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: New Castle Health and Rehab Center **DATE SURVEY COMPLETED:** May 6, 2025

SECTION SPECIFIC DEFICIENCIES	STATEMENT OF DEFICIENCIES ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES		COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint survey was conducted at this facility from April 29, 2025, through May 6, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation. The facility census on the first day was one hundred sixteen (116). The sample totaled five (5) residents.		6/24/2025
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 May 6, 2025: F610, F627, F658 F689, F842.		

Provider's Signature [signature] Title NHA Date 6/23/25

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	State Tag Title 16, Chapter 25 2508 **Title 16 Health and Safety** **Chapter 25 Health-Care Decisions (effective Until Sept 30, 2025)** **§ 2507. Surrogates.** (a) A surrogate may make a health-care decision to treat, withdraw or withhold treatment for an adult patient if the patient has been determined by the attending physician to lack capacity and there is no agent or guardian, or if the directive does not address the specific issue. This determination shall be confirmed in writing in the patient's medical record by the attending physician. Without this determination and confirmation, the patient is presumed to have capacity and may give or revoke an advance health-care directive or disqualify a surrogate. (b) (1) A mentally competent patient may designate any individual to act as a surrogate by personally informing the supervising health-care provider in the presence of a witness. The designated surrogate may not act as a witness. The designation of the surrogate shall be confirmed in writing in the patient's medical record by the supervising health-care provider and signed by the witness. (2) In the absence of a designation or if the designee is not reasonably available, any member of the following classes of the patient's family who is reasonably available, in the descending order of priority, may act,		

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	when permitted by this section, as a surrogate and shall be recognized as such by the supervising health-care provider: a. The spouse, unless a petition for divorce has been filed; b. An adult child; c. A parent; d. An adult sibling; e. An adult grandchild. f. An adult niece or nephew; g. An adult aunt or uncle. 2508 Obligations of health-care provider (a) Before implementing a health-care decision made for a patient, a supervising health-care provider, if possible, shall promptly communicate to the patient the decision made and the identity of the person making the decision. The decision of an agent or surrogate does not apply if the patient objects to the decision to remove life-sustaining treatment, providing that the objection is (1) by a signed writing or (2) in any manner that communicates in the presence of 2 competent persons, 1 of whom is a physician. (b) A supervising health-care provider who knows of the existence of an advance health-care directive or a revocation of an advance health-care directive shall promptly record its existence in the patient's health-care record and, if it is in writing, shall request a copy and, if it is not in writing, shall request a copy of the witness statement, and shall arrange	6/24/2025

Provider's Signature [signature] Title NHA Date 6/23/25

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	for its maintenance in the health-care record. (c) A primary physician who makes or is informed of a determination that a patient lacks or has recovered capacity or that another condition exists which affects an individual instruction or the authority of an agent, surrogate or guardian, shall promptly record the determination in the patient's health-care record and communicate the determination to the patient, if possible, and to any person then authorized to make health-care decisions for the patient. This requirement was not met as evidenced by: Based on record review and interview, it was determined for one (R1) out of three residents reviewed for accidents, the facility failed to ensure that when a DNR (do not resuscitate) order was entered in R1's EMR, the health-care provider documented the source of this decision and requested a copy of R1's DMOST (dated 6/21/23) for R1's medical record. 6/21/23 – During a previous facility admission, E5 (NP) completed the Delaware Medical orders for Scope of Treatment (DMOST) form with R1, which stated "Do not attempt resuscitation/DNAR". 11/6/24 -R1 was re-admitted to the facility with diagnoses including dementia. 11/6/24 11:48 AM – E6 (LPN) entered R1's EMR a DNR (do not resuscitate) order.	Step 1: R1 has been discharged from the facility. Step 2: All residents had the potential to be affected. On 6/13/2025 the facility completed a one week look-back audit of all residents with a DMOST in place. Documentation was reviewed, and corrections were made as indicated. Step 3: To prevent the potential for reoccurrence, the healthcare providers were educated by the NHA on the state regulations of the requirement to the health-care provider documentation of the source of the decision of an DMOST, furthermore that in the event of an absent surrogate that a family member is contacted to discuss code status. Root Cause Analysis was conducted by the Nursing Home Administrator and the Director of Nursing. The analysis determined that the primary contributing factor to the deficiency was the absence of a structured system for regularly auditing and monitoring compliance with DMOST documentation procedures.	6/24/2025

Provider's Signature [signature] Title NHA Date 6/18/25

SECTION SPECIFIC DEFICIENCIES	STATEMENT OF DEFICIENCIES ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	11/7/24 9:44 AM – E11 (contracted MD) signed the DNR order in R1's EMR. There was no recorded evidence in the11/6/24 note of E5's knowledge of the existence of the DMOST from 6/21/23 or that E5 requested that the facility obtain a copy of the 6/21/23 DMOST to be uploaded into R1's EMR. There was no documentation of the identity of the person who made the decision regarding R1's code status with the provider. 11/7/24 1:56 PM – R1's admission Minimum Data Set (MDS) assessment documented a Basic Inventory of Mental Status (BIMS) score of 9, which was reflective of moderate cognitive impairment. There was no recorded evidence in the 11/7/24 History and Physical note of E11's knowledge of the existence of the DMOST from 6/21/23 or that E11 requested that the facility obtain a copy of the 6/21/23 DMOST to be uploaded into R1's EMR. There was no documentation of the identity of the person who made the decision regarding R1's code status with the provider. 4/30/25 11:25 AM – During an interview, E5 (contracted NP) stated, "Social Work is involved in the decision (code status) process... To my knowledge, no calls were made to his brother" (who was listed with a phone number on R1's face sheet). E5 acknowledged that R1had known cognitive impairment. E5 (NP) confirmed that there was no documentation in either her 11/7/24 note or E11's 11/12/24 note stating who the code status decision was discussed with. When directly	Step 4: To monitor and maintain ongoing compliance the Social Worker and/or designee will review weekly audits of new admissions for four weeks with a goal of 100% achieved and sustained, then monthly times 2 months to ensure DMOST are in the resident EMR with the healthcare providers documentation where applicable, are in EMR with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the IDT will review the process, and revision will be made to maintain and sustain compliance.	

