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

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Veterans Home **DATE SURVEY COMPLETED:** March 6, 2025

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced Annual and Complaint survey was conducted at this facility from February 27, 2025, through March 6, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was sixty-nine (69). The survey sample totaled nineteen (19).		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **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 6, 2025: F626, F644, F657, F677, F684, F689, F690, F773, and F842.		

Provider's Signature _____ Title NHA Date 3-21-2025

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

DELAWARE HEALTH AND SOCIAL SERVICES

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

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Veterans Home

DATE SURVEY COMPLETED: March 6, 2025

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE

Provider's Signature _____ Title NHA Date 3.21.2025

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Veterans Home

DATE SURVEY COMPLETED: March 6, 2025

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 Annual and Complaint survey was conducted at this facility from February 27, 2025, through March 6, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was sixty-nine (69). The survey sample totaled nineteen (19).		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed March 6, 2025: F626, F644, F657, F677, F684, F689, F690, F773 and F842.		

Provider's Signature _____ Title _____ Date _____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 Emergency Preparedness survey was conducted at this facility from February 27, 2025 through March 6, 2025. The facility census was sixty-nine (69) 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 observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from February 27, 2025 through March 6, 2025. The deficiencies contained in this report are based on observation, interview, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was sixty-nine (69). The investigative sample totaled nineteen (19) residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; Activities of daily living (ADLs) - Tasks needed for	F 000		

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

Electronically Signed | 04/01/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 daily living, such as dressing, hygiene, eating, toileting, bathing; Alzheimer's Disease - Degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Antibiotic - Medication used to treat bacterial infections; Antipsychotic - Class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; BID - Twice a day; BIMS - (Brief Interview for 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; Bipolar Disorder - Mood disorder; CFU/ml - A unit used in microbiology to measure the number of viable bacteria in a sample; Cognitive Deficit - Abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; Culture & Sensitivity (C&S) - Laboratory test to identify what bacteria is causing an infection and which antibiotic will effectively kill the bacteria; Delusional disorder- A serious mental illness previously called paranoid disorder, in which a person can't tell real from what is imagined; Dementia - Brain disorder with memory loss, poor judgement, personality changes and disorientation OR loss of mental functions such as memory and reasoning that interferes with a	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 2 person's daily functioning; Enterococcus casseflíflavous - A baccteria capable of producing disease. this specific bacteria targets individuals that are immunocompromosed or cronically ill. This infection can be seriously invasive; Frequently Incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period; Gradual Dose Reduction (GDR) - Tapering of a dose to determine if symptoms, conditions or risks can be managed by a lower dose or if the medications can be discontinued altogether; Incontinence - Loss of control of bladder &/or bowel function; Interdisciplinary Team (IDT) - A coordinated group of staff from several different fields who work together towards a common goal or project; IV - Intravenous - within the veins, used to administermedications through a tube directly into the vein. Leukocytosis - Increased number of white blood cells; Major Depressive Disorder - Also known as depression, is a mental disorder characterized by at least two weeks of low mood that is present across most situations; 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; Medication Regimen Review (MRR) - Monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; Metabolic encephalopathy - A disease affecting the brain functioning due to some agent or condition such as a viral infection or toxins in the	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 3	F 000		

