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 12, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.		
	A Recertification and Complaint Survey was conducted by Healthcare Management Solutions LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B.		
	Survey Dates: 03/09/26 – 03/12/26 Survey Census: 62 Sample Size: 23 Supplemental Residents: 7		
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 12, 2026: F600, F657, F684, F689, F700, F812, and F883.		

Provider's Signature [signature] Title LNHA Date 3.27.26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **085051**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	**100 DELAWARE VETERANS BLVD , MILFORD, Delaware, 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
E0000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality on 03/09/2026 – 03/12/2026. The facility was found to be in compliance with 42 CFR 483.73.	E0000		03/26/2026
F0000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/09/26 – 03/12/26 Survey Census: 62 Sample Size: 23 Supplemental Residents: 7	F0000		03/26/2026
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F0600	F0600 Free from Abuse and Neglect CFR(s): 483.12(a)(1) Resident R4 was heard yelling down the hall and staff immediately responded to the area where they found resident R4 lying on the floor and bleeding from a nose laceration and c/o pain to his left wrist and shoulder. Resident R8 was in the vicinity at the time of the incident. Nursing Supervisor/RN reviewed the camera and identified that the resident R4 was pushed by R8 resulting in significant injury. Resident R4 was immediately transferred to the ER for evaluation and was diagnosed with closed left radius fracture, closed displaced comminuted right proximal humerus fracture, and a closed displaced right distal clavicle fracture. Upon his return to the facility R4 was placed on new unit away from R8. R8 was immediately placed on 1:1	04/26/2026

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 reverse for further 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.

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

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F0600 SS = G	Continued from page 1 This REQUIREMENT is NOT MET as evidenced by: Based on record reviews, interviews, and review of the facility's policy, the facility failed to ensure four of nine sampled residents (Resident (R) 4, R46, R8, and R41) reviewed for abuse were free from resident-to-resident physical abuse. On 07/22/25, R8 pushed R4 to the ground. As a result, R4 sustained a closed left radius fracture, a closed, displaced, comminuted right proximal humerus fracture, and a closed, displaced right distal clavicle fracture. Findings include: 1.Review of the facility's "5-day Follow Up Report" dated 07/25/25 provided by the Administrator, revealed that at the time of the incident on 07/22/25 at 5:30 PM, staff heard someone screaming. Upon entering the hallway, staff observed R4 sitting on the floor holding his head. Staff immediately ran down the hallway to investigate. The Nursing Supervisor/Registered Nurse (NS/RN) reviewed the surveillance video and noted R8 walking down the hall into R4's room. After a few seconds, R4 was seen coming out the room with R8 behind him. R8 pushed R4 to the floor. Staff immediately assessed R4, called 911 and transferred R4 to the emergency room (ER) for further evaluation. While at the hospital, R4 was diagnosed with fractures of the right shoulder and left wrist. R8 was placed on hourly safety checks as well as being seen by psych services due to some residual concerns from the incident. Review of R4's "Admission Record" located in the R4's electronic medical record (EMR) located under the "Profile" tab revealed R4 was admitted to the facility on 06/25/25 with diagnoses of dementia with agitation, depression, anxiety, and post-traumatic stress disorder (PTSD). Review of R4's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 07/01/25 located in the EMR under the "MDS" tab revealed a "Brief Interview for Mental Status (BIMS)" score of 12 out of 15, which indicated the resident was moderately cognitively impaired. Further review revealed that R4 did not display any behaviors during the review period. Review of R4's "Health Status Note" dated 07/22/25 located in the EMR under the "Progress Notes" tab revealed that at approximately 7:05PM, staff heard loud screaming and observed R4 on the floor. The fall was	F0600	Continued from page 1 supervision and then transitioned to hourly safety checks with a psychiatric consult, medication review, care plan was updated with specific triggers and interventions. All residents have the potential to be affected. A 100% facility wide audit of behavioral risk assessment was completed for all residents with cognitive impairments and a history of increased behaviors. Residents identified at risk were placed on enhanced supervision, reviewed for room placement and compatibility, and individualized behavioral interventions. The facility installed visual cues (personal identifiers at the residents' room door) to help reduce wandering into other resident bedrooms. Root cause was failure to identify and effectively manage resident R8's known history of aggression and poor impulse control resulting in insufficient supervision and lack of timely intervention to prevent a foreseeable resident-to-resident altercations. Systemic changes: Supervision Guidelines – residents with cognitive impairment/behavioral concerns will remain within staff's line of sight when out of bed and in common areas. The facility installed visual cues (personal identifiers at the resident's room door) to help reduce wandering into other residents' bedrooms. In addition, the residents will be encouraged to participate in structured staff-directed activities appropriate to their needs and abilities to ensure safety, engagement, and supervision. New Policy Development – a policy was developed regarding resident placement on the memory care unit along with a criteria tool. The education department or designee will educate Unit managers, Nursing supervisors, nursing admin on the new behavior management unity policy and assessment tool and supervision guidelines; the activity staff will also be educated on supervision guidelines. All staff will be reeducated on abuse, neglect, and mistreatment. The facility has contacted the Alzheimer's Association to complete in-person training at DVH on April 30, 2026. All nursing staff will be re-educated by the Education Department on abuse, neglect, and mistreatment, including resident-to-resident altercations and identification of triggers. The unit managers, nursing supervisors, nursing admin. will be educated on the behavior management unit policy, assessment tool and the supervision guidelines. Activities staff will also receive education on the supervision guidelines. All education will be completed by April 26, 2026. These trainings and subsequent audits are intended to reduce the risk of resident abuse and neglect and promote a	

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F0600 SS = G	Continued from page 2 unwitnessed. The resident c/o [complaint of] right shoulder pain and left wrist pain. Noted active bleeding from laceration on forehead measuring approximately 5cm [centimeter] x 1cm, and a second laceration on the nose measuring approximately 1cm x 1cm. Resident appeared clammy and diaphoretic...Resident was unable to be moved safely; nurse supervisor was notified immediately and 911 was called. EMTs [Emergency Medical Technicians] arrived approximately at 1930 [7:30PM] and transported resident to the ER for further evaluation...." Review of R4's "Post Fall Evaluation" dated 07/22/25 located in R4's EMR under the "Assessment" tab revealed that on 07/22/25 at approximately 7:10 PM, R4 experienced an unwitnessed fall in the hallway. At the time of the incident, the resident was ambulating in the hallway but was unable to clearly state the specific activity being performed. The cause of the fall was not immediately evident. The resident's pre-fall fall risk score was 10. Post-fall, the resident was assessed for ongoing fall risk. It was later identified that the fall was contributed to by another resident, who reportedly pushed R4, resulting in the fall. Following the incident, the resident reported constant right shoulder pain rated 10/10 [10 out of 10] ...order was received to send the resident to the ER for further evaluation. Review of the hospital's "After Visit Summary" dated 07/24/25 located in R4's EMR under the "Miscellaneous" tab revealed R4 was admitted to the hospital on 07/22/25 with a primary diagnosis of a closed, displaced distal clavicle fracture. Further review revealed R4 also sustained a closed left distal radius fracture, and closed, displaced comminuted right proximal humerus fracture. During an interview on 3/09/26 1:43 PM, R4 stated that he was shoved down by one of the residents [R8] who came into his room. R4 stated that he wanted the resident to leave and then he shoved me down. R4 stated that he hurt his right arm and wrist and was transferred to the hospital. R4 stated that the police came into the facility to investigate. R4 stated that when he returned from the hospital, they moved him to another unit and that he has not seen the resident [R8] since. R4 stated that he was not afraid and felt safe in the facility. Review of R8's "Admission Record" located in the R8's EMR located under the "Profile" tab, revealed R8 was admitted to the facility on 05/21/24 with diagnoses of dementia with mood disturbances, bipolar disorder,	F0600	Continued from page 2 safe, supportive environment. The DON/designee will complete the behavioral management (abuse and neglect) and common area monitoring audits daily for 7 days, weekly for 2 weeks, and monthly for 2 months, with a goal of 100% compliance during each phase of the audit schedule. If 100% compliance is not achieved, audits will continue until the goal is met. Staff educators or designee will report through QAPI to ensure compliance. Resident R41 walked over to resident R8 who was sitting in a chair in the TV room and touched him on the chest resulting in a physical altercation between resident R41 and R8. Staff immediately intervened, separating the residents R41 and R8 and assessing them for injuries. Neither resident was able to give details or recall the event when later interviewed. Care plan updated for R41 to reflect boundary issues and intrusive behaviors. For resident R8 the facility continued enhanced supervision and behavior management plan. For both residents separate seating was assigned and monitoring in place for common areas. All residents have the potential to be affected by this deficient practice. The facility conducted a 100% audit of all residents who utilize common areas, with a focus on identifying those with behavioral risks, including a history of aggression or poor impulse control. Residents identified as having increased behavioral risks have had their care plans reviewed and updated to include appropriate interventions. The facility implemented a monitoring tool to ensure appropriate supervision. The monitoring tool ensures that residents in common areas remain within staff line-of-sight, the residents will be encouraged to participate in structured staff-directed activities appropriate to their needs and abilities to ensure safety, engagement, and supervision. The staff assignments will be adjusted as needed to support adequate supervision and timely intervention. Root cause was failure to implement effective interventions for residents with poor boundaries and known behavior triggers, combined with inadequate supervision in a common area, resulting in a preventable altercation. Systemic changes: Supervision Guidelines – residents with cognitive impairment/behavioral concerns will remain within staff's line of sight when out of bed and in common areas. In addition, the residents will be encouraged to participate in structured staff-directed activities appropriate to their needs and abilities to ensure safety, engagement, supervision and to help prevent idle time and agitation that may lead to increased	

