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.
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STATE SURVEY REPORT

NAME OF FACILITY: Country Rest Home **DATE SURVEY COMPLETED: November 7, 2025**

SECTION	S' STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint Survey was conducted at this facility from November 5, 2025, through November 7, 2025. The deficiencies contained in this report are based on interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was fifty-one (51). The survey sample size was three (3). Findings include: Abbreviations/definitions used in this report are as follows: CNA – Certified Nurse Assistant; DON – Director of Nursing; LPN – Licensed Practice Nurse; MD – Medical Doctor; NHA – Nursing Home Administrator; RN – Registered Nurse; BIMS – (Brief Interview for Mental Status) – assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions) 8-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable);		

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	Dementia – a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation; Hypothyroidism - when your thyroid gland doesn't make and release enough hormone into your bloodstream; Resident assessment - a comprehensive process used in healthcare settings, like nursing homes, to evaluate an individual's needs, strengths, and preferences to develop an individualized care plan; Sertraline - a common prescription medication used to treat mental health conditions like depression and anxiety. **Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201	**Scope**		
3201.1.0 **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:**	**A.Individual/Resident Impacted:** Residents identified as (R1), (R2), and (R3). The facility was unable to retroactively correct the specific incidents involving these residents, as the residents involved have cognitive impairments and were unable to verbally confirm or refute the corrective actions implemented. **B.Identification of Other Residents Potentially Affected:** All current residents and all future admissions were identified as having the potential to be affected by the deficient practice.	11/21/2025

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F600 S/S G	**§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.** **This requirement was not met as evidenced by:** Based on interview, record review and a review of facility documentation, it was determined that for one (R2) out of three residents reviewed for abuse, the facility failed to ensure that (R2) was free from sexual abuse by (R1) resulting in psychosocial harm using the reasonable person concept for a resident with dementia. Findings include: A review of the facility policy titled "Abuse Prevention and Reporting Policy," last revised October 2025, indicated the facility, "... maintains a zero-tolerance policy toward all forms of abuse ...." A review of R1's clinical record revealed: 12/13/22 – R1 was admitted to the facility with diagnoses including, but not limited to, dementia and altered mental status. 12/19/22 – R1's care plan included, but was not limited to dementia.	**C.System Change:** Root Cause Analysis: The facility determined that the deficient practice resulted from: • Insufficient staff education related to abuse identification, specifically resident-to-resident abuse. • Lack of staff understanding that residents with cognitive impairment are unable to consent to sexual behaviors. • Inconsistent implementation and communication of behavioral care plan interventions for residents (R1) and (R2). • Failure to align CNA task assignments with care plan interventions, resulting in staff not consistently following the plan of care. During a follow-up interview, the Director of Nursing (DON) spoke with the nurse on duty at the time of the occurrence. The nurse acknowledged that staff did not recognize inappropriate touching between two residents with dementia as abuse and instead interpreted the behavior as a behavioral concern rather than a reportable abuse incident. The care plan for (R1) required supervision when seated near female residents. The care plan for (R2) required that she not be seated next to a specific male resident, identified as (R1). These interventions were not consistently followed due to lack of clarity, staff education, and failure to update CNA task documentation.	

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	4/10/25 – A review of R1's clinical record BIMS assessment documented R1 with a score of 7, indicating severe cognitive impairment. A review of R2's clinical record revealed: 3/7/25 – R2 was admitted to the facility with diagnoses including, but not limited to, vascular dementia. 3/9/25 – A review of R2's clinical record BIMS assessment documented R2 with a score of 8, indicating moderately cognitive impairment. 3/25/25 - R2's updated care plan included, but was not limited to, dementia – impaired decision making and mood state: depression. 5/13/25 8:24 PM - A facility incident report submitted to the State Agency documented that on 5/13/25 at 3:30 PM, R1 and R2 were sitting next to each other in the common room. R2 was rubbing R1's arm and then R1 put his hand on R2's breast, over her clothes. The nurse immediately redirected R1 away. 5/16/25 - R1's care plan was updated to include a new plan for socially inappropriate behavior with interventions: identify patterns of sexually inappropriate behavior, notify MD for the resident to be assessed medically for signs of inappropriate behavior, encourage participation in activities, and use a matter-of-fact approach when rendering care.	<u>Corrective Actions Implemented:</u> On 11/14/2025, the facility conducted a mandatory all-staff in-service addressing: • Results of the annual survey • The facility's Abuse Policy (Doc #1) • Definitions and types of abuse, including resident-to-resident abuse • Sexual behaviors and consent in residents with cognitive impairment • Staff were explicitly educated that residents with dementia cannot consent to sexual activity and that inappropriate touching must be immediately reported per facility policy and state regulations. The in-service was video recorded for staff unable to attend. All staff were required to complete a post-in-service competency quiz (Doc #2) to validate understanding. Behavioral care plans for (R1) and (R2) were revised using a side-by-side review to ensure interventions were clear, consistent, and complementary. Interventions requiring direct staff accountability were implemented, including: • Shift-by-shift sign-off verifying that the infant monitor in (R1)'s room is in place and functioning to alert staff of entry and exit.	