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	asked how it was determined that R1 would have a DNR order, E5 stated, "You would need to talk to Social Work." However, E5 did confirm that only a provider with admitting privileges, not a Social Worker, can sign off on medical orders. The facility failed to ensure that in the absence of a designation (surrogate) for a cognitively impaired resident that an available family member was contacted to discuss code status. 4/30/25 3:45 PM – During a telephone interview, F1 (R1's brother) stated, "...I was not aware that [R1] was in a long-term care center and nobody called me to discuss code status... Yes, I agreed to be on his advanced directive quite a while back...". 4/30/25 9:10 AM – A review of R1's EMR revealed no evidence of the DMOST form or the financial power of attorney document in R1's EMR. 5/6/25 1:40 PM – Findings were reviewed at the exit conference with E1 (NHA), E2 (DON), and E3 (RUPO). 9.0 Records and reports 9.8 Reportable incidents are as follows: 9.8.3 Resident elopement under the following circumstances: 9.8.3.1 A resident's whereabouts on or off the premises are unknown to staff and the resident suffers harm. 9.8.3.2 A cognitively impaired resident's whereabouts are unknown to staff and the resident leaves the facility premises.	Step 1: The facility was unable to correct the deficient practice of timely reporting of R1's elopement. Step 2: All residents have the potential to be affected, 5/9/2025 the facility completed a review of all reported events. Corrections made if indicated.	

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	9.8.3.3 A resident cannot be found inside or outside a facility and the police are summoned. This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R1) out of three residents reviewed for accidents, the facility failed to report R1's elopement within the eight-hour time frame as required. Additionally, the facility failed to submit the five day follow up for R1 within the required period. Findings include: 1. Review of R1's clinical record revealed: 11/6/24 - R1 was admitted to the facility with diagnosis including dementia. 2/3/25 – R1's quarterly MDS assessment documented a BIMS score of 00, which reflected severe cognitive impairment. 4/21/25 at approximately 9:30 PM – R1 eloped from the facility per the Incident Summary report field by E2 (DON) to the State Agency. 4/21/25 10:20 PM – R1 was located and returned to the facility by the police. R1 was found seated on the ground on the adjacent complex parking lot behind the facility. 4/22/25 6:12 PM – E2 (DON) filed Incident Summary report with the State Agency approximately twenty hours later. The facility failed to report R1's elopement within the eight-hour requirement.	Step 3: To prevent the potential for reoccurrence, the RVPO educated the Administrator and DON educated on the state regulations for reporting incident timely. A Root Cause Analysis was completed collaboratively by the Nursing Home Administrator and the Director of Nursing to identify the system failure contributing to the alleged deficiency. The review revealed that the facility lacked a formalized and consistent process for monitoring compliance with timely incident reporting protocols. Specifically, there was no designated staff responsible for ensuring that reportable events were communicated to the appropriate regulatory agencies within the required timeframe. Step 4: To monitor and maintain on-going compliance the DON and/or designee will review weekly reportable events for timely reporting for 1 month with a goal of 100% then monthly times 2 with a goal of 100%. All findings will be documented and submitted to facility QAPI for ongoing review and recommendations for continuous monitoring.	

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	5/6/25 – E1 (NHA) sent the five day follow up report with the State Agency. The five day follow up was due on the 4/29/25 so the five day follow up report was seven days late. 5/6/25 1:40 PM – Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (RUPO).	

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			5/12/2025

Provider's Signature [signature] Title NHA Date 10/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. BUILDING _____ B. WING _____	C 05/06/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from April 29, 2025 through May 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 was one hundred and sixteen (116). The investigative sample totaled five (5) residents. Abbreviation/definitions used in this report are as follows: 1:1 - one staff person assigned direct supervision of a resident; ADLs - activities of daily living/tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; AKI - Acute kidney injury; Anticonvulsant - medication to treat seizure disorder; Antidepressant - drug to counter depression; 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; BIMS- Brief Inventory of Mental Status, a structured assessemnt tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cognitive impairment, 8-12 reflects moderate cognition deficit and 13-15 score is reflective of normal cognition; BUE - bilateral upper extremities; CKD - chronic kidney disease; CNA - Certified Nurse's Aide; Court of Chancery - Delaware's court of equity that assigns guardianships;	F 000		

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

Electronically Signed | 05/23/2025

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F 000	Continued From page 1	F 000		

CT Scan - imaging test that takes detailed pictures of the inside of the body;
d/c - discontinue;
DNR - do not resuscitate;
DNAR - do not attempt resuscitation;
DON - Director of Nursing;
DSAMH - Delaware's Division of Substance Abuse and Mental Health;
ED - emergency department;
EMR - electronic medical record;
Epidural hematoma - collection of blood that forms between the skull and the outermost protective membrane covering the brain, often due to trauma such as a fall;
LPN - Licensed Practical Nurse;
MAR - Medication Administration Record;
MDS - Minimum Data set assessment, a federally mandated comprehensive, standardized, clinical assessment of all residents in medicare/medicaid nursing homes that evaluates functional capabillities and health needs;
mg - milligrams
mm - millimeter/unit of length;
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
PASRR - Preadmission Screening and Resident Review, federally required psychiatric screening prior to admission to a long-term care center;
Perforated eardrum - hole or tear of tissue that separates the ear canal from the middle ear;
pt - patient;
TB - tuberculosis;
Temporal bone fracture - skull fracture that affects the ear and sometimes the face/caused by significant force;
Temporal hemorrhagic contusion - scattered areas of bleeding on the surface of the brain;
Traumatic pneumocephalus - presence of air or gas within the cranial cavity/usually associated

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F 000	Continued From page 2 with disruption of the skull; UM - Unit Manager; UTI - urianry tract infection.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of a clinical record and other documentation as indicated, it was determined that for one (R5) out of five residents reviewed for accidents, the facility failed to have evidence of a thorough investigation for a cognitively impaired resident who was identified at the hospital with multiple injuries of unknown origin. Findings include: Cross refer to F658 example 1 and F689 example 2	F 610	Step 1: R5 investigation was completed. Step 2: All residents that have had an accident within the last 30 days were reviewed for a thorough investigation. Corrections made where indicated. Step 3: To prevent the potential for recurrence, RVPO educated NHA and DON on the completion of a thorough investigation for accidents.	5/27/25