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F0600 SS = G	Continued from page 3 severe with psychotic features, PTSD, insomnia, and depression. Review of R8's admission "MDS" with an ARD of 05/28/25 revealed R8 had a "BIMS" score of five out of 15, which indicated the resident was severely cognitively impaired. Further review revealed that R8 did not display any behaviors during the review period. Review of R8's "comprehensive care plan" initiated on 05/23/24 and last revised on 02/02/26, located in R8's EMR under the "Care Plan" tab revealed that R8 has a behavior problem related to bipolar disorder and dementia. R8 wanders. He refuses care at times. R8 becomes combative and has demonstrated physical aggression toward staff and others, including biting a certified nurse aide (CNA) on the shoulder and swinging his walker at a CNA. The pertinent interventions directed staff to anticipate and meet the resident's needs, divert resident by giving them alternative objects or activities, intervene as necessary to protect the rights and safety of others, and conduct safety checks every shift. On 09/27/25, the facility updated the care plan directing staff to conduct safety checks every hour. On 09/30/25 the facility updated the care plan directing staff to redirect the resident when others are in his personal space or when he is in other resident's space. Review of R8's "safety checks" dated 07/22/25 – 07/30/25 provided by the Administrator, revealed staff initiated and continued hourly safety checks of R8 to monitor the resident more closely. During an interview on 03/12/26 at 11: 25 PM, CNA11 stated that at the time of the incident, she was doing rounds with another CNA and helping another resident. She then heard R4 scream and noted that he was on the floor. She went to assist R4 and saw R8 coming down the hall, but she did not see what took place. After the incident, R8 was placed on hourly safety checks. During an interview on 03/12/26 at 12:51 PM, Assistant Director of Nursing (ADON) 1 stated that on 07/22/25, she just came on shift, at which time staff notified her that R4 was on the floor. She went to assess R4 and noted an abrasion on his forehead. She called 911. ADON1 stated she reviewed the camera footage to see what happened. She witnessed R8 walking down the hallway into R4's room and a few minutes later, R4 was seen coming out of his room with R8 behind him. R8 then pushed R4, who fell to the floor. After the incident, staff implemented hourly checks and obtained orders for psych to see R8. Additionally, they moved R4 to another	F0600	Continued from page 3 behaviors. The education department or designee will reeducate all staff on abuse, neglect, mistreatment, to include resident to resident altercations and triggers; the Unit managers, nursing supervisors, nursing admin and activity staff will also be educated on supervision guidelines. All nursing staff will be re-educated by the Education Department on abuse, neglect, and mistreatment, including resident-to-resident altercations and identification of triggers. The unit managers, nursing supervisors, nursing admin. will be educated on the behavior management unit policy, assessment tool and the supervision guidelines. Activities staff will also receive education on the supervision guidelines. All education will be completed by April 26, 2026. These trainings and subsequent audits are intended to reduce the risk of resident abuse and neglect and promote a safe, supportive environment. The DON/designee will complete the behavioral management (abuse and neglect) and common area monitoring audits daily for 7 days, weekly for 2 weeks, and monthly for 2 months, with a goal of 100% compliance during each phase of the audit schedule. If 100% compliance is not achieved, audits will continue until the goal is met. Staff educators or designee will report through QAPI to ensure compliance. Resident R56 went to resident R46 room and removed the blanket from his bed demanding he leave his house. RN3 heard yelling and went to R46 room to determine the nature of the yelling. Resident R46 was noted sitting on his bed reported R56 hit him in the face. Resident R46 was noted with slight puffiness to his left eye. RN3 immediately intervened and CNA 10 walked R56 back to his room and hourly safety checks were initiated. Resident R56 care plan was updated to reflect wandering, delusions, and aggression. R56 was immediately placed on hourly safety checks. R46 was assessed by an RN and monitored for injuries. All residents have the potential to be affected. A 100% behavioral audit was completed to identify any resident will increase behaviors. Interventions include reviewing care plans to ensure interventions are in place to address behavioral concerns. The facility installed visual cues (personal identifiers at the resident's room door) to help reduce wandering into other residents' bedrooms. Root cause was failure to effectively manage wandering and delusional behaviors (misidentification of environment), resulting in unauthorized room entry and physical aggression. The facility installed visual cues	

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F0600 SS = G	Continued from page 4 unit upon his return from the hospital. During an interview on 03/12/25 at 3:21 PM, NS/RN stated that R8 was dependent upon staff for all ADLs. He is independent with ambulation with a walker and requires some cues with eating and physical assistance. NS/RN stated that R8 does get aggressive at time with care. After the incident, R8 was placed on hourly checks. 2. Review of R41's EMR "Face Sheet" under the "profile" tab revealed he was admitted on 1/23/24 with diagnoses from the "Medical Diagnosis" tab including dementia, with agitation, Alzheimer's disease with early onset, depression, restlessness and agitation, bipolar disorder, current episode depressed, severe, with psychotic features, mood [affective] disorder, major depressive disorder, recurrent severe without psychotic features, visual hallucinations, PTSD. Review of R41's EMR significant change "MDS" under the "MDS" tab with an ARD of 08/13/25 with a "BIMS" score that could not be determined due to resident is rarely/never understood and was severely cognitively impaired. The "MDS" indicated R41 had delusions, physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurred one to three days, other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds) behavior occurred one to three days. Review of R41's EMR "Care Plan" under the "Care Plan" tab revealed R41 was at risk for ineffective coping related to dementia with psychotic features, had behaviors like aggressiveness towards others, hallucinations, delusions, easily agitated, sitting on another residents' legs, and tends to get into others personal space. "Physical Aggression Received" note dated 09/27/25 revealed R8 was sitting in a chair in the dayroom when the R41 walked next to his chair and placed his hand on R8's chest. R8 punched R41 in the face with the back of his fist, which R41 responded by punching R8 in his face directly afterwards. The residents were unable to describe what happened. Review of R8's EMR "Progress Notes" tab revealed a	F0600	Continued from page 4 (personal identifiers at the resident's room door) to help reduce wandering into other residents' bedrooms. In addition, the residents will be encouraged to participate in structured staff-directed activities appropriate to their needs and abilities to ensure safety, engagement, and supervision. The education department or designee will reeducate all staff on abuse, neglect, and mistreatment, to include resident to resident altercations and triggers; the Unit managers, nursing supervisors, nursing admin and activity staff will also be educated on supervision guidelines. All nursing staff will be re-educated by the Education Department on abuse, neglect, and mistreatment, including resident-to-resident altercations, identification of triggers and supervision guidelines. Activities staff will also receive education on the supervision guidelines. All education will be completed by April 26, 2026. These trainings and subsequent audits are intended to reduce the risk of resident abuse and neglect and promote a safe, supportive environment. The DON/designee will complete the behavioral management (abuse and neglect) and common area monitoring audits daily for 7 days, weekly for 2 weeks, and monthly for 2 months, with a goal of 100% compliance during each phase of the audit schedule. If 100% compliance is not achieved, audits will continue until the goal is met. Staff educators or designee will report through QAPI to ensure compliance.	

