his stomach for nutrition because he could not safely swallow food or liquids.

9/24/24 10:33AAM - During a wound care dressing change observation, E8 (LPN) did not wear a gown.

2. Review of R12's clinical record revealed:

2/7/24 - R12 was admitted to the facility with diagnoses including a stroke, and difficulty swallowing food and liquids.

R12's physician's orders included "enteral feed: two times a day via PEG tube (flexible tube going to the stomach for feeding)."

9/19/24 10:18 AM - During an observation, it was observed that R12's room lacked PPE (Personal Protective Equipment) for staff to use when providing care.

9/20/24 11:15 AM - During an observation, the continued lack of PPE for R12's room was observed.

9/24/24 1:34 PM - During an observation, the lack of EBP PPE was continued to be observed.

9/24/24 2:00 PM - During an interview with E18 (CNA), confirmed, "we have not had to use PPE while working with [R12]" during direct resident care activities.

3. Review of R105's clinical records revealed:

F 880

versus Enhanced Barrier Precautions to provide education and guidance. Root cause identified as facility failure to comply with CDC recommendations, effective April 1, 2024, to implement use of EBPs.

4. The Director of Nursing or administrative nurse will audit all residents with a chronic wound and/or indwelling medical device to ensure EBPs are in place and staff is compliant weekly for 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success to ensure EBPs are in place. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3months.

5. Date of completion: 11/18/24

F 880 Continued From page 99 F 880

4/30/24 - R105 was admitted the facility with diagnoses including two existing pressure ulcers to her buttock area.

7/23/24- A review of the care plan revealed that R105 had a chronic wound or pressure ulcer: stage 4 on the right buttock and stage 4 on the left buttock.

8/21/24 - A physician's order was written by E4 (MD) to cleanse the left buttock wound with wound cleanser, apply collagen/ hydrogel, and to cover the wound with bordered gauze, every day shift. The same treatment order was written for the right buttock wound.

9/19/24 10:48 AM - During an observation, it was observed that R105's room lacked PPE (Personal Protective Equipment) for staff to use when providing care.

9/20/24 11:20 AM - During an observation, the continued lack of PPE for R105's room was observed.

9/24/24 1:36 AM - During an observation, E8 (LPN) and E18 (CNA) preforming wound care to R105's wound. They were not wearing PPE (gown) during the procedure.

9/24/24 11:53 AM - During an interview with E8 (LPN) confirmed "I only have to wear goggles during wound dressing changes if it involves a wound vac." E8 (CNA) confirmed, "I thought I only had to wear gloves during the dressing change."
4. R26's clinical record revealed:

From 6/27/24 through 9/25/24, R26 was being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD WILMINGTON, DE 19803

(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 880	Continued From page 100 seen weekly by the Wound Care Consultant (WCC) for a chronic sacral pressure ulcer as documented in the skin notes. 9/25/24 at 8:00 AM - An observation of wound care with C1 (WCC) and E8 (LPN) revealed that no enhanced barrier precautions were in place despite R26 having a chronic sacral pressure ulcer. In addition, C1 and E8 failed to wear gowns during the sacral wound dressing change. 10/2/24 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits	F 883		11/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	**700 FOULK ROAD WILMINGTON, DE 19803**

(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 883	Continued From page 101 and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R9, R53 and R76) out of five residents sampled for influenza and pneumococcal vaccinations, the facility failed to provide education regarding the benefits and	F 883	F883: Influenza and Pneumococcal Immunizations 1. R9, R53 and R76 continues to reside at the facility and has been presented the education for the influenza and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD WILMINGTON, DE 19803

(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 883	Continued From page 102 potential side effects of either/both influenza and pneumococcal immunizations to each resident or the resident's representative and then offer the immunization. Findings include: 1. R9's clinical record lacked evidence that the resident was offered an up to date pneumococcal vaccination. R9 received the PCSV23 on 9/23/22. 2. R53's clinical record lacked evidence that the resident was offered an influenza vaccination during year 2023. 3. R76's clinical record lacked evidence that the resident was offered a pneumococcal vaccination. 10/2/24 at 3:00 PM - Discussed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative with the Ombudsman's Office.	F 883	pneumococcal vaccination. 2. All residents have the potential to be affected. 3. Unit Managers will be educated on the policy and procedure for offering and documenting immunizations by DON or designee. All new residents will be offered the influenza and pneumococcal vaccines as part of the facility's vaccination program. 4. As Influenza vaccination have been offered to current residents an audit of resident's immunization documentation will be conducted weekly to ensure residents have been offered the appropriate vaccines and documentation is completed by the DON or ADON. Throughout flu season, new resident files will be audited to ensure vaccination documentation is completed. Results of these audits will be brought to the QAPI Committee monthly for three months for further review and recommendations. 5. Date of completion: 11/18/24	
F 887 SS=E	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education	F 887		11/18/24