blood;
mg - Milligram;
mL - Milliliter;
Neuropathy - Disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness or pain;
Occasional Incontinence - Less than 7 episodes of urinary incontinence in 7 day look back period;
Parkinson's disease - A progressive disorder of the nervous system that affects your movementor a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination;
Post Traumatic Stress Disorder (PTSD) - 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;
Probiotic - Live microorganisms that provide good bacteria in the gut;
Prompted void - Technique of bladder training in which the patient is instructed to urinate according to a predetermined schedule;
Pulse oximetry - Measures blood oxygen saturation in the blood, desired range 94% - 100%;
Psychotic disorder - Condition of the mind that results in difficulties determining what is real and what is not;
Psychotropic (medication) - Any medication capable of affecting the mind, emotions and behavior;
PASSAR - Preadmission Screening and Resident Review - Screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 4 and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; Sacrum - Large triangular bone at base of spine; Scheduled (or timed) toileting program - Fixed time interval toileting assistance for resident's with urinary incontinence; Significant change - A decline or improvement in a resident's status. UA - Urinanlysis - An array of tests performed on urine, and one of the most common methods of medical diagnosis; Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); Urine culture and sensitivity (C&S) - A microscopic study of the urine culture performed to determine the presence of pathogenic bacteria in patients with suspected urinary tract infection; UTI - Urinary Tract Infection - bacteria in urine; Voiding Diary - A record of voiding (urinating) for 72 hours and/or 3 days; Wound - A break in the integrity of the skin;	F 000		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the	F 626		4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 626	Continued From page 5 State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R47) out of two residents reviewed for hospitalization, the facility lacked evidence that R47 was allowed to return timely to the facility. 11/26/24 - R47 was admitted to the facility. 12/6/24 - R47 was admitted to the hospital for altered mental status and for a psychiatric evaluation. The admission history and physical	F 626	F626 Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) A. R47 returned to the facility 12/13/24. B. All residents admitted to acute care facilities have the potential to be affected by the deficient practice. Delaware	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 626	Continued From page 6 also reflected that R47 had recently been diagnosed with a urinary tract infection. 12/8/24 - A hospital progress note revealed "Barriers: Patient is medically cleared for discharge. VA home is not taking patient on weekends ..." 12/9/24 - A discharge summary revealed that "His mental status has improved, he has been pleasantly confused during the hospital stay, which appears to be his baseline. He is medically stable for discharge." 12/10/24 - A daily medical progress report revealed "Barriers to discharge: medically cleared. Discharge disposition: placement issues." 12/12/24 - A daily progress report revealed "Disposition hospital issue: Patient was already discharged by prior provider, but VA home refused to take him. They think he needs to go to inpatient psych or memory unit ... If they think he needs to go to memory unit then he can go back to the same VA then they can start the process. Psych recommended no need for inpatient psych." 12/13/24 - R47's discharge instructions revealed "Disposition hospital issue: Patient was already discharged by prior provider, but VA home refused to take him. They think he needs to go to inpatient psych or memory unit ... If they think he needs to go to memory unit then he can go back to the same VA then they can start the process. Psych recommended no need for inpatient psych."	F 626	Veterans Home (DVH) can accept appropriate resident readmissions 7 days a week. Staff will be educated regarding readmissions to the facility by Staff Development RN no later than April 30, 2025. C. RCA: Inadequate communication between acute care facility and DVH. The admissions director/designee will communicate daily, unless otherwise agreed upon and documented, with discharge planners at the corresponding acute care facility to determine discharge plan that includes specific appropriate discharge date and time. Staff will be educated regarding readmissions to the facility by Staff Development RN no later than April 30, 2025. D. The Admissions director will track and analyze daily communication with acute care facility. to determine appropriate discharge time and date, daily x 14 days, weekly x 2 weeks, then monthly x 2. Results will be communicated through the QA process until100 % compliance is met.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 626	Continued From page 7 12/13/24 - R47 returned to the facility. 3/5/25 1:20 PM - In an interview, E2 stated that the facility wanted to send R47 to a specific behavioral health facility, but R47 was declined due to needing assistance with activities of daily living. E2 stated that the facility would not have refused R47 re-entry back to the facility but acknowledged that there concerns about the safety of the resident and staff due to his behaviors. E2 further stated that residents can return on the weekend although they prefer that they return during the week because leadership is also in the facility. E2 stated they would not refuse a resident to return. 3/6/25 12:33 PM - In an interview, E1 (NHA) and E2 stated they were not aware of any reason that R47 should not have returned to the facility on 12/9/24, which was a Monday. Both noted that they do not refuse weekend readmissions. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2.	F 626		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's	F 644		4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 644	Continued From page 8 assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R10) out of three residents sampled for PASARR, the facility failed to ensure that a referral for a PASARR screening was done for a new mental health diagnosis. Findings include: Review of R10's clinical record revealed: 1/29/24 - Review of R10's PASARR Level I screen outcome documented... "No Level II required .... No SMI (serious mental illness), ID (intellectual disability) or RC (related condition)." 1/31/24 - R10 was admitted to the facility with diagnoses of dementia and anxiety. 3/26/24 - A new diagnosis for R10 included psychotic disorder with delusions. 5/8/24 - R10's quarterly MDS documented a new diagnosis of psychotic disorder with delusions. 2/28/25 - An interview with E4 (social worker) revealed that, "When a resident has a new diagnosis and change in medical diagnosis, the PASARR level I will be resubmitted." The facility lacked evidence that R10, a resident	F 644	F644 Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) A. R10 continues to reside at the facility. A level 1 PASSAR was completed on 3/4/25 with no indication for a Level II. B. All residents have the potential to be affected. C. RCA: On January 29, 2025 the facility self- identified flaws in the PASARR completion through the QA process. A Performance Improvement plan (PIP) was initiated February 3, 2025. The PIP provided a new process in that the Social Services would attend the weekly Psych review meetings to be apprised of any change in diagnosis. Social Service personnel completed formal PASARR training on 3/5/25. This process is ongoing. D. The Social Service director will track and verify via audit tool currently in place and report through QA process until 100% compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 644	Continued From page 9 with a new mental health diagnosis, was referred to the state agency for a PASARR Level II evaluation and determination. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON) exit statement.	F 644		