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F0600 SS = G	Continued from page 5 "Follow-up visit Psychiatric Periodic Evaluation" dated 09/30/25 provided by the facility which indicated, "History of Present illness… psychiatric history of Major Depressive Disorder, Post-Traumatic Stress Disorder, insomnia, and dementia, seen today for follow-up psychiatric evaluation and psychotropic medication management. During the visit. the patient was alert and cooperative with the interview. Collateral information from the nursing staff revealed a recent altercation with another resident, during which the patient reportedly placed his hand on the other resident's chest and was subsequently punched in the face. No injury reported. Staff further reported ongoing behavioral concerns, including combativeness with care, intermittent refusal of medications, and episodes of agitation. Despite these behaviors, appetite and sleep patterns have been reported as generally stable." Resident was alert and oriented to person only, had no hallucinations, and no delusions, with poor short term and long term memory, and impaired judgement. There were no other progress notes in the medical record regarding this incident. During an interview on 03/11/26 at 1:56 PM, CNA 6 stated that she has worked with R41 and has seen him be aggressive or violent towards other residents when you enter his space because he doesn't like it. He swings at staff lately but not residents. We redirect, reassure him, tell him what we are doing or trying to accomplish. He hit other people last year. Normally he does not bother unless you touch him or strike at him. R41 wanders and walked up on R8 and R8 usually does not get bothered unless you invade his space. R8 pushed him and R41 pushed back. During an interview on 03/11/26 at 2:16 PM, the Activity Therapist (AT)1 stated "R41 likes to be by himself, with not a lot of noise, and likes to be alone. If something is next to him, it belongs to him. If they try to take his things, he has a problem with it depending on the day. Sometimes, he verbally tells him not to touch it. We redirect other residents away from him. R41 does get into altercations with other residents because he tries to see what is going on. If I see a resident-to-resident altercation I redirect them like if I see R41 going towards other residents or touching a walker, I redirect them before things get too involved. R8 does not hit unless he is provoked." During an interview on 03/12/26 at 2:03 PM, NS/RN stated R8 had his monitoring checks increased from 1 hour to 30-minute checks. He was seen and assessed by psych nurse practitioner, and they increased his	F0600		

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F0600 SS = G	Continued from page 6 antipsychotic (Quetiapine) from 100 milligrams to 150 milligrams in the morning. R41 was on 30-minute checks. 3.Review of the facility's "Initial Incident Report" dated 02/23/26 provided by the Administrator, revealed that on 02/03/26 at 5:53 PM, R56 on the Memory Care unit went into R46's room and removed the blankets from his bed. R46 stated he was hit in the face. The nurse immediately separated and assessed the residents. Staff moved both residents back to their rooms and initiated hourly safety checks for both residents. R46 did not sustain any physical or mental harm. Review of R46's "Admission Record" located in R46's EMR under the" Profile" tab revealed R46 was admitted to the facility on 01/24/24 with diagnoses of depression, anxiety, dementia without behavioral disturbances, PTSD, and insomnia. Review of R46's quarterly "MDS" with an ARD of 01/21/26 located in R46's EMR under the "MDS" tab revealed R46 was rarely or never understood. R46 required substantial to maximal assistance with activities of daily living. During the review period, R46 was noted to experience hallucinations, verbal behavioral symptoms directed toward others on one to three days, other behavioral symptoms not directed toward others on one to three days and wandering behaviors on one to three days. Review of R46's "comprehensive care plan" revised on 02/05/26 in the EMR under the "Care Plan" tab revealed R46 has behavior: cussing and verbally threatening staff, frustration toward staff and others, throws items at staff, refuses medications, aggression with new faces/staff, poor safety awareness. The care plan interventions were updated on 02/05/06 to include hourly safety checks. Review of the "Hourly Safety Checks" dated 02/05/26 through 03/12/26 provided by the Administrator revealed staff were monitoring R46's whereabouts hourly. Review of the "Physical Aggression Received Report" dated 02/03/26 revealed CNA10 went to R46's room and overheard the nurse talking and R56 saying that's mine. Upon entry, CNA10 witnessed R56 in R46's room standing by the sink still saying that's mine. CNA10 walked R56 off the unit to cool off. Further review revealed RN3 heard yelling while she was in another resident's room. When she came out into the hallway, she heard R56 yelling at R46 telling him to get out of here this is my house. Upon arrival to room, RN3 noted R46 sitting upright on the side of the bed. R56 was pulling the	F0600		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **085051**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/12/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE VETERANS HOME	**100 DELAWARE VETERANS BLVD , MILFORD, Delaware, 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
F0600 SS = G	Continued from page 7 covers at the foot of the bed, yelling and telling R46 to get out. RN3 intervened letting R56 know that this was R46's room and assisted R56 out of the room. R46 stated get a gun and shoot him. He hit me in my face. Left eye noted slight puffiness, pupils equal, reactive, and round. Review of R56's "Admission Record" located in R56's EMR under the "Profile" tab revealed R56 was admitted to the facility on 10/31/25 with diagnoses of anxiety, major depressive disorder, dementia with other behavioral disturbances and agitation. Review of R56's admission "MDS" with an ARD of 11/06/25 in the EMR under the "MDS" tab revealed R56 had severe cognitive impairment as evidenced by a "BIMS" score of three out of 15. R56 did not display any behaviors during the review period. R56 required supervision or touching assistance with ambulation. Review of R56's "comprehensive care plan" last revised on 02/06/26 located in the EMR under the "Care Plan" tab revealed R56 exhibits the following behaviors: compulsiveness, repeating words, invading personal space of others, passive aggressiveness, yelling at staff, disruptive at senior center, demanding, false accusations, restlessness, physical aggression, and attempting to assist residents he believes are in need of help. The pertinent interventions directed staff to assist the resident to develop more appropriate methods of coping and interacting. Divert resident by giving them alternative objects or activity i.e., 1 to 1, activity, gave food and fluids. Familiarize resident with own belongings and surroundings. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. One-on-one structured activity or taken out for a walk when getting restless or anxious. The care plan was also updated to include hourly safety checks. Review of the "Hourly Safety Checks" dated 02/05/26 through 03/12/26, provided by the Administrator revealed staff were monitoring R56's whereabouts hourly. During an interview on 03/10/26 at 9:30 AM, R46 denied any abuse or that anyone came into his room and punched him. Attempts to interview CNA10 on 03/12/26 at 3:00 PM and CNA6 at 3:45 PM were unsuccessful. Messages were left for CNA10 and CNA6 to call back for an interview; however, they did not return the call prior to survey	F0600		