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F 610	Continued From page 3 Review of R5's clinical record revealed: 3/20/25 - E4 (LPN) documented in a nurse's note that R5 fell while trying to sit on his chair in his room and had no injury. It should be noted that R5's 3/20/25 fall was witnessed and reported to the nurse by the assigned 1:1 CNA. R5's clinical record revealed that there were no other falls reported and documented after the 3/20/25 fall. 3/25/25 at 1:34 PM - The facility reported the following to the State Agency: "On 3/24/25 [R5] was noted with a blood and tissue in his ear and he stated that he had scratched his ear. He was also noted with a change of condition, slurred speech with increased weakness. He was assessed by the NP [E5, contracted] who gave orders to send him out to the hospital for further evaluation. Resident had a CT scan completed which indicated Right temporal hemorrhagic contusion...". 4/4/25 - The facility's five day follow-up report to the State Agency documented the following: - Describe any additional outcomes to the resident... "No signs of psychological distress. [R5] was noted to have blood and tissue in his ear but did not express any psychological harm or distress. Resident scratched his ear. No additional mention is made regarding his perspective on any psychological distress." - Provide summary of information of investigation related to the incident from the resident's clinical record... "The resident, [R5], was noted to have blood and tissue in his ear and a change of condition (slurred speech, increased weakness). After assessment, he was sent to the hospital,	F 610	A Root Cause Analysis was conducted by the Nursing Home Administrator and the Director of Nursing to identify the system failure related to the alleged deficiency. It was determined that the facility did not review all documentation in the patients' medical records, which resulted in the deficiency. Step 4: To ensure ongoing compliance, the DON or Designee will conduct: Weekly audits of accidents for four weeks until 100% compliance is achieve, then monthly times 2 months to ensure 100% compliance is achieved and all accidents are fully investigated. If compliance falls below the target, the Interdisciplinary Team (IDT) will review the process and implement revisions to ensure sustained compliance. Findings will be presented to the facility's QAPI for continued evaluation and recommendations.	

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F 610	Continued From page 4 where a CT scan showed a Right temporal hemorrhagic contusion." - Description of conclusion: "The investigation concluded that the incident likely resulted from [R5] fall a few days prior. The CT scan showed a Right temporal hemorrhagic contusion." It should be noted that the facility failed to inform the State Agency in the five day follow-up report all of R5's injuries identified in his hospital records, including a right temporal hemorrhagic contusion, right temporal bone fracture, small epidural hematoma and right hip bruise. Upon request of the facility's investigation in response to R5's injuries of unknown origin, the surveyor was provided the following documents: - 3/20/25 Event Report for the witnessed fall and two statements from E4 (LPN) and E13 (assigned CNA for 1:1); and - Typed statements from eight staff, dated 3/25/25, from phone interviews. There was no evidence that the facility's investigation included: - interviews/statements from other staff present on the shift and/or who relieved the 1:1 CNAs when they were on their breaks/lunch from 3/20/25 through 3/24/25; - review of timecards to ensure 1:1 staff were present and observing R5 during the timeframe; and - review and identification of the lack of CNA documentation, including the Point of Care Report and the 1:1 Observation/Monitoring Tool, from the 3/20/25 fall through 3/24/25 when R5 was transferred to the hospital. 5/1/25 at 3:01 PM - During an interview, E4 (LPN)	F 610		

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F 610	Continued From page 5 confirmed that E13 (CNA) told her that R5 had fallen on 3/20/25 and it was witnessed. E4 said she was told that R5 was trying to get out of his wheelchair and fell to his knees. E4 stated that R5 did not have any injury. E4 stated, "There was no blood or injury." 5/5/25 at 5:15 PM - During an interview, E13 (CNA) confirmed that she was the assigned 1:1 CNA when R5 fell on 3/20/25. E13 stated that she never saw him hit his head against anything. 5/5/25 at 12:02 PM - Reviewed findings with E1 (NHA) and E2 (DON). The facility failed to thoroughly investigate R5's injuries of unknown origin after a change of condition and emergent transfer to the hospital on 3/24/25. 5/6/25 1:40 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (RUPO).	F 610		
F 627 SS=D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2)(iv) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is	F 627		5/27/25

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F 627	Continued From page 6 endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care	F 627		

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F 627	Continued From page 7 institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §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 State plan, returns to the facility to their previous	F 627		

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F 627	Continued From page 8 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. §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each	F 627		

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F 627	Continued From page 9 resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care	F 627		

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F 627	Continued From page 10 provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 627	Step 1: R5 was issued a 30 day	

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F 627	Continued From page 11 determined that for one (R5) out of three residents reviewed for discharge, the facility failed to allow R5 to return to the facility and also failed provide a 30 day discharge to his family representative. Findings include: The facility's "Bed Hold Letter Policy - It is the policy of the facility to track Medicaid bed hold days and notify appropriate parties via Medicaid Bed Hold letter." Updated 9/26/20 The facility's "Admission Agreement- N. Bed Hold and Leave of Absence- ... If Resident's primary pay source is Medicaid, and if the State within which the facility is located provides for paid hold/ leave days, the facility will hold the bed for the Resident up to _____. If the resident's absence from the facility exceeds the days provided during a calendar year or the State does not provide for paid hold/leave days, the facility shall not hold the bed and the Resident will be discharged from the facility effective the first day following the last paid Medicaid hold/leave or in-house day ... Where a Resident's paid leave days for a calendar year have been exhausted or the State does not provide for paid hold/leave days, the Resident will be entitled to re-admission to the facility, if desired, to the Resident's 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." Last revised 11/9/16 Review of R5's clinical record revealed: 1/20/23 - R5 was admitted to the facility with	F 627	discharge notice immediately. R5 is expected to return to the facility on 5/28/2025 at approximately 3:00pm Step 2: All residents who have been discharged and/or transferred have the potential to be affected. On 5/9/2025 the facility reviewed discharges in the last 30 days to ensure that any involuntary discharges were presented with the 30-day discharge notice. The facility will take them back or find appropriate long-term care for the resident Step 3: To prevent the potential for reoccurrence, the RVPO educated the Administrator and Social Worker on the CMS regulations for involuntary and the 30-day discharge policy and procedure. Root Cause Analysis was completed by the Nursing Home Administrator and Director of Nursing to determine the system failure responsible for the alleged deficiency. It was determined that there was a failure in communication and adherence to discharge procedures. Facility did not follow established protocols for issuing a 30-day discharge notice, or residents transferred to acute care. Step 4: To monitor and maintain on-going compliance the Administrator and/or designee will review all discharges and transfers to acute care to ensure of timely return back to the facility when appropriate, weekly for 3 months until 100% compliance is achieved, then 2x a	

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F 627	Continued From page 12 diagnoses including but not limited to vascular dementia with psychotic disturbances. 1/18/25 - R5's care plan for "Behavioral Symptoms. Resident is a threat to self and/or others R/T (related to) episodes of aggression and elopement attempts" was updated with an intervention for "1:1 observation for safety." 3/24/25 10:25 AM - E6 (UM/LPN) documented in R5's EMR progress notes, "Resident noted with increased confusion, need additional assist with ADLs and unsteady gait. Also note blood to right ear ... [E5 NP] in house to evaluate with new order to send resident to ER for further eval (evaluation) ...". 3/24/25 11:43 AM - E22 (hospital MD) documented in [hospital] ED (emergency department) Physician Record, " ...57 year old male ...presenting with altered mental status ...". 3/25/25 - The facility mailed copies of R5's "Return to Facility Anticipated" form dated 3/24/25 and "Bed Hold Notice" to F2 (R5's brother who lived in Puerto Rico). The Return to Facility form stated that the reason for R5's transfer was "an immediate transfer or discharge is required by the resident's urgent medical needs." The facility provided the surveyor with copies of the addressed envelope and postage for this mailing to Puerto Rico. 4/2/25 10:55 AM - C4 documented in R5's hospital EMR, "Pt off restraints since 4/1 at 2345 (11:45 PM) ... once 24 hours without restraints pt able to return to [facility]."	F 627	month with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will review the process, and revision will be made to maintain and sustain compliance.	