F 657 SS=E	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		4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 10 by: Based on record review and interview, it was determined that for five (R1, R11, R64 and R66) out of nineteen sampled residents, the facility failed to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings. Findings include: 1. 2/11/08 - R1 was admitted to the facility. 1/15/25 - A quarterly MDS was completed. 1/28/25 - A quarterly care plan meeting note lacked evidence of input from the physician. 10/16/24 - A quarterly MDS was completed. 10/29/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 7/17/24 - An annual MDS was completed. 7/30/24 - An annual care plan meeting note lacked evidence of input from the physician. 2. 6/11/24 - R11 was admitted to the facility. 6/17/24 - An admission MDS was completed. 7/9/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 9/11/24 - A quarterly MDS was completed. 9/24/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 12/11/24 - A quarterly MDS was completed.	F 657	F657 Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) A. R1 suffered no untoward effect from the deficient practice. Though R1□s primary care physician (PCP) had direct input regarding care the PCP did not sign the Interdisciplinary Care Plan document prior to or at the time of the care plan meeting. B. All residents have the potential to be affected by the deficient practice. C. RCA: The facility did not offer specific opportunity for PCP to formally input suggestions if needed prior to care plan meetings. The care plan attendance document was amended at the time of the survey to allow for PCP input and signature. This document is presented prior to the care plan meeting by the Social Service director/designee for PCP review. Staff will be educated regarding IDT input for care plan meetings by Staff Development RN no later than April 30, 2025. D. The Social Service director/designee will present to the PCP the document for input and signature prior to the scheduled care plan meeting. The Social Service director will track the document weekly until 100% compliance is achieved. Results will be presented through the QA process. A. R11 no longer resides at the facility. Though R11□s primary care physician (PCP) had direct input regarding care the PCP did not sign the Interdisciplinary Care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 11 12/26/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 3. 6/6/24 - R64 was admitted to the facility. 6/12/24 - An admission MDS was completed. 9/11/24 - A significant change MDS was completed. 9/24/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 12/11/24 - A quarterly MDS was completed. 12/26/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 4. 8/1/24 - R66 was admitted to the facility. 8/7/24 - An admissions MDS was completed. 11/16/24 - A significant change MDS was completed. 11/19/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 2/5/25 - A significant change MDS was completed. 2/18/25 - A quarterly care plan meeting note lacked evidence of input from the physician. 3/5/25 1:20 PM - In an interview, E2 (DON) stated that while the charting system does not reflect that providers have direct input in the care plan meetings, all residents are seen and assessed by them on a consistent basis. E2 stated that he will	F 657	Plan document prior to or at the time of the care plan meeting. B. All residents have the potential to be affected by the deficient practice. C. RCA: The facility did not offer specific opportunity for PCP to formally input suggestions if needed prior to care plan meetings. The care plan attendance document was amended at the time of the survey to allow for PCP input and signature. This document is presented prior to the care plan meeting by the Social Service director/designee for PCP review. Staff will be educated regarding IDT input for care plan meetings by Staff Development RN no later than April 30, 2025. D. The Social Service director/designee will present to the PCP the document for input and signature prior to the scheduled care plan meeting. The Social Service director will track the document weekly until 100% compliance is achieved. Results will be presented through the QA process. A. R64 suffered no untoward effect from the deficient practice. Though R64□s primary care physician (PCP) had direct input regarding care the PCP did not sign the Interdisciplinary Care Plan document prior to or at the time of the care plan meeting. B. All residents have the potential to be affected by the deficient practice. C. RCA: The facility did not offer specific opportunity for PCP to formally input suggestions if needed prior to care plan meetings. The care plan attendance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 12 ensure that the process is revised to include input from the provider specifically at the time of the care plan meeting. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 657	document was amended at the time of the survey to allow for PCP input and signature. This document is presented prior to the care plan meeting by the Social Service director/designee for PCP review. Staff will be educated regarding IDT input for care plan meetings by Staff Development RN no later than April 30, 2025. D. The Social Service director/designee will present to the PCP the document for input and signature prior to the scheduled care plan meeting. The Social Service director will track the document weekly until 100% compliance is achieved. Results will be presented through the QA process. A. R66 suffered no untoward effect from the deficient practice. Though R66□s primary care physician (PCP) had direct input regarding care the PCP did not sign the Interdisciplinary Care Plan document prior to or at the time of the care plan meeting. B. All residents have the potential to be affected by the deficient practice. C. RCA: The facility did not offer specific opportunity for PCP to formally input suggestions if needed prior to care plan meetings. The care plan attendance document was amended at the time of the survey to allow for PCP input and signature. This document is presented prior to the care plan meeting by the Social Service director/designee for PCP review. Staff will be educated regarding IDT input for care plan meetings by Staff Development RN no later than April 30,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 13	F 657	2025. D. The Social Service director/designee will present to the PCP the document for input and signature prior to the scheduled care plan meeting. The Social Service director will track the document weekly until 100% compliance is achieved. Results will be presented through the QA process.	
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 observation, interview and record review, it was determined that for one (R18) out of three residents reviewed for ADL's, the facility failed to ensure ADL care was provided to dependent residents. Findings include: Review of R18's clinical record revealed: 6/25/24 - R18 was admitted to the facility. 6/26/24 - A care plan was initiated that R18 had an ADL self-care performance deficit related to Alzheimer's and limited mobility with the following interventions: "Check nail length and trim and clean on bath day and as necessary". 11/27/24 - A significant change MDS documented R18 was dependent of one staff for showering, hygiene, and ADL's.	F 677	F677 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) A. R18 continues to reside at the facility. R18□s nail were cleaned and trimmed on 3/2/25. B. All dependent residents have the potential to be affected by the deficient practice. C. RCA: Nursing staff did not observe residents□ nails during rounds or during care. Unit Mangers/designee will observe dependent resident□s nails for appropriate length and cleanliness during morning rounds and address any untoward findings at that time. Supervisory Staff will be educated regarding nail care by Staff Development RN no later than April 30, 2025.	4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 14 2/27/25 9:49 AM - An observation of R18 with long, overgrown nails with debris noted underneath. 2/28/25 12:40 PM - An observation of R18 with long, overgrown nails with debris noted underneath. 3/4/25 10:31 AM - An interview with E11 (CNA) confirmed that nail care was expected to be completed during the resident's showers two days a week. E11 confirmed R18 was documented as shower completed in the CNA task list on 3/1/25. 3/4/25 12:38 PM - An interview with FM1 confirmed that R18 was scheduled to have a shower on 3/1/25 and that FM1 cut R18's nails on 3/2/25. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 677	D. Unit Manger/designee will track nail care provided to dependent residents daily x 14, weekly x 2, then monthly x 2 until 100% compliance is achieved. Results will be reported through the QA process.	