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F0600 SS = G	Continued from page 8 exit. During an interview on 03/12/26 at 3:06 PM, the NS/RN stated that R56 was transferred to the dementia/locked unit because of his cognitive decline. R56 likes to swear and R46 does not like that and gets upset. R56 entered R46's room and R46 stated he was hit in the face. Staff immediately intervened, separated, and assessed the residents. After the incident, staff placed R56 on hourly safety checks. During an interview on 03/12/26 at 4:30 PM, the Administrator stated that they are tracking resident to resident incidents, resident complaints, and all reportable incidents. The facility provides mandatory education when there is an allegation of abuse. For the residents on the dementia/locked unit, we have moved residents, implemented stop signs on resident doors to help prevent residents from wandering into other resident rooms, and initiated safety checks (i.e., hourly, every 30 minutes or every 15 minutes) based on the situation. Currently, the facility is looking into some deescalation training for staff. Additionally, the facility has increased staff on the dementia/locked unit so that a staff member is in the common area and can view both halls, and a staff member in the dining/TV area to monitor residents. Review of the facility's policy titled, "Resident Abuse" revised on 04/05/23, revealed, "The Delaware Veterans Home (DVH) is committed to providing safe and respectful environments that support the health and well-being of all people receiving services. DVH seeks to institute guidelines and resources for staff and enforce zero tolerance for those actions which may jeopardize the health, safety or welfare of any person receiving services."	F0600		
F0657 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.	F0657	F0657 Care Plan Timing and Revision CFR (s): 483.21(b)(2)(i)-(iii) Resident R19 had a task for derma sleeves to be applied to bilateral upper extremities when OOB and biker gloves to both hands started on 2/3/25. Resident R19 also had worsening wound to his right buttocks, however his care plan reflected left buttocks excoriation. Also noted for resident R19 was a treatment for penial erosion treatment. None of this information was reflected in the care plan. Resident R19 care plan was immediately updated to reflect the derma sleeves, biker	04/26/2026

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F0657 SS = D	Continued from page 9 (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 by: Based on observation, record review, interview, and facility policy review, the facility failed to ensure care plans were revised and updated for one (Resident (R)19) out of 23 resident care plans reviewed. R19 developed two additional wounds and had protective devices added and were not updated to his comprehensive care plan. This had the potential for the resident to have unmet care needs. Findings include: Review of R19's "Face Sheet" located in the electronic medical record (EMR) and under the "Admissions" tab revealed the resident was admitted to the facility on 12/18/24 with diagnoses of Alzheimer's disease with late onset and dementia (severe) with behavioral disturbances. Review of R19's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/24/25 located in the EMR under the "MDS" tab revealed a "Brief Interview for Mental Status (BIMS)" score of zero out of 15 indicating severe cognitive impairment. Review of R19's "Tasks" located in the EMR under the "Tasks List" tab revealed certified nursing assistants (CNAs) would apply derma sleeves to the residents bilateral upper extremities when out of bed (OOB) and to apply biker gloves to the residents hands with a date initiated of 02/03/25. The "Tasks List" list did	F0657	Continued from page 9 gloves, wound location, and penile treatment. All residents have the potential to be affected by the deficient practice. The facility conducted a 100% audit of all resident care plans, completed by the QA ADON, to ensure accuracy, completeness, and that all appropriate interventions are in place. To sustain compliance, the facility has implemented the following interventions: Daily review of care plans during the clinical meetings to capture real-time updating of care plans to reflect changes in resident condition, behaviors, and required interventions. This process ensures that all resident needs are promptly identified, communicated, and addressed to prevent potential risks. Root cause included failure to ensure timely interdisciplinary communication and real time updating of care plans, resulting in inaccurate and incomplete care plans. Systemic change: All care plan updates are to be captured daily during the morning clinical meeting with participation from the interdisciplinary team (IDT). The staff educator will educate the Unit Managers and Nursing Supervisors on updating care plans for needed interventions. The Staff Educator or designee will provide training to Unit Managers and Nursing Supervisors on timely care plan updates by April 26, 2026. The expectation is that care plans will be reviewed and updated during the morning clinical meeting with participation from the interdisciplinary team (IDT). This process ensures that all resident needs are promptly identified, communicated, and addressed to prevent potential risks. The QA ADON will conduct care plan audits daily for 7 days, weekly for 2 weeks, and monthly for 2 months, with a goal of 100% compliance during each phase of the audit schedule. If 100% compliance is not achieved, audits will continue until the goal is met. Audit results will be reviewed through the QAPI process to ensure ongoing compliance.	

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F0657 SS = D	Continued from page 10 not indicate when the biker gloves were to be applied/removed. Review of R19's "Skin and Wound Note" dated 02/12/26 and located in the EMR under the "Assessments" tab revealed the resident had incontinence associated dermatitis (IAD) to the right buttock. The note indicated the wound was new and measured 2 centimeters (cm) by 1 cm with no depth. There was a moderate amount of serous exudate (thin, watery fluid) noted. The treatment was noted to be to cleanse the wound with normal saline, apply collagen, zinc oxide paste to the base of the wound, leave open to air, change daily and as needed (PRN). Review of R19's "Skin and Wound Note" dated 02/26/26 and located in the EMR under the "Assessments" tab revealed R19's right buttock wound was worsening, the stage/severity was partial thickness. The wound measured 9 cm by 4 cm with no depth. The treatment remained the same. Review of R19's March 2026 "Treatment Administration Record (TAR)" revealed an order dated 02/06/26 for wound care to cleanse the resident's penis with normal saline, pat dry and apply bacitracin ointment twice a day to the erosion site. Review of R19's comprehensive "Care Plan" located in the EMR under the "Care Plan" tab with a date initiated 12/18/24 and revised on 03/04/26 revealed the resident had a focus related to excoriation to his left buttock. Interventions include to provide treatment as ordered and the wound nurse would monitor weekly. Review of another focus area revised on 05/05/25 revealed the resident was at risk for skin impairment related to fragile skin, bowel incontinence, and limited mobility. There was no evidence the resident's "Care Plan" had been updated/revised to include the wound to his right buttock, the wound to his penis, or for the derma sleeves and biker gloves applied on the resident. During an observation on 03/09/26 at 3:28 PM and 03/10/26 at 11:00 AM revealed R19 was up in his Geri-chair in the common area, He had on derma sleeves and biker gloves (fingers exposed) to his bilateral arms and hands. During an interview on 03/11/26 at 12:50 PM, Registered Nurse (RN)1 stated that R19 always had on derma sleeves and open fingered gloves (biker gloves) to protect the backs of his hands and arms. RN1stated that when providing care, the resident tends to flail his arms around hitting staff or his bed rails, so they are put	F0657		

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F0657 SS = D	Continued from page 11 on for protection. During an interview on 03/12/26 at 1:20 PM, Nursing Supervisor (NS)3 who was the nursing supervisor on the unit where R19 resided confirmed the resident's care plans was not revised to reflect his new wounds to his right buttock, wound to his penis, for the derma sleeves and biker gloves. She revealed the facility had morning meetings to discuss when care plans needed updated. However, confirmed that R19's care plan was not updated and should have been. During an interview on 03/12/26 at 2:00 PM the Administrator confirmed R19's care plan was not updated for his newly developed wounds to his right buttock, penis, for the derma sleeves, and the biker gloves that were applied to the resident while out of bed. Review of the facility's policy titled, "Care Plan Development, Implementation and Timing" with a revised date of 03/20/23 revealed, "Care Plans provide direction for individualized care of the resident . . . and should be organized by the individuals specific needs . . . 9. The care plan is a living document that requires ongoing evaluation and revision as the needs of the resident change. 10. Care Plans will be reviewed and/or revised no less than once every three months between comprehensive assessments or with a significant change in resident status."	F0657		
F0684 SS = D	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 interview and record review, the facility failed to provide quality for one (Resident (R)47) of one resident reviewed for physician orders in the sample of 23 residents. Specifically, the facility failed to perform R47's daily weights as ordered. Failure to obtain daily weights as ordered for a resident with congestive heart failure can lead to potential worsening of the condition as well as	F0684	F0684 Quality of Care CFR (s):483.25 The facility failed to ensure the completion of daily weights for resident R47 which could have led to complications related to a diagnosis of congestive heart failure. Weights were immediately reviewed for R47. The medical director was informed of the missed weight and interventions implemented as indicated. All residents have the potential to be affected. The facility immediately ensured 100% of all residents that were receiving weights for a diagnosis of CHF were reviewed to ensure there were no discrepancies that needed to be addressed. This process ensures that all residents with a diagnosis of CHF and on daily weights are promptly identified, communicated, and addressed to prevent potential risks. Root cause was failure in daily weight monitoring	04/26/2026