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F 627	Continued From page 13 4/3/25 11:30 AM - C5 (hospital case manager) documented in R5's hospital EMR, "As per rounds, pt has a safety sitter at this time and is not in restraints. Patient's psych medications were adjusted ...As per facility, patient will need insurance auth (authorization) and PASRR prior to return." 4/7/25 12:48 PM - C5 (hospital case manager) documented in R5's hospital EMR, "As per rounds, pt agitated and now has wrist restraints ...". 4/7/25 3:19 PM - C5 documented in R5's hospital EMR, "Spoke with Admissions at [facility], pt does not need to be sitter free for return to their facility, he needs to be out of restraints for 24 hours ...PASRR approved and uploaded to facility via Ensocare." 4/8/25 8:56 AM - C5 documented in R5's hospital EMR, " ...Spoke with [facility] yesterday, pt needs to be restraint free X 24 hours prior to acceptance. Received Ensocare message from [facility] "Just to reiterate, patient has no bed hold and currently I don't have a bed ...". 4/9/25 11:08 AM - C5 documented in R5's hospital EMR, "As per rounds, pt has been restraint free since 1400 (2 PM) yesterday. Updates sent to [facility] with inquiry about bed availability later today vs tomorrow if pt remains restraint free ...". 4/9/25 1:08 PM - C5 documented in R5's hospital EMR, " [Facility] declined patient at this time..". 4/9/25 3:20 PM - C5 documented in R5's hospital EMR, "Spoke with Admission, they report they	F 627		

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F 627	Continued From page 14 declined pt because they do not have a bed available at this time and will contact this writer when a bed becomes available. Called DE (Delaware) Ombudsman office at [phone number]." 4/10/25 8:12 Am - C5 documented in R5's hospital EMR stating that the facility staff said, "I have no idea when we will have a bed available . This patient requires a private room and a room close to the nursing station, which we do not have available." C5 also documented, "F/u (follow up) with DE Ombudsman today due to facility declining pt return ...". 4/11/25 2 :44 PM - C5 documented in R5's hospital EMR, "CM (case management) received return call from Ombudsman's office, [C7] [phone number]. He reports he spoke with [facility]. Pt's bed hold expired and pt is planned for next available bed." 4/14/25 10:49 AM - C5 documented in R5's hospital EMR, " ...Discussed during rounds, pt is back in restraints. Updates sent to [facility], no bed available at this time. Pt will need to be restraint free for 24 hours and will need room near nurse's station in order for facility to accept him back ...". 4/15/25 10:33 AM - C5 documented in R5's hospital EMR, "Discussed during rounds, pt will be out of restraints for 24 hours at 1400 (2 PM) today and is otherwise medically stable for return to [facility]. Updates sent to facility, facility continues to decline pt return due to no bed being available near the nurse's station. Called pt's LTSS case manager, she reports she is going to [facility] today and is requesting public	F 627		

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F 627	Continued From page 15 guardianship for pt." 4/22/25 - R5's PASRR documented PASRR level I with no PASRR level II evaluation required. 4/29/25 1:55 PM - This surveyor identified that there were two empty male beds in the facility XXXB [room number] and XXXB [room number]. Additionally, XXXA [room number] bed was a private room near the nurse's station but was currently under a bed hold. 4/30/25 3:28 PM - C8 (complex cases case manager) documented in R5's hospital EMR, "...Per Liaison, they [facility] are not accepting the patient back as they cannot meet his care needs and feel he is a danger to the other residents. Per Liaison, Administrator [E1] spoke with Ombudsman [C9] regarding this patient and was advised that this patient was not appropriate for their facility. Per Liaison, Administrator states the Ombudsman [C9] advised that [hospital] work with the LTSS CM (case manager) to place patient in an out of state facility. CM to submit OSEC referral as [facility] is the patient's residence ...". 4/30/25 4:14 PM - This surveyor informed E1(NHA) and E3 (RUPO) at the request of the State Agency that the facility would need to accept R5 back and proceed with the 30 day discharge notice process. 5/2/25 2 29 PM - C8 documented in R5's hospital EMR, "CM received call from [facility] Liaison asking, if per the request of the building, she can come in and have the patient sign the 30 day notice. CM stated that she would have to follow up with manager ...However the patient has	F 627		

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F 627	Continued From page 16 vascular dementia compounded with a TBI (traumatic brain injury) and that he is unable to sign. CM also stated to her knowledge, a 30 day notice cannot be given to a patient while they are in the hospital ...". 5/2/25 11:23 AM - During an interview, E21 (business office manager) confirmed that Medicaid was R5's payor source. 5/5/25 2:38 PM - During an interview, E1 (NHA) confirmed that envelope mailed to F2 (R5's brother) on 3/25/25 contained R5's DMOST, the bed hold policy and all the transfer paperwork. E1 stated that there was no discharge paperwork contained in the 3/25/25 mailing packet. E1 stated the facility's policy for Medicaid residents was a seven day bed hold. 5/5/25 5:38 PM - C2 (hospital psychiatry NP) documented in R5's hospital EMR progress note, " ...From a psychiatric standpoint, there are no barriers to discharge back to a long-term care facility." 5/6/25 - Upon conclusion of the survey, R5 remained in the hospital. 5/6/25 1:40 PM- Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (RUPO).	F 627		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 658		5/27/25