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (R422, R9, R35 and R41) out of four residents reviewed for quality of care,	F 684	F684 Quality of Care	4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 684	Continued From page 15 the facility failed to ensure care/treatment in accordance with professional standards of practice. For R422 the facility failed to provide treatment for a urinary tract infection for four days causing a change in condition that required a transfer to the hospital. This delay in care resulted in harm to R422. For R9, the facility failed to provide treatment for a urinary tract infection for two days. For R35 and R41, the facility failed to follow a doctor's order. Findings include: Cross Refer F773 1. Review of R422's clinical record revealed: 5/23/24 - R422 was admitted to the facility with a history of a stroke affecting his right dominant side, Parkinson's disease and dementia. 6/13/24 - A nursing progress note documented that E16 (MD) was notified that R422 was getting confused, disoriented and drowsy. 6/13/24 - A physician's order was written by E16 for a urinalysis and urine culture. 6/14/24 - A nursing progress note documented the urine sample was collected and sent to the lab for analysis and culture. 6/16/24 - A review of the lab results revealed a urine culture with a positive growth of enterococcus casseliflavous greater than 100,000 CFU /ml, indicating R422 had a urinary tract infection. 6/16/24 - The clinical record lacked evidence that R422's positive urine culture was treated.	F 684	CFR(s): 483.25 A. R422 no longer resides at the facility. B. All residents have the potential to be affected by the deficient practice. C. RCA: Facility was transitioning from lab provider that was unable to upload results to electronic medical record timely. New lab was not fully integrated to deliver results directly to the electronic medical record (EMR). Supervisor failed to adequately inform provider of lab results. The facility contracted with a new lab service to ensure results are available to providers in the electronic medical record. Lab orders are documented in the record as well as tracked and reviewed at the daily clinical meeting. A document has been created to alert the Interdisciplinary Team of pending lab orders and remains active until the results have been received and communicated to the provider. Documentation of this process will be implemented in the resident record form order to resolution of order including providers response to the lab result. Licensed Staff will be educated regarding timeliness of reporting lab results by Staff Development RN no later than April 30, 2025. D. Clinical ADON/designee will monitor all lab orders to ensure labs were obtained, received by lab, reported through the electronic medical record, communicated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 684	Continued From page 16 6/17/24 and 6/18/24 - The clinical record lacked evidence that the UTI was being addressed. 6/19/25 3:30 PM - A change in condition evaluation performed by E23 (RN) documented, "resident noted with increasing lethargy, altered mental status...increased lethargy." 6/19/24 4:50 PM - A physician progress note documented a change in condition: "altered level of copiousness, increased confusion, disorientation, altered mental status ...with increased lethargy, send patient to the ER (emergency room) for further evaluation and possible admission." 6/19/24 6:32 PM - Hospital records documented R422 was admitted with altered mental status. A urinalysis was positive for a large number of leucocytes and many bacteria. Awaiting urine culture and sensitivity. R422 was immediately treated with IV antibiotics. 7/13/24 10:18 AM - Hospital records documented that R422 was treated for encephalopathy likely in the setting of a UTI. Upon admission, all tests performed ruled out a stroke and the principal diagnosis was a UTI. 7/8/24 - R422 was discharged from the hospital and chose not to return to the facility. 3/5/25 10:50 AM - During an interview, E2 (DON) stated that lab results are faxed to the nurse supervisor's office. If a lab result is critical and requires immediate attention, the nurse supervisor or the nurse who is assigned to the resident will call the on-call provider, if the	F 684	to the provider and response by the provider, daily x 14, weekly x 2, monthly x 2. Results will be reported through the QA process until 100% compliance has been achieved. A. R9 continues to reside at the facility. B. All residents have the potential to be affected by the deficient practice. C. RCA: provider was not made aware of results nor were they reviewed by the provider in electronic medical record. The facility contracted with a new lab service to ensure results are available to providers in the electronic medical record. Lab orders are documented in the record as well as tracked and reviewed at the daily clinical meeting. A document has been created to alert the Interdisciplinary Team of pending lab orders and remains active until the results have been received and communicated to the provider. Documentation of this process will be implemented in the resident record form order to resolution of order including providers response to the lab result. Licensed Staff will be educated regarding timeliness of reporting lab results by Staff Development RN no later than April 30, 2025. D. Clinical ADON/designee will monitor all lab orders to ensure labs were obtained, received by lab, reported through the electronic medical record, communicated to the provider and response by the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 684	Continued From page 17 provider is not present. 3/6/25 9:25 AM - During an interview, E16 confirmed that she was unaware of the critical lab value for R422 E16 stated that her NP would have been on-call that weekend. In addition, E16 confirmed there were no progress notes and no antibiotic orders for R422. E16 also confirmed she ordered the urine analysis and culture, but did not follow up on the results. 3/6/25 9:48 AM - During an interview via telephone E13 (NP) confirmed that she was not notified of R422's positive urinary tract infection results. 2. Review of R9's clinical record revealed: 1/16/24 - R9 was admitted to the facility. 12/18/24 6:43 PM - A nursing progress note documented that R9 had contacted 911 services due to having hallucinations. Due to the resident having a history of the behaviors, a note was left in the physician communication log and R9 had continued to be monitored. 12/19/24 9:30 AM - A physician's order was written for a urinalysis with a culture and sensitivity to be collected on 12/20/24. 12/20/24 - A urine sample was collected and sent to the lab for analysis and culture. 12/20/24 - A provider note by E13 (NP) documented, " ... Was asked to see patient [R9] today due to complaints of intermittent hallucinations unit manager reports patient having intermittent visual hallucinations. Today's urinalysis results showed 2+protein and trace of	F 684	provider, daily x 14, weekly x 2, monthly x 2. Results will be reported through the QA process until 100% compliance has been achieved. A. R35 continues to reside at the facility. B. All residents with hold/give parameters have the potential to be affected. C. RCA: Nursing staff failed to follow parameters as ordered by the provider. Providers will review medications currently ordered with parameters to determine if those parameters are still appropriate per standard of care. When determined that parameters are required, Unit manager/designee will reconcile with nurse giving meds during med pass that parameters were followed and documented in electronic medical record. Licensed Staff will be educated regarding following parameters by Staff Development RN no later than April 30, 2025. D. Unit manager/ designee will compile reconciliation information daily x 14, weekly x 2, then monthly x 2 until. Results will be reported through the QA process until 100% compliance has been achieved. A. R41 continues to reside at the facility. B. All residents with hold/give parameters	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 684	Continued From page 18 leukocytes ... Urinalysis review. Will await urine culture and sensitivity ...". 12/23/24 12:26 PM - The lab results revealed the urine culture was positive for a urinary tract infection with a positive growth of greater than 100,000 colony forming units of Serratia Marcescens (a type of bacteria). 12/23/24, 12/24/24 and 12/25/24 - The clinical record lacked evidence that R9's UTI was addressed. 12/26/24 1:28 PM - A progress note by E14 (RN) documented, "Provider onsite and reviewed UA C&S results. New order for gentamicin 40mg/ml - administer 7 mls BID x 5 days for UTI. Probiotic to be ordered BID for 10 days." 12/26/24 1:35 PM - A physician's order was written for gentamicin sulfate (antibiotic) 40mg/mL, inject 3.5 mL in the muscle two times a day for urinary tract infection for 5 days. There was a delay of two days before the urine results were reviewed and R9 received antibiotics. 3/4/25 2:20 PM - An interview with E15 (RN) stated that if the unit manager is working, they will keep track of results for labs. Otherwise, the supervisor will be available to keep track of lab results. If a lab result is critical, the result can be called to the on-call provider if a provider is not present. 3/4/25 2:29 PM - An interview with E14 stated that lab results automatically populate in the resident's chart. E14 stated that positive results	F 684	have the potential to be affected. C. RCA: Nursing staff failed to follow parameters as ordered by the provider. Providers will review medications currently ordered with parameters to determine if those parameters are still appropriate per standard of care. When determined that parameters are required, Unit manager/designee will reconcile with nurse giving meds during med pass that parameters were followed and documented in electronic medical record. Licensed Staff will be educated regarding following parameters by Staff Development RN no later than April 30, 2025. D. Unit manager/ designee will compile reconciliation information daily x 14, weekly x 2, then monthly x 2. Results will be reported through the QA process until 100% compliance has been achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 684	Continued From page 19	F 684		