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	In the aforementioned updated care plan for R1, there was no intervention to keep R1 apart or under supervision. 5/16/25 - R2's care plan was updated to include a new plan for sexually inappropriate behavior with interventions: encourage involvement in activities and redirect the resident from entering other residents' rooms. 5/19/25 5:45 PM – A facility incident report submitted to the State Agency documented that on 5/19/25 at 10:30 AM, R1 and R3 were sitting next to each other in the common room. R1 had put his hand on R3's breast, on the outside of her clothes. A CNA immediately redirected R1. 5/20/25 - R1's behavioral care plan interventions were updated to include: administer sertraline, to limit R1's behaviors, per MD order and monitor for effectiveness; if the resident is sitting next to a female resident in the dining room or common area, he is to be directly supervised; the resident must be supervised in common area due to behaviors; psych consult as needed; be firm, but kind when redirecting the resident, maintaining his dignity. 5/20/25 – R2's care plan for sexually inappropriate behavior was updated with new interventions to discourage her from sitting with a particular male resident, whenever possible, and to be discreet when redirecting the resident, so as not to embarrass or shame the resident. 9/5/25 - A BIMS assessment documented R2's cognition was scored as a 99, where R2 was unable to answer the questions.	• Initiation of 15-minute safety checks for (R2). CNA task assignments were revised to clearly reflect all required care plan interventions to ensure consistent communication and implementation. **D. Monitoring and Success Evaluation**: Staff Competency Monitoring: One hundred percent (100%) of nursing staff are expected to demonstrate competency in identifying and reporting abuse. A random sample of three staff members per week will be interviewed by the DON or designee for 30 days following the mandatory in-service. If 100% compliance is achieved: • Monitoring will continue weekly for four (4) weeks • Then monthly for three (3) months If 100% compliance is maintained for three consecutive months, the corrective action will be considered effective and incorporated into the facility's QAPI program. Care Plan and Environmental Monitoring: All three incidents occurred in a common area. An Intervention Checklist (Doc #3) was developed to ensure required supervision and	

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	10/7/25 - A review of R1's clinical record, BIMS assessment documented R1 with a score of 6, indicating severe cognitive impairment. 10/23/25 10:59 AM – A facility incident report was submitted to the State Agency and documented that on 10/22/25 at 9:37 PM, R1 exited his room and sat in a chair next to R2 in the common room. After an unknown time, R1 was seen touching R2's breast, on the outside of her clothes. A CNA and a nurse immediately redirected R1. There was insufficient evidence that the care plan for R1 was updated following the incident on 10/22/25. 10/29/25 – R2's care plan for sexually inappropriate behavior was updated with new interventions to complete and document 15-minute checks for R2, since she seeks out the male resident. 10/29/25 - The facility's 5-day follow-up summary submitted to the State Agency documented that the recliner chairs in the common area were modified by moving R1's chair apart from the other resident chairs to prevent R1 from having physical contact with other residents. 11/5/25 10:45 AM – During an interview, E4 (CNA) stated that R2 is being redirected from sitting in the chair next to R1 because R2 continues to try to sit next to R1. After the incident on 10/22/25, E4 stated that R2 had no negative outcome. R2 has been herself and has not changed her routine. 11/5/25 11:28 AM – During an interview, E5 (CNA) stated that during the incident on 10/22/25, R1 and R2 were sitting next to	environmental controls for (R1) are consistently implemented, including: • Use of a designated recliner positioned away from other residents • Strategic placement of furniture to serve as a barrier • Verification that the infant monitor is in place and functioning Monitoring schedule: Daily assessments by the DON or designee for three (3) weeks If 100% compliance is achieved: • Twice weekly for three (3) weeks • Weekly for three (3) weeks • Monthly for three (3) months If compliance is maintained for three months, the corrective action will be considered effective and incorporated into the facility's QAPI program.	