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F 658	Continued From page 17 (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R1 and R5) out of five residents sampled for accidents, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of Practice by failing to have a registered nurse (RN) complete and document an RN admission assessment and post-fall assessment. Findings include: "Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024... RN... Admission Assessments... Post Fall Assessment & Documentation... updated 10/11/24." 1. Review of R1's clinical record revealed: 11/6/24 - R1 was admitted to the facility with diagnosis including dementia. 11/6/24 11:35 AM - E10 (LPN) initiated R1's admission observations in the EMR. 11/6/24 12:30 PM - E10 (LPN) completed R1's admission observations in the EMR. 11/6/24 12:31 PM - E10 (LPN) completed R1's functional abilities assessment in the EMR. 11/6/24 12:39 PM - E10 (LPN) completed R1's TB (tuberculosis) screen in the EMR. 11/6/24 1:05 PM - E6 (LPN) completed R1's baseline care plan checklist in the EMR. 5/2/25 11:40 AM- A review of the EMR admission observations revealed the following information	F 658	Step 1: Facility unable to re assess R1 and R5 for they are currently out of the facility and have been discharged from the facility Step 2: All residents have the potential to be affected, 5/9/2025 the facility completed a 24 hour look back of all the assessments that were completed to ensure that they were completed by or reviewed and validated by a registered nurse, correction made when indicated. Step 3: To prevent the potential for reoccurrence, Director of Nursing educated all RNs on the professional standards of the Delaware Board of Nursing Scope of Practice. Root Cause Analysis was completed by the Nursing Home Administrator and Director of Nursing to determine the system failure responsible for the alleged deficiency. It was determined that the facility had a lack of knowledge of the Delaware Board of nursing professional license standards. Step 4: To monitor and maintain on-going compliance the DON and/or designee will review All assessment requiring RN assessments according to the Delaware State Board of Nursing Standards and scope of practice will be review weekly x 4 until 100% compliance is achieved and monthly x 2 to ensure that they were	

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F 658	Continued From page 18 for each newly admitted resident were reviewed, assessed and documented on: language, hearing, speech and vision, nervous system, respiratory system, cardiovascular system, gastrointestinal system, genitourinary system, and musculoskeletal system, pain assessment, skin, infectious disease and resident preferences. Any section that included the word system had both a history and physical observation as part of the documentation. The facility failed to meet the professional standards of the Delaware State Board of Nursing by allowing LPNs to work outside of their scope of practice and complete R1's admission assessments. 5/2/25 2:15 PM - During an interview, E2 (DON) confirmed that the above listed documentation was all part of the admission assessment and that for R1's 11/6/24 admission, there was not an RN involved in R1's admission assessment process. 5/2/25 2:202 PM - E1 (NHA) stated, "Those are not assessments. They are labeled in the EMR as observations." The facility was unable to provide evidence of any other documentation that could be identified as an admission assessment that was performed by an RN. 2. Review of R5's clinical record revealed: 3/20/25 3:23 PM - A nurse's note by E4 (LPN) documented, "this writer was made aware by staff that resident fell and got himself back to sit in his chair. Pt (Patient) assess (sic) no apparent injury	F 658	completed by an RN, correction and education to be completed as applicable. With the goal of achieving and maintaining 100% compliance. If compliance falls below the target, the Interdisciplinary Team (IDT) will review the process and implement revisions to ensure sustained compliance. Findings will be presented to the facility's QAPI for continued evaluation and recommendations.	

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F 658	Continued From page 19 noted. Resident stated he was trying to sit on his chair. Pt denies injury upon assessment...". 3/20/25 6:01 PM - The facility's event report for R5's fall was completed by E4 and documented the fall details, observations of pain and R5's body, neurological check, review of other body systems, possible contributing factors, interventions, therapy referral and vital signs. 5/2/25 at 2:19 PM - During an interview, E4 confirmed that after R5's 3/20/25 fall she completed the post fall assessment and documentation. The facility failed to ensure an RN performed and documented R5's 3/20/25 post-fall assessment. 5/6/25 1:40 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (RUPO).	F 658		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and review of clinical records, hospital records and facility documentation as indicated, it was determined that for two (R1 and R5) out of five residents reviewed for accidents,	F 689	Step 1: R1 and R5 are currently not in the facility and have been discharged. Step 2: All residents that have had an	5/27/25

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F 689	Continued From page 20 the facility failed to ensure the environment remained as free of accident hazards as was possible and each resident received adequate supervision. For R1, the facility failed to ensure R1, a resident with cognitive impairment and care planned to wear a wandering device, received adequate supervision and assistive devices to prevent an elopement. On 4/21/25 at approximately 9:30 PM, R1 eloped from the facility via the facility front door. R1 remained unaccounted for until 10:20 PM when the police located and returned R1 to the facility. An IJ was called on 5/1/25 at 1:30 PM. The IJ was abated on 5/1/25 at 3:54 PM For R5, the facility failed to supervise a cognitively impaired resident who was on 1:1 (one to one) supervision for safety/behaviors. On 3/24/25, R5 was emergently transferred to the hospital for a change in condition and upon examination was identified with multiple injuries of unknown origin, including a non-displaced temporal bone fracture and small epidural hematoma. R5 was harmed. Findings include: 1. The facility's "Elopement/Unauthorized Absence Policy: The facility will identify residents with potential and/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. In the event of a resident elopement, the facility will implement its policies and procedures promptly to locate the resident in a timely manner ... Assessment: 1. All residents will be assessed for the risk of elopement using the Elopement Observation on admission, quarterly and as needed."	F 689	accident were reviewed to ensure that the environment is free of hazards. Residents that are currently on the elopement risk list were all reassessed for their risk of elopement. All bedbound residents were assessed for their risk of elopement. All residents are assessed for elopement quarterly and/or if indication of assessment is needed. 24-hour front lobby door monitoring in place as of 5/1/2025 to ensure assistive devices are being monitored to prevent an elopement. Corrective action taken when indicated. Step 3: To prevent the potential for reoccurrence, DON/designee educated CNAs on appropriate completion of 1:1 documentation. All licensed staff educated on the Elopement/Unauthorized Absence Policy, Elopement assessments schedule, and reassessing elopement risk residents. Root Cause Analysis was completed by the Nursing Home Administrator and Director of Nursing to determine the system failure responsible for the alleged deficiency. It was determined that a lack of ongoing oversight contributed to the undesired outcome. Step 4: To monitor and maintain on-going compliance the DON and/or designee will review 1:1 documentation weekly x 4 until 100% compliance is achieved for appropriate completion and then monthly x 2 until 100% compliance is achieved. All findings will be documented and submitted to facility QAPI for ongoing review and recommendations for	

