DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: New Castle Health and Rehab **DATE SURVEY COMPLETED: March 29, 2021**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report Incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from March 22, 2021 through March 29, 2021. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation. The facility census on the first day of the survey was 104. The survey sample size was three (3).	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements.	
3201	**Regulations for Skilled and Intermediate Care Facilities**	**3201.9.8.4**: Significant Injuries **Step 1:** R1 fall event reported to Delaware Department of Health (DEDOH) by self-observation at time of survey.	4/16/21
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 March 29, 2021: F657, F740, and F791.	**Step 2:** Residents who fall and require neuro-checks; by order, have the potential to be affected. On 4/14/21 the Director of Nursing (DON) and/or designee conducted an audit of falls with ordered neuro-checks from time of survey exit to present. Where necessary a reportable event was generated and submitted to the DEDOH. **Step 3:** Review and Root Cause Analysis with the Center's Interdisciplinary Team was conducted. It was determined that lack of reporting was related to a misunderstanding of the state's reportable event requirements. To prevent the potential for reoccurrence the NHA and/or designee educated the DON and Risk Manager on the Delaware State reportable event requirements.	
3201.9.8.4	**Significant injuries.**		
3201.9.6	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be**		

Provider's Signature [signature] Title Administrator Date 4/15/21

NAME OF FACILITY: New Castle Health and Rehab DATE SURVEY COMPLETED: March 29, 2021

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. The method of reporting shall be as directed by the Division.	**Step 4:** To monitor and maintain ongoing compliance the NHA and/or designee will audit falls occurring within the facility on a weekly basis for 3 months and/or 100 % compliant to ensure that timely reporting has occurred, where necessary. Results will be reported to the facility's QAPI team for continued review and recommended change.	
3201.9.8	**Reportable Incidents are as follows:**		
3201.9.8.4.2	**Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.**		
	This requirement was not met as evidenced by:		
	Based on record review, interview and review of other related documentation, it was determined that for one (R1) out one sampled residents for falls, the facility failed to notify the State Agency of R1's fall which required ongoing neurological checks for an injury to the head. Findings include:		
	Review of R1's clinical record revealed:		
	11/6/2020 - R1 was admitted to the facility.		
	1/8/2021 4:43 PM - A nursing note documented "Charge nurse notified by CNA resident noted lying on the floor close to his bed...hematoma noted on resident head. NP [nurse practitioner] notify order neuro checks every 4 hour and apply ice pack to hematoma on resident right side of head. Resident denies pain. POA [power of attorney] notify...".		
	1/9/2021 5:09 AM – A nursing note documented "Resident received in bed awake, alert and responsive. S/P [status post] fall. Hematoma to right head is reducing. Denies any pain. On Neurological checks and within normal limits...".		

Provider's Signature [signature] Title Administrator Date 4/15/21

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: New Castle Health and Rehab **DATE SURVEY COMPLETED: March 29, 2021**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	3/26/2021 11:00 AM - A review of the State's Incident Reporting System revealed that R1's fall on 1/8/2021 at 4:43 PM, was not reported to the State Agency. 3/26/2021 4:03 PM - An email communication from E2 (DON) revealed that "Resident has not fallen in the facility since 1/8/2021. This is his first and only fall; occurring from bed to floor. No injury. MD [medical doctor] and RP [representative party] made aware at time of event...". The facility failed to notify the State Survey Agency of R1's fall that resulted in an injury to the head and physician orders for neurological assessments. 3/29/2021 2:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit teleconference.		