also get faxed to the facility where the fax is monitored each shift for any results. E14 stated, "If there was a positive urinary culture result, we try to let the provider know immediately so the medication can be ordered for the resident since the provider does not order anything until the culture results are completed."

3. Review of R35's clinical record revealed:

8/17/22 - R35 was admitted to the facility.

4/30/24 - A physician's order for lisinopril 10 mg give one tablet by mouth one time a day for hypertension (high blood pressure). Hold for systolic blood pressure less than 100 and hold if heart rate is less than 60.

7/10/24 - The July MAR documented R35 had a blood pressure listed 120/77 and heart rate of 56 and a signature indicating lisinopril medication was administered.

7/1/24 - 7/23/24 - A pharmacist's medication regimen review documented that for R35, recommendation to the facility: "[R35] is receiving lisinopril 10mg with parameters to hold is systolic blood pressure (SBP) is less than 100 or heart rate (HR) less than 60 and was the medication was given (per MAR)."

9/20/24 - A physician's order for lisinopril 10 mg give 0.5 tablet by mouth one time a day for hypertension (high blood pressure). Hold for systolic blood pressure less than 100 and hold if heart rate is less than 60.

12/27/24 - The December MAR documented R35 had a blood pressure listed 114/75 and heart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 684	Continued From page 20 rate of 55 and a signature indicating lisinopril medication was administered. 1/1/25 - 1/13/25 - A pharmacist's medication regimen review documented that for R35, recommendation to the facility: "[R35] is receiving lisinopril 10mg with parameters to hold is systolic blood pressure (SBP) is less than 100 or heart rate (HR) less than 60 and was the medication was given (per MAR)." 3/6/25 10:30 AM - An interview with E18 (RN) confirmed that if a resident has vitals outside the parameters medication should be held and notification to the provider if an ongoing pattern. E18 confirmed that R35 received the lisinopril on 12/27/24 per the MAR. 4. Review of R41's clinical record revealed: 3/3/22 - R41 was admitted to the facility. 12/4/24 - A physician's order for cozaar 25 mg give 50 mg tablet by mouth one time a day for hypertension (high blood pressure). Hold for systolic blood pressure less than 120. 12/5/24- The December MAR documented R41 had a blood pressure of 119/68 and a signature indicating cozaar medication was administered. 12/9/24 - The December MAR documented R41 had a blood pressure of 110/70 and a signature indicating cozaar medication was administered. 12/14/24 - The December MAR documented R41 had a blood pressure of 112/76 and a signature indicating cozaar medication was administered.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 684	Continued From page 21 12/15/24 - The December MAR documented R41 had a blood pressure of 116/83 and a signature indicating cozaar medication was administered. 12/1/24 - 12/19/24 - A pharmacist's medication regimen review documented that for R41, the pharmacist recommendation to the facility: "[R41] is receiving cozaar with parameters to hold is systolic blood pressure (SBP) is less than 120. On 12/5, 12/9, 12/14, and 12/15 SBP was less than 120 and the medication was given (per MAR)." 3/6/25 10:30 AM - An interview with E18 (RN) confirmed that if a resident has vitals outside the parameters medication should be held and notification to the provider if an ongoing pattern. E18 confirmed that R41 received the lisinopril on the aforementioned dates per the MAR. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 684		
F 689 SS=D	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 interviews and record review, it was determined that for one (R4) out of three residents reviewed for accidents, the facility failed	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
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 22 to implement the correct assistant device to transfer the resident to prevent accidents. Based on review of the facility's evidence to correct the non-compliance and the facility's substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 12/20/24. Findings include: Review of R4's clinical record revealed: 7/11/23 - R4 was admitted to the facility. 11/20/23 - A new diagnoses for R4 included, but was not limited to, peripheral autonomic neuropathy, lack of coordination, generalized muscle weakness and unsteadiness on the feet. 10/16/24 - A care plan documented that R4 was high risk for falls related to impaired gait/balance. 11/15/24 - A new order documented R4 was a total assist for transfer and to be transferred with two staff using a Hoyer lift. 12/4/24 - R4's annual MDS documented a BIMS score of 15, revealing an intact cognitive state. R4 was documented with impairments on both sides for upper and lower extremities and was dependent on staff for transferring. 12/14/24 12:35 AM - A facility progress note by E6 (RN) documented, "Resident in shower room getting ready for a shower. When lowering resident into shower chair resident started to sit himself down, even after staff (CNA and RN) repeatedly told him not to sit yet. Resident started slipping out of sling and he was gradually lowered to the ground. once resident was sitting on the ground, we repositioned the sling and was able to	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 23 hoyer lift him into the chair. Resident had no c/o pain during or after the entire process. Resident and RN report no injuries ...". 12/16/24 10:46 AM - A facility incident report revealed that R4 had a witnessed fall while being transferred using a sit-to-stand transfer and the resident was a Hoyer lift for transferring. R4 slipped out of the sling and was lowered to the floor by the staff where no harm occurred to the resident. 3/4/25 9:53 AM - During an interview E6 stated that E7 (CNA) and her, were transferring R4 to a shower chair using the sit-to-stand transfer. E6 stated that R4 was already in a sling for a sit-to-stand transfer when she came to assist and did not stop to check if that was the correct mode of transfer for R4. When R4 was being lifted in the sit-to stand method, R4 was trying to sit and could not get his legs back up. E6 stated that they lowered him to the floor and assessed him and he had no injuries. 3/4/25 10:47 AM - During an interview E7 stated that they used a sit-to stand transfer of R4 to the shower chair. When R4 was lifted, he began to "wiggle" and then he was lowered to the floor. E7 stated R4 was supposed to be a Hoyer lift transfer and R4 did not have any injuries after the incident. 