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F0684 SS = D	Continued from page 12 hospitalization and decline in overall condition. Findings include: Review of R47's electronic medical record (EMR) "Face Sheet" under the "Admission" tab indicated R47 was admitted to the facility on 07/01/25 with diagnoses including acute kidney failure, heart failure, atrial fibrillation, atherosclerotic heart disease, and edema. Review of R47's quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 12/31/25 in the EMR under the "MDS" tab documented R47 had heart failure and renal insufficiency. Review of R47's EMR "Order Summary Report" dated 03/12/26 found under the "Orders" tab in R47's EMR documented an order for daily weights for congestive heart failure dated 07/02/25. The order specified to call the cardiologist if daily weight gain is greater than three pounds. Review of R47's "Care Plan" revision date of 07/02/25 in the EMR under the "Care Plan" tab documented, "fluid imbalances and kidney insufficiency due to congestive heart failure." The goal for R47 was to "remain free of fluid imbalance as evidenced by decreases in or absence of edema, anxiety, agitation, restlessness, confusion, congestion, and jugular vein distension." The intervention was for "daily weights" to be obtained. Review of R47's EMR "Weights and Vitals Summary" under the "Wts/Vitals" tab revealed that no weights were documented on 08/23/25, 08/24/25, 09/27/25, 10/11/25, 10/23/25, 11/06/25, 11/19/25, 11/24/25, 11/26/25, 12/03/25, 12/17/25, 12/18/25, 02/16/26, 02/26/26, and 02/28/26. Interview on 03/11/26 at 10:07 AM, Registered Nurse (RN)2 stated that R47 is to have daily weights due to his diagnosis of congestive heart failure. Interview on 03/12/26 at 8:45 AM, Nursing Supervisor (NS)1 confirmed that R47 has a physician order for daily weights. NS1 stated the staff are to enter the weights are recorded under the "Wts/Vitals" tab in the EMR.	F0684	Continued from page 12 process for residents with a diagnosis of CHF resulting in missed weights. Systemic change: Residents with a diagnosis of CHF with an order for daily weights will be reviewed by the clinical ADON/designee and the IDT team during morning clinicals. Staff educators/designees will complete training for all nursing supervisors, unit managers, and the dietician on the weight review process and reporting. The Staff education/designee will provide training to the unit managers, nurse supervisors and ADONs on the weight process by 4/26/2026. Unit managers will audit weights daily x7 days, weekly x2 weeks, monthly x2 with 100% compliance required during each phase of the audit schedule. Dietitian will provide update during QAPI to ensure 100% compliance.	
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25 (d)(1)(2) Resident R51 sustained a skin tear to his left elbow	04/26/2026

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F0689 SS = D	Continued from page 13 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 observations, record reviews, interviews, and document review, the facility failed to prevent an accidents. Specifically, a resident fell from a Hoyer lift during a transfer for one out of three residents (Resident (R)51) reviewed for Hoyer lifts. This failure to prevent an accident which resulted in R51 experiencing actual harm of a skin tear to the resident's right elbow. Findings include: Review of R51's electronic medical record (EMR) "Face sheet" under the "Admissions" tab that R51 was admitted on 02/26/24. Under the EMR section titled "Medical Diagnosis" tab had pertinent diagnosis including spinal stenosis, lumbosacral region, Alzheimer's disease, vascular dementia with other behavioral disturbance, bipolar disorder, pain, spinal stenosis, Review of R51's " quarterly Minimum Data Set (MDS)" in the EMR under the "MDS" tab with an Assessment Referent Date (ARD) of 08/13/25 with a "Brief Interview for Mental Status (BIMS)" score could not be conducted due to resident was rarely/never understood. Review of the "MDS" indicated that R51 was dependent on staff for transfers from bed to chair. Review of R51's "Care Plans" under the "Care Plan" tab in the EMR revealed an "ADL self-care performance deficit r/t [related to] Dementia...is totally dependent on one staff to provide shower... and was dependent on Hoyer lift x2 [with two people assist] ..." Review of R51's "Physician Orders" dated 08/06/24 in the EMR under the "Physician Orders" tab revealed, "Transfer: Hoyer lift..." Review of R51's EMR review under the tab titled "Progress Notes" revealed a "Health Status Note" dated 08/12/25 at 5:46 PM revealed, "resident s/p [status post] fall, while trying to get him back from the shower bed back to his wheelchair, the Hoyer lift tip	F0689	Continued from page 13 when the lift tipped over related to CNA7 pushing the lift feet apart instead of using the electronic button. CNA 6 and CNA 8 reacted quickly and lowered resident R51 to the floor to prevent serious injury. The resident was assessed by the RN charge nurse. An x-ray was completed the next day due to increased signs of pain and was negative for fracture or dislocation. All staff involved were immediately removed from assignment and lift competencies completed before returning to duty. All residents have the potential to be affected. The facility conducted a 100% audit of all residents' transfer status to identify those requiring mechanical lift assistance. Therapy services were consulted to validate that each resident requiring a mechanical lift remains appropriate for that level of assistance and that equipment in use meets the resident's current needs, including weight requirements and functional status. Care plans were reviewed and updated as necessary. This process ensures that all resident transfer needs are accurately identified, communicated, and implemented to prevent potential risk. Root cause included failure in staff competency and adherence to mechanical lift operation protocol. To prevent recurrence, the facility has implemented the following systemic changes: non-compliance with lift procedures will result in immediate removal from duty and retraining the staffing. The staff educator/designee will conduct the following: all nursing staff will complete documented mandatory mechanical lift retraining with return demonstration. Training includes: Proper use of lift controls, required two-person assistance when utilizing mechanical lift for transfers and pre-use equipment safety check. Lift training and competencies to be completed annually for all current staff and with all new employees during orientation. The Staff Educator or designee will ensure that 100% of nursing staff are retrained on mechanical lift use by April 26, 2026. To monitor compliance and the effectiveness of corrective actions, direct observation audits of mechanical lift use will be conducted daily for 7 days, weekly for 2 weeks, and monthly for 2 months, with 100% compliance goal during each phase of the audit schedule. If the goal is not met the audit will be extended until 100% compliance is reached. Audit findings will be reviewed by the QAPI ADON or designee and results, trends, and any identified areas for improvement will be reported at QAPI meetings.	

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F0689 SS = D	Continued from page 14 [sic] over and he was lower [sic] to the floor by the CNAs [Certified Nursing Assistants]..resident [R51] had a skin tear..." Review of R51's EMR "Progress Notes" tab indicated an "Incident Note" dated 08/12/25 at 7:05 PM revealed, "CNA came to me and stated [R51] was on the floor in his sling. The Hoyer lift was being used with the legs widened, to put the resident in his Geri-chair. As the resident was heading to the chair, the Hoyer tipped sideways. The CNAs held the sling on each side of the resident's head, preventing him from hitting anything and resident was lowered to the floor. His L [left] elbow had a 1.0 cm x 0.1cm [centimeter] skin tear...." Review of R51's EMR under the "Progress Notes" tab indicated a "Post Fall Evaluation Fall dated 08/12/2025 at 4:20 PM, Fall was witnessed. Fall occurred in the bathroom.... Activity at the time of fall: transferring via Hoyer with staff assistance of two. Reason for fall: Hoyer tipped sideways. Did an injury occur as a result of the fall: Yes. Injury details: 1.0 cm x 0.1cm skin tear on R [right] elbow. Did fall result in an ER [emergency room] visit/hospitalization: No. Fall Details Note: CNA stated this resident was on the floor in his sling. The Hoyer lift was being used with the legs widened, to put the resident in his Geri-chair. As the resident was heading to the chair, the Hoyer tipped sideways. The CNAs held the sling on each side of the resident's head, preventing him from hitting anything and resident was lowered to the floor. His L [left] elbow had a 1.0cm x 0.1cm skin tear." Review of R51's EMR "Physician Order" under the "Orders" tab revealed an order dated 08/13/25 that indicated, "2- view X-RAY to rt [right] humorous, rt hand and rt forearm." The facility's investigation revealed the Hoyer tipped to the side because CNA7 pushed the lift's feet apart instead of using the button. CNA6 and CNA8 lowered him to the ground. Statements from the CNAs involved revealed the same conclusion. Review of R51'sEMR under the "Progress Notes" tab revealed a note titled "Lab Results" dated 08/13/25 at 6:05 PM revealed, "[R51] lab results hand [2 views] right, no gross fracture or dislocation, humerus [minimum of 2 views] Right no acute fracture or dislocation, Forearm [2 views] Right, no fracture or dislocation. review with team health provider with no new order." During an interview on 03/12/26 at 8:49 AM, Nursing	F0689		