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD WILMINGTON, DE 19803

(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 887	Continued From page 103 regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or	F 887		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	**700 FOULK ROAD** **WILMINGTON, DE 19803**

(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 887	Continued From page 104 information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (R9, R30, R53 and R76) out of five residents sampled for Covid-19 vaccinations, the facility failed to provide education regarding the benefits and potential side effects of Covid-19 immunizations to each resident or the resident's representative and then offer the immunization. Findings include: 1. R9's clinical record lacked evidence that the resident was offered an up to date Covid-19 vaccination. The last documented Covid-19 vaccination was received on 4/9/21. 2. R30's clinical record lacked evidence that the resident was offered an up to date Covid-19 vaccination. The last documented Covid-19 vaccination was received on 11/22/23. 3. R53's clinical record lacked evidence that the resident was offered an up to date Covid-19 vaccination. The last documented Covid-19 vaccination was received on 12/6/22. 4. R76's clinical record lacked evidence that the resident was offered an up to date Covid-19 vaccination. The last documented Covid-19 vaccination was received on 9/10/21. 10/2/24 at 3:00 PM - Reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative with the	F 887	F887: COVID-19 Immunization F-887 1. R9, R30, R53 and R76 continues to reside at the facility and has been presented the education for the COVID-19 vaccination. The facility will administer vaccination upon delivery from the pharmacy. 2. All residents that have not received the COVID-19 vaccination have the potential to be affected by this practice. The Infection Control Practitioner will audit of all residents who have not received the COVID-19 vaccination to provide education on vaccination to identified resident, administer and document if the resident consents or document declination if resident refuses. 3. Root cause analysis completed results identified that the facility failed to follow the COVID-19 Vaccination policy. Upon admission (the admission nurse) and per administration frequency guidelines, the resident will be offered applicable immunizations if they have not yet received them or are due for the immunization. The resident will be provided education on the immunization via the Vaccine Immunization Statement by Licensed Nurse. If the resident consents to the immunization, it will be administered per order and documented in the medication record. If they decline	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD WILMINGTON, DE 19803

(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 887	Continued From page 105 Ombudsman's Office.	F 887	the immunization, the declination will be recorded in the record. New admission chart checks will also review for documentation of accepting/declining applicable vaccinations. Staff Developer will educate all licensed nurses on the policy regarding COVID-19 Vaccination and record keeping. Declinations will be documented in the immunization tab. 4. IP/designee will audit 5 residents for COVID-19 education and consent/declination of vaccine weekly X 4 weeks until 100%, then every 2 weeks X 1 month until 100%, then X 1 month until 100%. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. 5. Date of completion: 11/18/24	
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to provide a safe, sanitary, environment for residents, staff and the public. Findings include: 9/23/24 1:30 PM - An observation of three trash dumpsters located were located next to the facility. Two of the dumpsters contained full clear trash bags, and the third dumpster was full of	F 921	F921: Safe/Function/Sanitary/Comfortable Environment 1. No residents were identified. Trash that had fallen out of the containers was picked up and disposed of properly. 2. All residents have the potential to be affected.	11/18/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	**700 FOULK ROAD WILMINGTON, DE 19803**

(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 921	Continued From page 106 ripped up boxes. The two dumpsters with the clear bags revealed the following: -Both dumpsters had opened lids, with clear bags of facility trash hanging over sides of dumpsters. -Both dumpsters had open bags of trash with the contents of the bags, including contaminated feces soiled resident briefs and used PPE gloves on the ground surrounding the dumpsters. 9/23/24 1:40 PM - During an interview, E1 (NHA) confirmed the above findings. 9/23/24 4:00 PM - An observation of the trash dumpsters revealed that the two dumpsters with resident trash had been emptied, but that the soiled resident briefs and used PPE gloves on the ground remained. 9/23/24 4:30 PM - During an interview, E1 confirmed the 4:00 PM findings. 9/24/24 8:00 AM - An observation revealed that soiled resident briefs and used PPE gloves on the ground in front of and next to the dumpsters had been removed, but soiled resident briefs and used PPE trash remained behind left dumpster and back fence. 9/24/24 9:40 PM - During an interview, E1 confirmed the above findings. 9/25/24 8:00 AM - An observation revealed that the trash behind left dumpster and back fence had been removed. 9/26/24 8:00 AM - An observation revealed a clear bag of resident trash was on the ground in front of the dumpster.	F 921	3. Route cause analysis showed that further education was needed for those who empty trash to ensure that a homelike environment is maintained. 4. Administrator/designee will audit outside trash cans weekly x 4 weeks until 100% consecutively and then monthly x 3 months until facility reaches 100% success. The results of these audits will be reviewed with the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meeting monthly x 3 months. 5. Date of completion: 11/18/24	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING ______ B. WING ______	C 10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD WILMINGTON, DE 19803

(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 921	Continued From page 107 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.	F 921		