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F 689	Continued From page 21 The facility's "Resident Observation Policy", last revised 5/28/21, stated, "... B) DON will assign a staff member to complete appropriate observation/interventions which may include but are not limited to: every 15 or 30 minutes checks or 1:1 monitoring. Staff members will complete the observation/monitoring tool as follows:... C) If resident is on 1:1 monitoring, additional staff member assigned will remain with the resident in view at all times. Should the assigned staff member need to leave the area they are responsible to ensure the resident is directly observed during their absence by another staff member. Interim staff member will utilize observation/monitoring tool as above...". [Manufacturer] Code Alert Wander Management User Manual - "Resident Generated Alarms - Do not rely exclusively on resident generated alarms for resident care and safety ... The most reliable method of resident monitoring combines close personal surveillance with correct operation of monitoring equipment ...The transmitter is placed on the wrist or ankle of the resident. If a transmitter is detected in an Exit Alarm Zone and the door is open, an alarm sounds at the exit. Depending upon which equipment you have installed, the Wander management Solution can automatically lock doors and deactivate elevators ... The Wander management solution, by itself, cannot prevent the elopement of residents ...Signal Strength 2. An alarm must occur when the transmitter is within 4-feet of the monitored door. If applicable, the door should also lock ...". [Manufacturer's] Technology, 2018. 1. Review of R1's clinical record revealed: Cross refer F658 example 1 and F842.	F 689	continuous monitoring with the goal of achieving and maintaining 100% compliance. If compliance falls below the target, the Interdisciplinary Team (IDT) will review the process and implement revisions to ensure sustained compliance. Findings will be presented to the facility's QAPI for continued evaluation and recommendations.	

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F 689	Continued From page 22 11/6/24 - R1 was admitted to the facility with diagnosis including but not limited to, dementia. 11/6/24 11:35 AM - E10 (LPN) documented on the admission elopement observation, "No- clinically not at risk for elopement ...No identified risks for elopement." 11/7/24 1:56 PM - R1's admission Minimum Data Set (MDS) assessment documented a Basic Inventory of Mental Status (BIMS) score of 9, which was reflective of moderate cognitive impairment. 11/19/24 - R1's baseline care plan documented "Problem- Resident experiences wandering ... Approach - ... Safety/Wanderguard: electronic bracelet for safety - check placement every shift ...". 12/2/24 10:35 AM - E11 (MD) and E12 (Social Work Director) completed the DSAMH (Division of Substance Abuse and Mental Health) 24-hour Emergency Detention form on behalf of R1 stating that R1 was dangerous to self as evidenced by " ...exhibiting increasing delusions paranoia. He believes he has been kidnapped by the Russians. He refers to the staff as spies ...frequently combative. Physically aggressive with staff ...". The facility failed to complete a re-assessment of R1's elopement risk at this time. 1/19/25 9:21 PM - E17 (RN) documented in R1's EMR progress notes, "Pt (patient) was seeing (sic) holding security band cut and in hand. Pt keeps band in closet in dirty clothes bin. Pt is	F 689		

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F 689	Continued From page 23 refusing to wear band. Writer is unsure how pt was able to remove band. Incoming nurse to be informed, hopefully band can be reapplied during sleep ...". 2/3/25 -R1's quarterly MDS assessment documented a BIMS score of 00, which reflected severe cognitive impairment. Review of the March 2025 MAR (Medication Administration Record) on nineteen different occasions E18 (RN), E19 (RN) and E20 (RN) (out of a potential ninety-three shifts) documented that R1 had removed his wander guard during the month of March. 3/13/25 - The Court of Chancery (a Delaware court of equity that assigns guardianships) assigned R1 a guardian, stating R1 was a person with a disability by reason of mental or physical incapacity ... and is in danger of substantially endangering his health ...". The facility failed to complete a re-assessment of R1's elopement risk at this time. Review of the April 2025 MAR on five different occasions E18 (RN) (out of a potential sixty-two shifts) documented that R1 had removed his wander guard prior to the 4/21/25 elopement. 4/21/25 at approximately 9:30 PM - R1 eloped from the facility by exiting via the unattended, alarmed front door of the facility per the report that the facility filed with the State Agency. Review of the facility's abatement plan revealed that the facility took the following immediate measures:	F 689		

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F 689	Continued From page 24 - 4/21/25 9:30 PM - facility immediately initiated Code Green- elopement protocol. Staff searched the facility both inside and outside the facility. - 4/21/25 9:45 PM - the local police were called and made aware of the missing resident. Staff members continued searching the area by car. - 4/21/25 10:20 PM - R1 was located and returned to the facility by the [local] Police. R1 was found seated on the ground on the adjacent complex parking lot behind the facility. - 4/21/25 10:20 PM - Once in the facility, R1 placed on 1:1 supervision indefinitely. NP and Guardian notified of the elopement. - 4/21/25 - R1's care plan was updated for elopement. - 4/21/25 10:30 PM - DON (E2) entered the facility and checked exit doors ensuring that the door locking mechanism was properly functioning. A head count of all residents in the facility was also completed by the DON. - 4/21/25 10:45 PM - House wide education was initiated regarding elopement was initiated by the DON and continued until all staff were educated. - 4/22/25 2:30 PM- The Staff development nurse called all staff not scheduled and provided elopement education via the telephone. This was completed by 2:30 PM. - 4/22/25 - Elopement drills were completed on all 3 shifts. - 4/22/25 - Maintenance director audited all exit doors. - 4/22/25 - R1 evaluated by NP and Psych provider. - 4/22/25 - An Ad Hoc QAPI meeting to discuss the elopement incident was held. - 4/23/25 6:30 AM -The last elopement drill	F 689		

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F 689	Continued From page 25 was completed with night shift. 4/22/25 6:12 PM - E2 (DON) reported to the State Agency, "On 4/21/25 at approximately 9:30 PM, staff noticed that the front door alarm was going off. Staff immediately responded to the alarm and noted the wheelchair of [R1] in the lobby; staff quickly looked outside and did not note the resident. Elopement protocol initiated; the staff immediately completed a house wide search of the resident and he was not located. External search of the facility initiated and police were notified to assist in the search ... Police officers located the resident in the neighboring apartment complex compound, seated on the ground and was returned to the facility by officers at approximately 10:20 PM ...". The facility failed to provide adequate supervision of R1 to prevent an elopement. R1 was outside the facility without supervision at night for approximately 50 minutes. 4/23/25 6:30 AM - The last elopement drill was completed with the night shift. 4/29/24 8:24 AM - During an interview, E13 (front desk receptionist) stated, "The (front) door is locked 24/7. You have to be buzzed to be let in." 4/29/25 10:10 AM - During an interview, E2 stated that the facility does not have video footage of the elopement incident at the front doorway. 4/29/25 11:10 AM - During an interview, E14 (receptionist) stated, "You need a code to get in and out. I work day shift. I typically arrive around 6:30 AM and stay until 3 PM. Then there is a part-time worker who is here until 7 PM. After 7	F 689		