3/5/25 9:32 AM - During an interview E8 (DOT) stated R4 was changed from a sit-to-stand transfer to a Hoyer lift because R4's participation would not allow him to do the sit-to-stand safely. E8 stated that R4 would not hold on and let go during the sit-to-stand causing him to be a safety risk.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 24 3/6/25 9:05 AM - During an interview E9 (ADON) stated that after the incident re-education was completed that included: lift and transfer competencies, chain of command notification for resident refusals, how to access the transfer status of residents, how to access the Kardex for transfer status of residents, the appropriateness of providing more assistance. The facility audited the evaluations on the Hoyer lift for the residents. In addition, on-going audits are reviewed weekly. The facility created a subcommittee for falls where they are planning to implement additional appropriate signage such as stars for residents at risk. Based on the review of the facility's thorough investigation, documented response, completion of in-service training and audits, staff interviews and no further incidents related to injuries using a Hoyer lift, R4's accident was determined to be past non-compliance. The plan of correction was initiated on 12/14/24 and completed on 12/20/24. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 690	Continued From page 25 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R33) out of one resident reviewed for bowel and bladder, the facility failed to provide services to maintain or restore bowel and bladder continence. Findings include: 1. Review of R33's clinical record revealed: 5/21/24 - R33 was admitted to the facility with the following diagnosis, including but not limited to, unspecified dementia, bipolar disorder, and PTSD (Post Traumatic Stress Disorder).	F 690	F690 Bowel/Bladder Incontinence, Cather, UTI CFR(s): 483.25(e)(1)-(3) A. R33 continues to reside at the facility. Assessment indicates every 2-hour check and change and is care planned for same. B. All residents have the potential to be affected by the deficient practice. C. RCA: Staff failed to adequately assess changes in cognition and toileting abilities. Unit Manager/designee will reassess incontinent residents to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 690	Continued From page 26 5/21/24 - A care plan was initiated for R33 was at risk for bladder incontinence related to dementia with the following interventions: check and change every two hours as needed, clean peri area with each incontinent episode, encourage fluids during the day to promote prompted voiding responses, and monitor and document any possible causes of incontinence. 10/2024 - A review of the October CNA documentation record revealed that R33 was incontinent of urine 33 times out of 94 opportunities and incontinent of bowel 19 out of 90 opportunities. 11/20/24 - A quarterly MDS assessment documented that R33 required substantial/ maximum assist of one for toileting. The MDS also documented that R33 had a BIMS score of 4 indicating cognitive decline and was occasionally incontinent of bladder, frequently incontinent of bowel, and was not indicated for a toileting program. 11/2024 - A review of the November CNA documentation record revealed that R33 was incontinent of urine 44 times out of 91 opportunities and incontinent of bowel 31 out of 90 opportunities. 12/2024 - A review of the December CNA documentation record revealed that R33 was incontinent of urine 46 times out of 95 opportunities and incontinent of bowel 30 out of 93 opportunities. 1/2025 - A review of the January CNA documentation record revealed that R33 was	F 690	determine appropriateness of current toileting schedule and will be adjusted as indicated. Toileting schedules will be communicated to staff via electronic record. Care plans will be updated reflecting appropriate toileting schedule as indicated. Toileting schedule will be reviewed at the time of admission, quarterly, with significant change and PRN. Nursing Staff will be educated regarding toileting schedules by Staff Development RN no later than April 30, 2025. D. ADON/designee will review toileting schedule assessments daily x 14, weekly x 2, monthly x 2 and report findings through QA process until 100% compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 690	Continued From page 27 incontinent of urine 49 times out of 96 opportunities and incontinent of bowel 36 out of 93 opportunities. 2/2025 - A review of the February CNA documentation record revealed that R33 was incontinent of urine 38 times out of 84 opportunities and incontinent of bowel 25 out of 84 opportunities. 2/19/25 - A quarterly MDS assessment documented that R33 required substantial/ maximum assist of one for toileting. The MDS also documented that R33 had a BIMS score of 4 indicating cognitive decline and was frequently incontinent of bladder, always incontinent of bowel, and was not indicated for a toileting program. 3/4/25 10:31 AM - An interview with E11 (CNA) confirmed that R33 is dependent for care and R33 is able to verbalize when he needs to use the bathroom. E11 stated that R33 no longer uses a urinal and has not been on a toileting program that she can recall. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 690		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician,	F 773		4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 773	Continued From page 28 physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined, for two (R442 and R9) out of three residents sampled for laboratory services, the facility failed to promptly notify the ordering medical practitioner of abnormal laboratory results. Findings include: Cross refer F684 1. Review of R422's clinical record revealed: 5/23/24 - R422 was admitted to the facility with diagnoses that included Parkinson's disease, history of a stroke affecting the right dominent side and dementia. 6/13/24 - A physician's order was written for a urinalysis with a culture and sensitivity. 6/16/24 - The results were faxed to the facility supervisor's office which revealed R422's urine culture had a positive growth of enterococcus casseliflavous (a type of bacteria) greater than 100,000 cfu/ml, indicating a urinary tract infection. 3/5/25 - A review of R422's clinical record revealed lacked evidence of the laboratory results and notification of provider. 