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F0689 SS = D	Continued from page 15 Supervisor/Registered Nurse [NS/RN] stated that R51 was dependent with ADLs, used a Hoyer lift with two people assist to transfer. NS/RN stated that anyone who uses a Hoyer Lift or a sit to stand lift needed to have two people to operate the lift safely. The incident was two CNAs [CNA6 and CNA8] that lowered [R51] in the bathroom, to the floor and he had an elbow injury. The two CNAs who were involved had Hoyer lift reeducation. We evaluated their competencies and those two people had extra reeducation. They were agency staff who are still working with us but not working today. [R51] uses a recliner Geri chair." During an interview with CNA6 on 03/12/26 at 10:35 AM, showed the Joerns Hoyer Advanced 340 and stated "it is less steady and the one they had an accident with. This lift the CNA had to manually push a foot pedal to open the legs. It is stored in the shower room and rarely used." During an interview on 03/12/26 at 1:56 PM, NS/RN stated, "[R51] was using the manual mechanical lift at the time. We educated the staff as an intervention. There was no change in lift use. It was a witnessed fall. Staff were educated using mechanical lift. The CNAs observed the Hoyer tilting and lowered him to the floor. The straps were maybe more to one side than the other." During an interview on 03/12/26 at 2:11 PM, the Director of Nursing (DON) stated, "I was doing my rounds and found out [R51] was having pain in his right arm because he fell out of the lift. He was getting a shower and when they were putting him back into the chair is when he fell. The CNAs were using the electric Hoyer lift. The two CNAs [CNA6 andCNA8] and [CNA7] were operating the machine. [CNA7] was on light duty and was not supposed to be using the Hoyer lift. [CNA7] was trying to get the legs open, and it did not open. She was trying to pull the legs out and it started tipping to the side. The other two CNAs [CNA6 and CNA8] lowered him to the floor so he would not have too much injury. He was grimacing and making a moaning noise for his right elbow movement. The facility did x-rays and they showed no broken bones. [CNA7] was not supposed to be using the lift anyway. Maintenance and the DON looked at it and there were no problems with the Hoyer lift. She [CNA7] no longer works here after this incident. We did competencies with all the staff, and they were able to demonstrate proper use of the Hoyer Lift." Review of the facility's undated document titled, "Delaware Veterans Home Hoyer Lift Competency" provided by the Administrator revealed that an evaluator would	F0689		

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F0689 SS = D	Continued from page 16 mark either pass or fail with a space for follow up needed. The Administrator stated that the facility had no specific policy and procedure for Hoyer Lifts, just this Competency document. The Procedure indicated, "...Ensure two staff members are present when using the lift... 8. Position Hoyer Advance lift with legs open as far under the bed as possible (keep brakes off). Lower cradle to allow sling to be attached. 9. Attach both sides of the sling to their respective side of the cradle. Short straps at top, long straps at bottom to facilitate sitting position. 10. Utilizing the handheld control or the control panel, lift resident up until buttock is above mattress. Grasp residents' legs and turn so legs are off the bed. 11. Roll Hoyer Advance away from the bed. Position resident over desired location (chair, wheelchair). 12. Lower resident into place...".	F0689		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to assess the entrapment risk of bedrails used for mobility assistance and failed to	F0700	F 0700 Bedrails CFR(s): 483.25(n)(1)-(4) Resident R19 was admitted with severe Alzheimer's disease, during wound care resident was noted to have ¼ rails on his bed but was unable to use the rails when he was turned. According to RN1, resident R19 has never demonstrated the ability to use the rails. Bed rails were immediately removed from R19 bed. All residents have the potential to be affected by the deficient practice. The facility conducted a 100% audit of all residents to identify individuals with bed rails and to determine each resident's physical and cognitive ability to safely and effectively utilize ¼ bed rails. For residents identified with bed rails in use, a bed rail assessment was completed to evaluate safety, functional ability for transfers and bed mobility. Corrective actions implemented include: immediate removal of bed rails for any resident who did not demonstrate the ability to safely use them. Care plan review and updates to reflect appropriate interventions. This process ensures that all residents with bed rails are appropriately assessed, monitored, and provided with the least restrictive and safest intervention to prevent injury and maintain compliance. Root cause includes failure to assess functional ability related to bed rail usage. System change: a bed rail assessment will be completed: upon admission, with any significant change in condition and quarterly. Bed rails will not be implemented until: less restrictive	04/26/2026

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F0700 SS = D	Continued from page 17 obtain consents for three of eight residents (Resident (R)19, R24, and R37) reviewed for accident hazards out of a total sample of 23 residents. Additionally, R24's first bed rail assessment indicated the resident did not need bed rails; however, bed rails were on the bed. Failure to assess and determine hazards could lead to injury, entrapment, or death. Findings include: 1. Review of R19's "Face Sheet" located in the electronic medical record (EMR) and under the "Admissions" tab revealed the resident was admitted to the facility on 12/18/24 with diagnoses of Alzheimer's disease with late onset and dementia (severe) with behavioral disturbances. Review of R19's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/24/25 located in the EMR under the "MDS" tab revealed a "Brief Interview for Mental Status (BIMS)" score of zero out of 15 indicating severe cognitive impairment. During an observation on 03/10/26 at 3:30 PM R19 was observed in bed with ¼ side rails in the up position on both sides of his bed. There was no evidence in R19's EMR of any assessment of the side rails, any risks or benefits provided, or any consent signed by the resident's representative. During an interview and observation on 03/11/26 at 12:50 PM, Registered Nurse (RN)1 was completing a treatment to the resident's wound. She turned him to his left side, and the resident was unable to grab the side rail. She indicated he was not able to use the side rails that were in the up position for mobility or to hold on to during care. She revealed he has never been able to use the side rails or hold on to them. 2. Review of R24's "Face Sheet" located in the EMR under the "Admissions" tab revealed the resident was admitted to the facility on 06/06/24 with diagnosis of left femur fracture. Review of R24's admission "MDS" with an ARD of 06/12/24 located in the EMR under the "MDS" tab revealed a "BIMS" score of 13 out of 15 indicating the resident was cognitively intact. Review of the quarterly "MDS" with and ARD of 12/10/25 located in the EMR under the "MDS" tab revealed a "BIMS" score of 15 out of 15 indicating the resident was cognitively intact. Review of the "Bed Rail Assessment" dated 06/06/24 and	F0700	Continued from page 17 alternatives have been trialed, deemed necessary and documented. Development of bed rail policy and consent form has been formulated to include: assessment criteria, documentation of alternative interventions trialed, and informed consent requirements prior to use. Training will include: all unit Managers and Nursing Supervisors education on: bed rail assessment process, bed rail policy, and consent requirements. All nursing staff will be educated on entrapment zones. The staffing educator/designee will educate all Unit Managers and Nursing Supervisors on: assessment process for bed rail usage, the new bed rail policy, and consent document. All nursing staff will be educated on entrapment zones. Education will be completed by 4/26/2026. Ongoing education will be incorporated into new hire orientation. The clinical ADON/designee will conduct audits that include: bed rail use and consent documentation daily x 7 days, weekly x2 weeks, and monthly x2 months. All new admissions will be assessed for alternative/bed rail usage. Ongoing compliance will be monitored through the QAPI process to ensure sustained adherence to regulatory requirements and 100% compliance. 2. Resident R24 was noted with ¼ rails in place which he reported he uses for positioning however, resident could not identify if he had been educated on the risks and/or benefits associated with side rail usage. Resident and POA were immediately educated on the risks and benefits of bed rails, and a consent was obtained. All residents have the potential to be affected by the deficient practice. The facility conducted a 100% audit of all residents to identify those with bed rails and evaluate appropriateness of bed rail use. Completion of bed rail assessments for all applicable residents. Education provided to residents and/or POAs regarding risks and benefits. Informed consent obtained for all residents with bed rails. Care plan updates to reflect interventions. This process ensures all residents are appropriately assessed, educated, and protected from potential harm related to bed rail use. Root cause includes failure to provide informed consent/education. System change: a bed rail assessment will be completed: upon admission, with any significant change in condition and quarterly. Bed rails will not be implemented until: less restrictive alternatives have been trialed, deemed necessary and documented.	