Provider's Signature _____ Title Administrator Date 4/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from March 22, 2021 through March 29, 2021. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation. The facility census on the first day of the survey was 104. The survey sample size was three (3). Abbreviations/Definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; FM - family member; IDT - Interdisciplinary Team; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RN - Registered Nurse; RNAC - MDS Coordinator, Registered Nurse Assessment Coordinator; SS - Social Services; SW - Social Worker. BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment; ie - that is; MDS - Minimum Data Set (standardized assessment forms used in nursing homes); Power of Attorney - a written document in which one person appoints another person to act as an agent on his or her behalf;	F 000		

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

Electronically Signed | 04/14/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Resident representative - an individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; TBI - traumatic brain injury.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		4/16/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 2 by: Based on record review and interview, it was determined that for three (R1, R2 and R3) out of three residents sampled for care plans, the facility failed to ensure that all required members of the Interdisciplinary Team (IDT) participated in, or provided input, to the formation of resident care plans. Findings include: 1. Review of R1's clinical record revealed: 11/6/2020 - R1 was admitted to the facility. 11/17/2020 9:27 AM - An Admission Care Plan Conference Summary note by E3 (RNAC) lacked evidence the attending physician and a CNA responsible for R2 participated in the care planning process. 2/9/2021 9:56 AM - A Quarterly Care Plan Conference Summary note by E3 (RNAC) lacked evidence that the attending physician and a CNA responsible for R2 participated in the care planning process. 3/28/2021 10:23 AM - In response to a request for the facility's care plan policy and for evidence that resident's CNA and physician provided input to the care plans, an email communication from E1 (NHA) only provided the policy. 2. Review of R2's clinical record revealed: 7/10/2015 - R2 was admitted to the facility. 8/18/2020 12:23 PM - An Annual Care Plan Conference Summary note by E4 (RNAC) lacked evidence the attending physician and a CNA responsible for R2 participated in the care	F 657	Preparation and submission of this Plan of Correction does not constitute an admission of or agreement with, it is required by State and Federal Law. It is executed and implemented as a means to continuously improve the quality of care to comply with State and Federal requirements. F657 D: Care P an Timing and Revision Step 1: A care plan meeting was held for residents R2 and R3. R1 no longer resides in the facility. The meeting was conducted with input from the full Interdisciplinary Team (IDT), including each resident's Certified Nursing Aide (CNA) and physician. Documentation was then generated to identify all participants and reflect the context of the discussion. Step 2: Residents who require periodic care plan meetings have the potential to be affected. On 4/14/21 the MDS Coordinator and/or designee conducted an audit of all care plan meetings from time of survey exit to present to ensure full IDT support was documented. This includes the res dent's physician and CNA. Where necessary, the care plan meeting was rescheduled and completed. Documentation was then generated to identify all participants and reflect the context of the discussion. Step 3: Review and Root Cause Analysis with the Center's Interdisciplinary Team was conducted. It was determined that;	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 3 planning process. 11/10/2020 8:42 AM - A Quarterly Care Plan Conference Summary note by E3 (RNAC) lacked evidence that the attending physician and a CNA responsible for R2 participated in the care planning process. 2/4/2021 9:08 AM - A Quarterly Care Plan Conference Summary note by E3 (RNAC) lacked evidence that the attending physician and a CNA responsible for R2 participated in the care planning process. 3/28/2021 10:23 AM - In response to a request for the facility's care plan policy and for evidence that resident's CNA and physician provided input to the care plans, an email communication from E1 (NHA) only provided the policy. 3. Review of R3's clinical record revealed: 12/20/2018 - R3 was admitted to the facility. 8/18/2020 7:57 AM - An Annual Care Plan Conference Summary note by E4 (RNAC) lacked evidence the attending physician and a CNA responsible for R2 participated in the care planning process. 11/12/2020 8:27 AM - A Quarterly Care Plan Conference Summary note by E3 (RNAC) lacked evidence that the attending physician and a CNA responsible for R2 participated in the care planning process. 