3/5/25 10:34 AM - During an interview, E2 (DON) stated that all lab results are faxed to the nurse	F 773	F773 Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) A. R422 no longer resides at the facility. B. All residents have the potential to be affected by the deficient practice. C. RCA: Facility was transitioning from lab provider that was unable to upload results to electronic medical record timely. New lab was not fully integrated to deliver results directly to the electronic medical record (EMR). Supervisor failed to adequately inform provider of lab results. The facility contracted with a new lab service to ensure results are available to providers in the electronic medical record. Lab orders are documented in the record as well as tracked and reviewed at the daily clinical meeting. A document has been created to alert the Interdisciplinary Team of pending lab orders and remains active until the results have been received and communicated to the provider. Documentation of this process will be implemented in the resident record form order to resolution of order including providers response to the lab result. Licensed Staff will be educated regarding timeliness of reporting lab results by Staff Development RN no later than April 30,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 773	Continued From page 29 supervisor's office. If a lab result is positive the supervisor or the nurse assigned to the resident notifies the on-call provider if a provider is not present. 3/6/25 9:25 AM - During an interview, E16 (MD) confirmed that there was no evidence of provider notification, progress notes. E16 confirmed the lab results were positive and she was not notified. 2. Review of R9's clinical record revealed: 1/16/24 - R9 was admitted to the facility. 12/19/24 9:30 AM - A physician's order was written for a urinalysis with a culture and sensitivity to be collected on 12/20/24. 12/20/24 - A urine sample was collected and sent to the lab for analysis and culture. 12/23/24 12:26 PM - The lab results revealed the urine culture was positive for a urinary tract infection with a positive growth of greater than 100,000 colony forming units of Serratia Marcescens (a type of bacteria). 12/26/24 1:28 PM - A progress note by E14 (RN) documented, "Provider onsite and reviewed UAC&S results. New order for gentamicin (antibiotic) 40mg/ml - administer 7 mls BID x 5 days for UTI. Probiotic to be ordered BID for 10 days." There was a delay of two days before the provider was notified and reviewed the urine results. 3/4/25 2:20 PM - An interview with E15 (RN)	F 773	2025. D. Clinical ADON/designee will monitor all lab orders to ensure labs were obtained, received by lab, reported through the electronic medical record, communicated to the provider and response by the provider, daily x 14, weekly x 2, monthly x 2 until 100% compliance has been achieved. Results will be reported through the QA process. A. R9 continues to reside at the facility. The result of R9□s culture revealed a specific bacterium, however R9 did not meet McGeers criteria for a Urinary Tract Infection. B. All residents have the potential to be affected by the deficient practice C. RCA: provider was not made aware of results nor were they reviewed by the provider in electronic medical record. Lab orders are documented in the record as well as tracked and reviewed at the daily clinical meeting. A document has been created to alert the Interdisciplinary Team of pending lab orders and remains active until the results have been received and communicated to the provider. Documentation of this process will be implemented in the resident record form order to resolution of order including providers response to the lab result. Licensed Staff will be educated regarding timeliness of reporting lab results by Staff Development RN no later than April 30, 2025. D. Clinical ADON/designee will monitor all lab orders to ensure labs were obtained, received by lab, reported	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 773	Continued From page 30 stated that if the unit manager is working, they will keep track of results for labs. Otherwise, the supervisor will be available to keep track of lab results. If a lab result is critical, the result can be called to the on-call provider if a provider is not present. 3/4/25 2:29 PM - An interview with E14 stated that lab results automatically populate in the resident's chart. E14 stated that positive results also get faxed to the facility where the fax is monitored each shift for any results. E14 stated, "If there was a positive urinary culture result, we try to let the provider know immediately so the medication can be ordered for the resident since the provider does not order anything until the culture results are completed." 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2.	F 773	through the electronic medical record, communicated to the provider and response by the provider, daily x 14, weekly x 2, monthly x 2 until 100% compliance has been achieved. Results will be reported through the QA process.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 842		4/30/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 31 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(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(h)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 32 (ii) A record of the resident's assessments; (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 that for two (R33 and R47) out of five residents reviewed for unnecessary medications, the facility failed to have medical records that accurately documented with R33's and R47's medication having an inaccurate indication. Findings include: 1. Review of R33's clinical record revealed: 5/21/24 - R33 was admitted to the facility with the following diagnoses, including but not limited to, unspecified dementia, bipolar disorder, and PTSD (Post Traumatic Stress Disorder). 12/24/24 - A review of physician's orders documented trazadone (anti-depressant) 150 mg give 0.5 mg tablet by mouth in the evening for insomnia. 3/4/25 9:51 AM - An interview with E5 (Psych NP) revealed that R33 is taking trazadone for PTSD and not insomnia. E5 confirmed that she will update the diagnosis for use on R33's physician orders. 2. Review of R47's clinical record revealed:	F 842	F842 Resident Records □ Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) A. R33 continues to reside at the facility. Diagnosis has been updated to PTSD for the medication in question. B. All residents with anti-depressant medication orders have the potential to be affected by the deficient practice. C. RCA: Interdisciplinary team including the Psych Nurse Practitioner failed to identify appropriate diagnoses accompanied medications. All current antidepressant medication orders will be reviewed by the Interdisciplinary Team (IDT) to ensure appropriate diagnosis is provided. Any new anti-depressant orders will be reviewed by the IDT to ensure appropriate diagnosis is in place during daily clinical meeting and during weekly Psych/Gradual Dose Reduction (GDR) meeting. Licensed Staff will be educated regarding appropriate diagnosis for psychoactive medications by Staff Development RN no later than April 30,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. BUILDING _____ B. WING _____	C 03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD MILFORD, DE 19963