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F0700 SS = D	Continued from page 18 located in the EMR under the "Assessments" tab revealed the resident was assessed to not need to have bedrails and the resident signed the assessment stating such. The assessment indicated bed rails were not indicated at this time. Review of the "Bed Rail Assessment" dated 07/17/25 and located in the EMR under the "Assessments" tab revealed the assessment was blank. During an observation and interview on 03/10/26 at 3:55 PM revealed R24 was in bed and ¼ side rails in the up position on both sides of the bed. He indicated he used them for positioning. He could not remember being informed of the risks and benefits prior to his use of the side rails or when the side rails were put on his bed. 3. Review of R37's "Face Sheet" located in the EMR under the "Admissions" tab revealed the resident was admitted to the facility on 02/11/08 with diagnosis of hemiplegia and hemiparesis (paralysis) follow cerebral infarction (stroke) affecting left non-dominant side. Review of R37's quarterly "MDS" with an ARD of 01/14/26 located in the EMR under the "MDS" tab revealed a "BIMS" score of 15 out of 15 indicating the resident was cognitively intact. Review of the "Bed Rail Assessment" dated 03/23/25 and located in the EMR under the "Assessments" tab revealed the assessment was blank. During an observation and interview on 03/09/26 at 3:00 PM revealed R37 was in bed with bilateral ¼ side rails in the up position. R37 stated that he used the side rails for positioning and mobility. He could not remember if anyone had ever went over the risks and benefits with him or when they were put on his bed. During an interview on 03/12/26 at 1:35 PM, the Administrator revealed she thought that ¼ side rails didn't require a consent or the risks and benefit to be explained to the resident and/or representative. She confirmed there were no consents signed or any evidence R19, R24, or R37 or their representative were provided the risks and benefits for side rails being placed on their beds. She further revealed the facility did not have a policy for bed rails.	F0700	Continued from page 18 Development of bed rail policy and consent form has been formulated to include: assessment criteria, documentation of alternative interventions trialed, and informed consent/education requirements prior to use. Training will include: all unit Managers and Nursing Supervisors education on: bed rail assessment process, bed rail policy, and informed consent/education requirements. All nursing staff will be educated on entrapment zones. The staffing educator/designee will educate Unit Managers and Nursing Supervisors on: assessment process for bed rail usage, the new bed rail policy, and consent document. All nursing staff will be educated on entrapment zones. Education will be completed by 4/26/2026. Ongoing education will be incorporated into new hire orientation. The clinical ADON/designee will conduct audits that include: bed rail use and consent documentation daily x 7 days, weekly x2 weeks, and monthly x2 months. All new admissions will be assessed for alternative/bed rail usage. Ongoing compliance will be monitored through the QAPI process to ensure sustained adherence to regulatory requirements and 100% compliance. 3. Resident R37 was noted in his bed with ¼ rails in place which the resident reported he uses for positioning and mobility. However, resident R37 could not remember if he had been educated on the risks or benefits associated with side rail use. Resident R37 and POA were immediately educated on the risks and benefits of bed rails and consent was signed and placed in the resident's chart. All residents have the potential to be affected by the deficient practice. The facility conducted a 100% audit of all residents to identify those with bed rails and evaluate appropriateness of bed rail use. Completion of bed rail assessments for all applicable residents. Education provided to residents and/or POAs regarding risks and benefits. Informed consent obtained for all residents with bed rails. Care plan updates to reflect interventions. This process ensures all residents are appropriately assessed, educated, and protected from potential harm related to bed rail use. Root cause includes failure to provide informed consent/education. System change: a bed rail assessment will be completed: upon admission, with any significant change in condition and quarterly. Bed rails will not	

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F0700 SS = D		F0700	Continued from page 19 be implemented until: less restrictive alternatives have been trialed, deemed necessary and documented. Development of bed rail policy and consent form has been formulated to include: assessment criteria, documentation of alternative interventions trialed, and informed consent/education requirements prior to use. Training will include: all unit Managers and Nursing Supervisors education on: bed rail assessment process, bed rail policy, and informed consent/education requirements. All nursing staff will be educated on entrapment zones. The staffing educator/designee will educate Unit Managers and Nursing Supervisors on: assessment process for bed rail usage, the new bed rail policy, and consent document. All nursing staff will be educated on entrapment zones. Education will be completed by 4/26/2026. Ongoing education will be incorporated into new hire orientation. The clinical ADON/designee will conduct audits that include: bed rail use and consent documentation daily x 7 days, weekly x2 weeks, and monthly x2 months. for all residents with bed rails. All new admissions will be assessed for alternative/bed rail usage. Ongoing compliance will be monitored through the QAPI process to ensure sustained adherence to regulatory requirements and 100% compliance.	
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve	F0812	A. The facility failed to thoroughly dry and remove debris from three of the 6x6x6 stainless steel pans and six of the 6x24x6 stainless steel pans prior to stacking and thoroughly cleaning the blade for one of the two can openers for 61 out of the 62 residents. The root cause of the deficient practice was a failure in the facility's dishwashing and sanitation process, including inadequate staff adherence to established infection control and sanitation protocols, resulting in improperly cleaned and dried equipment. On 3/9/2026, upon notification of this deficient practice, all wet nested pans and dishes that were identified were immediately separated and re-washed, re-sanitized, and air-dried on the drying rack. Additionally, all pans and dishes were re-washed and re-sanitized on 3/09/2026. The can openers were immediately removed from the table assembly, and the can opener and blade assembly were cleaned, sanitized, and reinstalled on 03/09/2026. B. All residents have the potential to be affected by deficient practice. An immediate 100% audit of all storage areas and dish racks was conducted to identify any other improperly stored wet items. No other wet-nested items were found. The two can openers were immediately cleaned and re-sanitized. The two can openers were immediately cleaned and re-sanitized	04/26/2026

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F0812 SS = F	Continued from page 20 food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and facility policy review, the facility failed to ensure kitchen staff thoroughly cleaned and air-dried pots and pans as well as insured one of two can openers had been cleaned. This failure increased the potential risk of foodborne illness and had the potential to affect 61 of 62 residents that received food through dietary services. One resident received nutrition through tube feeding. Findings include: During an observation on 03/09/26 at 10:30 AM, three 6x6x6 stainless steel pans and six 6x24x6 stainless steel pans were stacked together on storage rack were noted to be wet inside with some food debris remaining. During an interview on 03/09/26 at 10:50 AM, the Food Service Director (FSD) stated, "The pans are wet and they shouldn't be. They should be dry before they get put away and the pans should be clean and have no food remining on them." During an observation on 03/09/26 at 11:00 AM, one of two can openers bolted to a preparation table had a black substance on the blade. During an interview at this time, the FSD stated "The blade is dirty. It should be clean." Review of the facility's policy titled, "Food Preparation Area" dated 12/13/06 revealed, "All machines and equipment that require cleaning shall be cleaned after use.....under the heading Washing Pots and Pans. Wash pots and pans thoroughly in the first sink. Use a brush, cloth or nylon scrub pad to loosen the remaining soil. Immerse in second sink, removing all traces of food and detergent. Remove dishes from sanitizer sink to open shelving rack for air drying. Invert glasses, cups and plate covers, pots and pans to allow more thorough drying."	F0812	Continued from page 20 C. Dietary staff were immediately re-educated on proper dishwashing procedures, including the requirement that all dishware be fully air-dried before stacking or storage, and that the can openers must be cleaned and sanitized after each use. All food service staff were instructed to inspect items before using them to ensure they are clean, dry, and free of food debris. Education was completed on 03/30/2026 and included infection control principles and the risk of bacterial growth associated with wet nesting and improperly cleaned equipment. Signs were placed around the drying racks and dish room to remind staff to completely air-dry equipment and pans prior to stacking them. The Food Service Director or designee will provide ongoing supervision to ensure staff adherence to these practices. D. The Food Service Director or designee will conduct 100% audit of all pots, pans, and can openers for cleanliness and complete drying for 5 days x 2 weeks, then weekly for 4 weeks, then monthly x3 months, until 100% compliance is achieved. The findings will be reviewed monthly in the QAPI meeting to ensure compliance	
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that-	F0883	F0883 Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) Resident R5 received the pneumococcal 23 vaccine 11/11/21 with no documentation to state if the resident	04/26/2026