2/2/2021 9:11 AM - A Quarterly Care Plan Conference Summary note by E3 (RNAC) lacked evidence that the attending physician and a CNA	F 657	although resident CNAs and physicians are used as a resource documentation does not always reflect their inclusion. To prevent the potential for reoccurrence the Nursing Home Administrator (NHA) and/or designee educated the MDS Coordinator on the Interdisciplinary Team with emphasis on who this group includes. Step 4: To monitor and maintain on-going compliance the MDS Coordinator and/or designee will audit IDT documentation following a care plan meeting 1 time a week for 3 months and/or 100 % compliant ensure all IDT members are represented. If required, the MDS Coordinator will then review care plan summary with missing team members to ensure they contributed and document accordingly. Re-education will be provided to the employee who conducted the meeting. Results will be reported to the facility's QAPI team for continued review and recommended change.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 4 responsible for R2 participated in the care planning process. 3/28/2021 10:23 AM - In response to a request for the facility's care plan policy and for evidence that resident's CNA and physician provided input to the care plans, an email communication from E1 (NHA) only provided the policy. There was no evidence of participation in the care planning process for three residents by required IDT members. 3/29/2021 2:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit teleconference.	F 657		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined, for one (R3) out of two sampled residents, with mood and behavioral issues, the facility failed to provide the necessary behavioral health services to attain the highest practicable mental and psychological well-being.	F 740	F740 D: Behavioral Health Services Step 1: Behavioral health services are being provided; and have been provided, for R3. The resident is currently seen by the center psychiatrist on a monthly basis.	4/16/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 5 Findings include: Review of R3's clinical record revealed: 12/20/2018 - R3 was admitted to the facility. 12/28/2018 (last revised on 2/25/2021) - A care plan was initiated by E5 (SW) for "Altered or at risk for altered behaviors and/or mood r/t [related to] dx [diagnosis] of depression and anxiety evidenced by thoughts that she'd be better dead." Interventions included: - Assist resident to identify strengths, positive coping skills, anger management techniques and reinforce these (12/28/2018) - Refer to psychiatrist and/or psychologist/counselor as needed (5/14/2019) - Monitor/assess root cause to mood issues (1/29/2020) - Attempt to "work through" anxieties (1/29/2020) 1/26/2021 3:10 PM - A quarterly note by E5 (SW) documented "[R3] is reviewed as a quarterly update with no changes in her plan of care. She is alert and verbal capable of making her needs known...She scored 14 on the bims, 14 on the mood interview with no behaviors (moderate depression) but thoughts of feeling she'd be better off dead which she always feel but today her feelings are centered around her health condition and being told her cat that she has home is being put out due to problems the home owners are having. She was visibly upset stating [that] the cat has been in the home for 13 years and she considers him as her child and distraught that she's unable to care for the cat and now he's being put out. [E5] attempted to console her and encourage her to be hopeful her friend who has been caring for the cat will continue. She has no	F 740	The resident is also seen on a weekly basis by the facility Social Services Director in an attempt to provide an outlet for the resident's behavioral care needs. On 4/1 the resident was offered psychological services. She continues to decline this service. Step 2: Residents with behavioral health needs have the potential to be affected. On 4/14/21 the SSD and/or designee conducted an audit of all residents with psychiatric diagnoses to ensure they are being followed by the psychiatrist and social services. Where necessary an appointment with the psychiatrist was made. Step 3: Review and Root Cause Analysis with the Center's Interdisciplinary Team was conducted. It was determined that the resident's behavioral healthcare needs are being met by the facility to the extent that they are currently possible. To prevent the potential for reoccurrence the NHA and/or designee will identify additional psychiatric care providers within the community that service long term care centers and determine if they are appropriate for this setting. Step 4: To monitor and maintain on-going compliance the SSD and/or designee will residents with a psychiatric diagnosis 1 time monthly for 3 months and/or 100 % complaint to ensure they continue to see the psychiatrist and social services director. Results will be reported to the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 6 plan to harm herself but will continue to be followed by psych.". 