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F 689	Continued From page 26 PM, to get in a person has to ring the doorbell and then a nurse or aide has to let them in. To get out you have to have the code to open the door." 4/29/25 7:02 PM - During a telephone interview, E15 (RN/ evening shift supervisor) stated, "I was working as the supervisor. I was on the southside unit. The resident was on the northside unit. Two CNAs told me that he [R1] had eloped. I started a search. I told everyone to search the rooms. One of the nurse aides saw that the wheelchair was in the main lobby and that he [R1] was missing. I notified the police and then the DON. A couple of the CNAs got in their cars and drove around looking for him. One of the CNAs went to the Wawa area. The police came and I gave a description. We did not have picture because he refused a picture. Within 40 minutes he was located. When he was back in the building, he was really agitated. He did say that he fell. He refused everything. [E16, LPN] is regularly assigned to him. He was very disrespectful to her and he got in her space. No I don't remember hearing the alarm, I was in a little office on the Southside ... I had no idea that he could walk that fast. Every time I saw him, he was pushing a WC. He is up walking at all times. He did have a Wanderguard on. Wanderguard should be checked every shift. I believe it was on his ankle." 4/30/25 10:26 AM - During an interview, E6 (LPN/unit manager) stated, [R1] had an order for the Wanderguard device ... He would take it off a lot. He was not an exit seeker prior to that night." 5/1/25 11:39 AM - The surveyor with E1 (NHA) and E2 (DON) performed a demonstration of the front door locking system. Without a Wanderguard device, when the surveyor put	F 689		

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pressure on the door handle, an alarm had an immediate two beeps and then beep approximately every second for 15 seconds continuously. Then at 15 seconds, the door lock released and the door could be opened. With the Wanderguard device, when the surveyor put pressure on the door handle, an alarm had an immediate two beeps and then beep approximately every second for 20 seconds continuously. Then at 20 seconds, the door lock released and the door could be opened. For this demonstration , E2 (DON) held the Wanderguard device and E1 (NHA) timed the alarm.

Of note, the door alarm did not trigger an alarm when the Wanderguard device came within four feet of the sensors on the door.

5/1/25 1:30 PM - An IJ was called.

5/1/25 3:54 PM - The abatement plan that the facility would have staff at the front door 24 hours until the door locks could be adjusted, was accepted by the State Agency.

5/2/25 11:30 AM - The surveyor confirmed the abatement by reviewing the schedule and interviewing the day shift front desk personnel.

2. Cross refer to F610, F658 example 2

Review of R5's clinical record revealed:

1/20/23 - R5 was admitted to the facility for long term care.

1/18/25 - R5's care plan for "Behavioral Symptoms. Resident is a threat to self and/or others R/T (related to) episodes of aggression

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and elopement attempts" was updated with an intervention for "1:1 observation for safety."

2/11/25 - The quarterly MDS assessment documented that R5 was cognitively impaired with a BIMS score of 5; independent for toileting/showering/dressing/ambulating; active diagnoses included, but were not limited to: dementia, seizure disorder and depression; history of falls; current medications include antipsychotic, antidepressant and anticonvulsant; and the use of a wander/elopement alarm.

3/20/25 3:53 PM - A nurse's note by E4 (LPN) documented, "this writer was made aware by staff that resident fell and got himself back to sit in his chair. Pt (Patient) assess (sic) no apparent injury noted. Resident stated he was trying to sit on his chair. Pt denies injury upon assessment...".

It should be noted that there was no documented evidence that R5 had another fall in the facility after 3/20/25.

Review of the facility's 1:1 documentation for R5 that was provided to the surveyor lacked documented evidence of R5 being supervised by a staff person on Sunday, 3/23/25, from 7:00 AM through 3:00 PM and on Monday, 3/24/25, from 12 AM through 7:30 AM.

3/24/25 9:03 AM - A social services note documented, "Resident observed attempting to leave the building by pushing and banging on the door. Resident continues to state to not like it her (sic) and wants to leave. Resident alert and verbal able to make needs known however has impaired cognition with a dx (diagnosis) of dementia. Resident was redirected by staff and

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F 689	Continued From page 29 brought back to his room where he remains on 1:1 for supervision." 3/24/25 9:59 AM - A progress note by E5 (NP) documented, "... Patient was seen and examined... nursing staff concerned due to altered mental status and bloody drainage from the left ear. He is status post fall. No visible injury apart from bloody ear, which nursing staff reported that he scratched himself. He is unable to answer my questions at this time. Awake and sitting on a WC (wheelchair)... Plan: Perforated eardrum/ bloody drainage- Acute, suspected otoscopic exam revealed perforated eardrum... Since patient is post fall with AMS (altered mental status), will transfer to ED (emergency department) to more immediate imaging... Altered mental status- Acute... He is unable to answer and follow verbal commands...". 3/24/25 10:25 AM - A nurse's note by E6 (UM/LPN) documented, "Resident noted with increased confusion, need additional assist with adls (activities of daily living) and unsteady gait. Also note blood to right ear. Resident is s/p (status post) fall. [E5, NP] in house to evaluate with new order to send resident to ER for further eval (evaluation)...". 3/24/25 11:04 AM (arrival time) - The hospital record documented, "... Patient... presenting with AMS... was unable to answer orientation questions... ED provider called [facility]... Reported that since this AM he has not been acting like himself, reportedly able to ambulate although dragging his right leg... They stated he has been compliant on all his seizure medications and no seizure activity was noted today. Denied significant head trauma... Reportedly noted to	F 689		

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F 689	Continued From page 30 have slurred speech... He was noted to have bleeding from his right ear, at which point a trauma alert was called... Dried blood in and around the R (right) ear... Head CT [CT scan results]: 1. Right temporal hemorrhagic contusion. 2. Right temporal bone fracture... with 7 mm epidural hematoma... and traumatic pneumocephalus...". 3/25/25 10:37 AM - A progress note by E6 (UM/LPN) documented, "IDT (Interdisciplinary team) met to review residents (sic) plan of care. Resident... with comorbities than (sic) include seizure disorder... dementia... alert and oriented with a BIMs of 5... continent of bowel and bladder, self propels wheelchair and requires supervision for ADLs. On 3/20/25 resident sustained a witnessed fall during attempt to transfer from wheelchair. Per witness statement resident stood from wheelchair and fell to knees. Resident was able to independently get up from floor. No apparent injuries observed at this time...". 3/25/25 6:49 PM - An IDT note by E2 (DON) documented, "... Long-term care resident... past medical history of weakness, vascular dementia, MDD, CKD, Seizures, Neuropathic intracranial hemorrhage and hypotension. He is alert and orient (sic) he is able to make his needs known. He self-propels on a wheelchair. He is independed (sic) for ADLs. On 3/24/25 he was noted with blood and tissue in his ear, and he stated that he had scratched his ear. He was also noted with a change in condition, slurred speech with increased weakness. He was assessed by the NP who gave orders to send [R5] out to the hospital for further evaluation. Resident had a CT scan completed which indicated Right temporal	F 689		