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

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F0883 SS = D	Continued from page 21 (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal	F0883	Continued from page 21 was offered PCV15, PCV20, or PCV21 per CDC guidelines. Resident R5 was educated on the need for a PCV 20, and consent was obtained. Vaccine received on 4/6/26. All residents have the potential to be affected. The Infection Control ADON conducted a 100% audit using the Pneumorecs VaxAdvisor, a CDC approved vaccine application to determine vaccine need. All residents identified as requiring the Pneumococcal Vaccination was offered the vaccine. This process ensures all residents are appropriately identified for vaccine needs and timely follow up to protect the resident from potential adverse reactions. Root cause include failure to follow updated Centers for Disease Control and Prevention pneumococcal guidelines and documentation process. System change: The administrator has reviewed and revised the Pneumococcal Vaccination Policy to align with current CDC guidelines. For all residents we will utilize the PneumoRecs VaxAdvisor application to ensure accurate and consistent adherence to pneumococcal vaccine recommendations. For all new admissions, the Infection Control ADON/designee will: utilize the PneumoRecs VaxAdvisor system to verify current vaccination status and identify any gaps to initiate appropriate follow-up. The staff educator training will include: review of the pneumococcal vaccination policy and use of the PneumoRecs Vax Advisor system. The Staff Educator or designee will provide education to unit managers, nursing supervisors and the assistant directors of nursing on the revised pneumococcal vaccination policy and the use of the PneumoRecs VaxAdvisor system. Education will be completed by April 26, 2026. The IC ADON will conduct audits to ensure pneumococcal vaccinations are current and compliant with CDC guidelines. Audits will be performed daily for 7 days, weekly for 2 weeks, and monthly for 2 months, with 100% compliance required during each phase of the audit schedule. All new admissions will have their pneumococcal vaccination status verified using the PneumoRecs VaxAdvisor system to ensure compliance with current vaccination guidelines. Ongoing compliance will be monitored through the QAPI process to ensure sustained adherence to regulatory requirements and continued 100% compliance. 2. Resident R13 received the PPSV 23 on 10/16/23 with no documentation to support if the resident was offered	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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DELAWARE VETERANS HOME	100 DELAWARE VETERANS BLVD , MILFORD, Delaware, 19963

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F0883 SS = D	Continued from page 22 immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, review of the Centers for Disease Control and Prevention (CDC) guidelines, and facility policy review, the facility failed to ensure two of five residents (Resident (R) 5 and R13) reviewed for pneumococcal vaccines out of a total sample of 23 residents were offered an updated pneumococcal vaccine. The facility further failed to ensure their pneumococcal policy was revised to reflect updated guidance per the CDC for the administration of pneumococcal vaccines. This had the potential for the residents to have an increased risk of contracting pneumonia. Findings include: 1.Review of R5's "Face Sheet" located in the electronic medical record (EMR) under the "Admissions" tab revealed the resident was admitted to the facility on 05/25/21 and was over 65 years old. Review of R5's "Immunization Record" located in the EMR under the "Immunizations" tab revealed R5 received the pneumococcal polysaccharide vaccine (PPSV) 23 on 11/11/21. There was no evidence that the resident was offered the PCV15, PCV20, or PCV21 per recommendations of the CDC in order to be complete for the pneumococcal vaccine. 2. Review of R13's "Face Sheet" located in the EMR under the "Admissions" tab revealed the resident was admitted to the facility on 04/06/23 and was over 65 years old. Review of R13's "Immunization Record" located in the EMR under the "Immunizations" tab revealed R13 received the PPSV 23 on 10/16/23. There was no evidence that the resident was offered the PCV15, PCV20, or PCV21 per recommendations of the CDC in order to be complete for the pneumococcal vaccine. During an interview on 03/12/26 at 10:15 AM, the Infection Preventionist (IP) confirmed R5 and R13 were not offered to receive either a pneumococcal conjugate vaccine (PCV) 15, PCV 20, or PCV21. The IP revealed they were unaware of the update guidance from CDC and confirmed the facility's policy was not updated to reflect the new guidance. Review of the facility policy titled, "Pneumococcal	F0883	Continued from page 22 PCV15, PCV20, or PCV21 per CDC guidelines. Resident R 13 was educated on the need for PCV20 but refused, education was completed on risk vs. benefits of not receiving the vaccine. All residents have the potential to be affected. The Infection Control ADON conducted a 100% audit using the Pneumorecs VaxAdvisor, a CDC approved vaccine application to determine vaccine need. All residents identified as requiring the Pneumococcal Vaccination was offered the vaccine. This process ensures all residents are appropriately identified for vaccine needs and timely follow up to protect the resident from potential adverse reactions. Root cause include failure to follow updated Centers for Disease Control and Prevention pneumococcal guidelines and documentation process. System change: The administrator has reviewed and revised the Pneumococcal Vaccination Policy to align with current CDC guidelines. For all residents we will utilize the PneumoRecs VaxAdvisor application to ensure accurate and consistent adherence to pneumococcal vaccine recommendations. For all new admissions, the Infection Control ADON/designee will: utilize the PneumoRecs VaxAdvisor system to verify current vaccination status and identify any gaps to initiate appropriate follow-up. The staff educator training will include: review of the pneumococcal vaccination policy and use of the PneumoRecs Vax Advisor system. The Staff Educator or designee will provide education to unit managers, nursing supervisors and the assistant directors of nursing on the revised pneumococcal vaccination policy and the use of the PneumoRecs VaxAdvisor system. Education will be completed by April 26, 2026. The IC ADON will conduct audits to ensure pneumococcal vaccinations are current and compliant with CDC guidelines. Audits will be performed daily for 7 days, weekly for 2 weeks, and monthly for 2 months, with 100% compliance required during each phase of the audit schedule. All new admissions will have their pneumococcal vaccination status verified using the PneumoRecs VaxAdvisor system to ensure compliance with current vaccination guidelines. Ongoing compliance will be monitored through the QAPI process to ensure sustained adherence to regulatory requirements and continued 100% compliance.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/12/2026

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

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F0883 SS = D	Continued from page 23 Immunizations" updated 04/04/24 revealed, "Purpose: To reduce the risk of serious respiratory infection to facility residents by offering pneumococcal vaccine . . . B. A second dose is recommended for anyone over 65 who received the first dose before the age of 65 and at least 5 years have passed . . . E. The policy will be reviewed annually and revised according to any new recommendations by the CDC. Review of CDC guidelines located at https://cdc.gov/acip-recs/hcp/vaccine-specific/pneumococcal.html and dated 01/08/25 revealed, "...Administer PCV15, PCV20, or PCV21 for all adults 50 years or older who have never received any pneumococcal conjugate vaccine, or whose previous vaccination history is unknown. Adults aged 50 years and older if a PPSV23 only was given, give a single dose of PCV21, PCV20, or PCV15 after one year after the last PPSV23 dose."	F0883		