2/4/2021 - A psychiatrist's note documented "The patient is seen as she expressed suicidal thoughts, not wanting to be alive, but no plans. The patient is sad, depressed, hopeless, and helpless. She has to go for surgery next day as she has uterine cancer ...and she is expecting another major surgery on her aorta ...in March ... [she] is physically compromised and she is worried about her pending two surgeries and that makes her depressed and she does not want to be alive ...she does not want to die, not suicidal, is frustrated, does not have a plan to hurt herself. We will continue current treatment ...The patient is safe at this time.". 2/12/2021 7:45 AM - A social worker note documented "[E5 (SW)] spoke with [R3] who was expressing concerns over not feeling well and differences with her roommate. [E5] asked if she'd be interested in changing rooms and she declined stating she was in the room first and things were not that bad that she'd want to leave. [E5] will continue to monitor for psychosocial concerns and address as needed.". 2/26/2021 - A psychiatrist's (E7) note documented "Patient is still depressed and worried about her physical health. Not suicidal. We will follow medications.". 3/16/2021 1:17 PM - A social worker note documented "[E5 (SW)] spoke to [R3] this day who discussed her concern of her recent wounds and her upcoming appts [appointments] that she's nervous about attending. She is worried of the overall outcome of the surgery that's	F 740	facility's QAPI team for continued review and recommended change.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 7 scheduled. [E5] attempted to encourage her to have positive thoughts for positive outcomes to occur. [E5] will continue to provide visits for the purpose of addressing her psychosocial needs". 3/22/2021 1:30 PM - During an interview, E6 (RN, Risk Manager) stated that "[R3] is jealous of her roommate and has been noncompliant with wound care interventions. So, we have been trying to meet with her every couple days to address her concerns.". 3/22/2021 1:30 PM - During an interview, E5 (SW, Grievance Officer) stated R3 has multiple concerns because she feels "staff are not giving her help and tends more to her roommate". E5 stated R3 has been noncompliant with facility rules such as mail ordering and keeping diet pills and tobacco in her room. E5 added R3 has banned certain staff from entering her room when she gets mad at them and has financial problems. E5 stated she visits her once a week to provide reassurance. 3/22/2021 3:30 PM - During an interview, R3 became tearful and stated that she complained to E1 (NHA) because E7 (Psychiatrist) called her a "pill popper". R3 stated she is not receiving any counseling, just short visits from E7. R3 expressed she feels ignored by staff and she feels staff always help her roommate. R3 continued to be tearful as she spoke of being confined to a wheelchair because of multiple bilateral hip surgeries, cancer diagnosis and upcoming surgeries. 3/22/2021 4:30 PM - Above comments from R3 and that R3 began crying were reviewed with E1 (NHA) who stated that at this time R3 has banned	F 740		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 740	Continued From page 8 her from entering her room, but other staff are visiting her regularly to address her concerns and R3 has her cell phone number and can call her anytime. E1 added that R3 has recently alienated her main family support person. 3/26/2021 4:03 PM - In response to a request for documentation of psycho-social interventions, an email communication from E2 (DON) revealed that "The facility is unaware of any other concerns from [R3] at this time [only aware of R3's concerns about wound healing]...Facility continues to monitor [R3's] needs. This includes an at least biweekly discussion with facility social worker [E5], giving [R3] an opportunity to express her needs as the occur to her.". 3/29/2021 2:00 PM - During an interview, E1 (NHA) stated that the facility has trouble getting a psychologist or counselor for residents, but they have a physiologist that will conduct teleconferences with residents. She will consider offering counseling services to R3. Although the facility staff made visits to R3 to try to address her concerns, no evidence was provided that behavioral health/counseling services were provided to R3 except for visits from the psychiatrist who she had made a complaint about. 3/29/2021 2:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit teleconference.	F 740		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services	F 791		4/16/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 9 The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 10 reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to assist a resident/family in making dental appointments for dental services for one (R2) out of one sampled resident for dental services. Findings include: 8/11/2020 (most recent revision date) - The facility's "Dental Services Policy", indicated that "The facility will assist residents in obtaining routine and 24-hour emergency dental care/services to meet the needs of each resident ...Social Services personnel or designee will, if necessary or requested, assist the resident/resident representative in making dental appointments and transportation arrangements to and from the dental services location ...". Review of R2's clinical record revealed: 7/10/2015 - R2 was admitted to the facility. 