(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 33 11/26/24 - R47 was admitted to the facility with the following diagnoses, including but not limited to, anxiety disorder, major depressive disorder, unspecified dementia, and PTSD. 2/28/25 - A review of physician's orders documented risperidone (antipsychotic) 0.5 mg give one tablet by mouth two times a day for agitation. 3/4/25 9:51 AM - An interview with E5 (Psych NP) revealed that agitation is not a proper indication for use of risperidone. E5 confirmed that she will update the diagnosis for use on R47's physician orders. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 842	2025. D. Clinical ADON/designee will review anti-depressant orders for appropriate corresponding diagnosis daily x 14, weekly x 2, then monthly x 2 and report findings through QA process until 100% compliance is achieved. A. R47 continues to reside at the facility. Diagnosis has been updated for the medication in question. B. All residents with anti-psychotic medication orders have the potential to be affected by the deficient practice. C. RCA: Interdisciplinary team including the Psych Nurse Practitioner failed to identify appropriate diagnoses accompanied medications. All current anti-psychotic medication orders will be reviewed by the Interdisciplinary Team (IDT) to ensure appropriate diagnosis is provided. Any new anti-psychotic orders will be reviewed by the IDT to ensure appropriate diagnosis is in place during daily clinical meeting and during weekly Psych/Gradual Dose Reduction (GDR) meeting. Licensed Staff will be educated regarding appropriate diagnosis for psychoactive medications by Staff Development RN no later than April 30, 2025. D. Clinical ADON/designee will review anti-psychotic orders for appropriate corresponding diagnosis daily x 14, weekly x 2, then monthly x 2 and report findings through QA process until 100% compliance is achieved.	