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	085039	A. BUILDING _____ B. WING _____	C 05/06/2025

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F 689	Continued From page 31 hemorrhagic contusion...". 5/2/25 2:49 PM - During an interview, E6 (UM/LPN) stated that she did not recall any complaints or issues with R5 on Friday, 3/21/25, the day after he fell (3/20/25). E6 stated that she did not work over the weekend. E6 stated on Monday dayshift, 3/24/25, "when I came in, R5's 1:1 [E8, assigned CNA] pulled me into his room saying R5 was erratic and trying to hit her. E6 stated that R5 was on the toilet and he could not get up on his own, which is not how he normally is." E6 stated, "I knew something was wrong." E6 stated that she was trying to put him in his wheelchair and she noticed blood on his ear. E6 stated that R5 told me that it was a scratch. E6 stated that R5 participated in the scheduled smoking breaks and he did not go out for the 8:30 AM scheduled smoking break. E6 stated "Between us trying to get him settled and [E5, NP] seeing him and sending him out, R5 did not have time to got to the smoking break. Normally he went to every smoking break. That day he was not asking to go to the smoking break." Review of the facility's timecard records revealed that E6 (UM/LPN) clocked in on Monday, 3/24/25, at 8:19 AM. The offgoing nightshift nurse, E9 (LPN), worked a double shift and was assigned to a different hallway for 3/24/25 dayshift. According to the facility's 7-3 C.N.A. Assignment Sheet Date: 3/24/25, E6 was the assigned nurse for the entire hallway where R5's room was located. 5/5/25 12:41 PM - During an interview, E8 (CNA) confirmed that she was the assigned 1:1 CNA for R5 on Monday dayshift, 3/24/25. E8 stated that she did not talk to anyone when she took over his care nor received report from previous CNA or a	F 689		

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F 689	Continued From page 32 nurse. E8 stated there was nobody sitting outside his room from night shift. E8 stated that when R5 got up, he was kind of not himself and she noted his ear was bleeding. It was dried blood. E8 stated that "From the beginning, he was talking about [name of country]... he wants to go home." E8 stated that "[R5] walked to the front door by pushing his wheelchair. When he got to the front door, [R5] went off. [R5] threw the wheelchair at me. Someone opened the front door because they did not see him. Then three of us pulled the door closed and [R5] came back at me." E8 stated that "[R5] was not himself... he was out of it and aggressive." E8 stated that after the front door, he walked himself back and sat down on his bed. The nurse [E6, UM/LPN] cleaned his ear again. Then the [NP] came and saw him and sent him out. E8 stated that "the first time [R5] had his ear cleaned up was before the door incident and the second time it was cleaned up was after the door incident." E8 stated that "when [R5] acts up, he kicks and uses his hands." E8 stated that she has never seen him bang his head. According to the facility's timecard records, E7 (assigned 1:1 CNA for Sunday nightshift, 3/23/25-3/24/25) clocked out on Monday, 3/24/25, at 7:00 AM. E8 (assigned 1:1 CNA for dayshift) clocked in on Monday, 3/24/25, at 7:21 AM. The facility lacked evidence that R5 had 1:1 supervision. 5/5/25 12:02 PM - Finding was reviewed with E1 (NHA) and E2 (DON). 5/6/25 1:40 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (RUPO).	F 689		

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F 842	Continued From page 33	F 842		
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- (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,	F 842		5/27/25

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F 842	Continued From page 34 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; (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 one (R1) out of four residents reviewed for accidents, the facility failed to have his advanced directive and copy of his DPOA (Durable Power of Attorney) readily accessible on his EMR during his 11/6/24 admission. Findings include: Review of R1's clinical record revealed:	F 842	Steps 1: The facility immediately located and uploaded R1s Power of Attorney (POA) and Advance Directive documents into the electronic health record (EHR) system. Steps 2: All residents have the potential to be affected. On 5/9/2025 DON/ designee reviewed all residents in the facility to	

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F 842	Continued From page 35 6/21/23 - During a previous Facility admission, E5 (NP) completed the DMOST (Delaware Medical Orders for Scope of Treatment) form with R1, which stated "Do not attempt resuscitation/DNAR." 11/6/24 - R1 was admitted to the facility with diagnosis including dementia. 11/6/24 11:48 AM - E6 (LPN) entered into R1's EMR a DNR (do not resuscitate) order. 11/7/24 9:44 AM - E11 (MD) signed the DNR order in R1's EMR. 11/7/24 1:56 PM - R1's admission Minimum Data Set (MDS) assessment documented a Basic Inventory of Mental Status (BIMS) score of 9, which was reflective of moderate cognitive impairment. 4/30/25 9:10 AM - A review of R1's EMR revealed no evidence of the DMOST form or the financial power of attorney document in R1's EMR. 4/30/25 10:35 AM - During an interview, E12 (SW director) stated, "At admission, we were notified that R1 had a financial PO [person's name]. We did not get a copy of the Advanced Directive from the hospital or assisted living facility." 4/30/25 10:47 AM - During an interview, E21 (business office manager) stated, "We never got a copy of the POA (power of attorney) since [financial POA] was paying the bill. He told us that he was applying for guardianship." The facility failed to obtain proof of R1's financial	F 842	ensure an advance directives and POA paperwork, where applicable, were available on the residents chart/ record/.Corrections made were as indicated in obtaining documentation. Step 3: To prevent the potential for reoccurrence, Administrator educated admission coordinator, BOM and social worker on ensuring all advance directives and POA paperwork are in residents medical records as soon as possible. Root Cause Analysis, led by the Nursing Home Administrator and Director of Nursing, identified a breakdown in the admissions intake and records management process, primarily due to inconsistent follow-through and lack of cross-checks during chart setup. Step 4: To monitor and maintain ongoing compliance, the Admissions Coordinator or Designee will conduct: Weekly audits of new admissions for four weeks until 100% compliance is achieved, then monthly times 2 months until 100% compliance is achieved to ensure advance directives and POA, where applicable, are in medical records. All findings will be documented and submitted to facility QAPI for ongoing review and recommendations for continuous monitoring with the goal of achieving and maintaining 100% compliance. If compliance falls below the target, the Interdisciplinary Team (IDT) will review the process and implement revisions to ensure sustained compliance. Findings	

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F 842	Continued From page 36 POA and R1's completed DMOST form. 5/6/25 1:40 PM - Finding was reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (RUPO).	F 842	will be presented to the facility's QAPI for continued evaluation and recommendations.	