3/13/2019 - A care plan for "Resident has oral health problem - hx [history] of cavities and poor oral care" was initiated by E4 (RNAC) included an intervention for "referral to dental services". 6/10/2020 - Dental Consult report revealed "decay multiple teeth ...[R2] needs multiple fillings.". 3/22/2021 1:55 PM - During an interview, E5 (SW, Grievance Officer) stated that FM1 (family member) was informed that after the 1/6/2021 exam the facility's in-house dental provider recommended extractions (and does not fill	F 791	F791 D: Routine/Emergency Dental Services Step 1: Dental services were provided to R2 while residing within the facility. However, R2 and their Responsible Party (RP) did not agree with the initial plan of care, opting for a more expensive procedure that was originally not covered by R2□s insurance plan. Resident□s RP was unwilling to cover the cost of the procedure. The resident changed coverage to a provider that did accommodate this service. Subsequently a dental appointment was obtained for R2. Step 2: Residents who have sought dental service and have identified that the procedure was not covered by their insurance plan have the potential to be affected. On 4/14/21 the Social Services Director (SSD) and/or designee conducted an audit of resident dental service requests to identify if services were not provided because of insurance. Where observed the SSD and/or designee called the dentist to ensure that coverage was still not accommodated. RP offered the option to pay for service that are not covered by insurance. The affected resident and/or Responsible Party (RP) was then notified, and the event documented.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 11 cavities), but FM1 would like R2's cavities filled instead of extractions. When asked if it was part of the facility's role to assist with making an appointment for fillings, E5 stated yes, but she has not had time to follow-up. 3/22/2021 4:40 PM - During an interview, E1 (NHA) stated she has a list of dental providers covered by R2's insurance and that they will work on making an appointment. 3/24/2021 3:25 PM - During an interview, FM1 (family member) stated that "I have had several conversations since last summer with the social worker [E5] about filling [R2's] 13 cavities which are causing him pain. E5 was supposed to make an appointment for fillings in October when we changed his insurance to cover fillings. Almost one year has passed with 13 cavities lingering in his mouth because the social worker hasn't made an appointment. I'm confused as to the reason for the delay." 3/26/2021 9:23 AM - In an email communication, E5 (SW, Grievance Officer) wrote that "After repeated no success at reaching an outside dentist on January 6, 2021 [name of facility's in-house dental provider] was in the building and I asked R2 if he'd like to be seen and he said yes. On February 26, 2020 after getting correspondence from [name of facility's in-house dental provider] regarding their next visit, they stated to plan to extract R2's teeth so I called [FM1] to make her aware. She stated that she would not want this as he is too young to have missing teeth. I immediately reached out to the [facility's in-house dental provider] and learned they do not fill cavities only provide sealants...I was also able to make [FM1] aware of the	F 791	Step 3: Review and Root Cause Analysis with the Center□s Interdisciplinary Team was conducted. It was determined that the lack of appointment was related to the resident□s insurance plan initially being denied by the dental office for the requested service. Should it be identified that dental services are not covered by a resident□s insurance plan the facility will review coverage every 3 months to identify if there was a change make RP aware. RP offered the option to pay for service that are not covered by insurance or change to a different dental plan. The NHA and/or designee educated the SSD on the new process. Step 4: To monitor and maintain on-going compliance the NHA and/or designee will audit non-covered dental procedures 1 time a month for 3 months and/or 100 % complaint to ensure follow up calls were made per protocol to insurance company, ensure RP was made aware. RP offered the option to pay for service that are not covered by insurance or change to a different dental plan. Results will be reported to the facility□s QAPI team for continued review and recommended change.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 03/29/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 12 conversation had with the dentist and told her that a representative from [R2's insurance] would be in touch with her as she would like to speak with someone from the company.". There was no evidence of follow-up by the facility in making appointments to have R2's cavities filled. 3/26/2021 4:03 PM - After the surveyor began the investigation, an email communication from E2 (DON) revealed that "...Further inquiry into fillings being completed resulted in an appointment on 4/23/2021. The cost and insurance coverage was again discussed with [FM1] who has agreed to the service.". 3/29/2021 2:00 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit teleconference.	F 791		