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	each other talking. Then R1 placed his hand on R2's breast over her clothes and E5 immediately redirected R2 by separating them. R2 did not react during the incident. R2 did not push R1's hand away, make any gestures, or show any emotional changes. After the incident on 10/22/25, R1 and R2 cannot sit next to each other anymore and are kept separated. E5 stated that R2 has been the same person, that she has not changed, and continues to socialize with people. 11/5/25 12:30 PM – During an interview, E6 (CNA) stated that they keep R1 and R2 separated and in different chairs, apart from each other. E6 stated that R2 attempts to get close to R1, but they redirect her. E6 stated that after the incident on 10/22/25, R2 has not changed or acted any differently than before. 11/7/25 8:49 AM – During an interview, E7 (RN) stated that on 10/22/25 he looked over at R1 and R2 and saw that R1 was touching R2. R2 did not have any reaction to R1 touching her. E7 called out to R1 and R2, but E5 was already on her way to R2 to redirect her. After the incident, R2 has been her regular self and has not had any changes in her behavior. R1 and R2 are not allowed to sit together. 11/7/25 9:55 AM – During an interview, E2 (DON) confirmed that R2's care plan was updated on 5/20/25 to discourage her from "... sitting with a particular male resident ..." (R1) and that it should have been followed as it was written. 11/7/25 1:30 PM - Findings reviewed with E1 (NHA), E2 and E3 (ADON) during the exit conference.		

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F609 S/S D	**§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for one (R2) out of three residents reviewed for abuse, the facility failed to report allegations of abuse to the State Agency within two hours. Findings include: A facility policy, "Abuse Prevention and Reporting Policy," last revision date October 2025, included "... The administrator or designee must report the allegation to the Delaware Division of Health Care Quality (DHCQ) within 2 hours for all allegations of abuse ...." A review of R2's clinical record revealed: 3/7/25 – R2 was admitted to the facility. 10/23/25 10:59 AM - An incident report from the facility was submitted to the State	**A.Individual/Resident Impacted:** (R1), (R2) and (R3). Unable to correct as the residents involved do not speak to the correction that was made. **B.Identification of other residents with the potential to be affected:** All current residents and future admissions. **C.System Changes:** The root cause was a lack of education and awareness regarding abuse identification and reporting procedures. Staff on duty did not recognize the events as potential abuse and were unaware of the two-hour reporting requirement to DHCQ via WellSky. Not all nurses had access or training to submit reports in the system and the administrative personnel were off site at the time. All licensed nurses have been trained by DON and provided with the WellSky Link, provider ID and login instructions. Access is now available on all nurses' station computers to allow 24/7 reporting. The Abuse Prevention and Reporting Policy {doc #1) was revised to include specific steps and clear expectations for reporting alleged abuse within two hours. All staff were in-serviced by the DON on abuse identification and reporting and the mandatory staff meeting on 11/14/2025. Each staff member completed a Post Inservice Test. The inservice included the "How to Report On-Line" procedure {doc #4}, which was also posted for reference at the nurses' station on 11/6/2025. Training will be completed annually and after any occurrence of	11/21/2025

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	Agency and documented an allegation of sexual abuse. The report documented that staff witnessed R1 touching R2 in an inappropriate manner. 11/7/25 8:49 AM – During an interview, E7 (RN) revealed that after the incident on 10/22/25, he had forgotten to notify E2 (DON). E7 stated that he reported to the next shift. 11/7/25 9:55 AM – During an interview, E2 confirmed that the incident occurred on 10/22/25 at 9:37 PM and the report was submitted on 10/23/25 at 10:59 AM. The facility did not submit a report of an allegation involving abuse to the State Agency within the two-hour timeframe. 11/7/25 1:30 PM - Findings reviewed with E1 (NHA), E2 and E3 (ADON) during the exit conference.	alleged abuse. The charge nurse on each shift will verify that all alleged abuse incidents are reported within two hours. The DON or designee will review the incident log and WellSky submissions daily for accuracy and timeliness. Compliance will be reviewed through daily monitoring and discussed during monthly QAPI meetings. **D.Success Evaluation:** 100% of alleged abuse incidents will be reported to the DON or designee immediately and to DHCQ within two hours. 100% of nursing staff will demonstrate competency in identifying and reporting abuse and in using the WellSky system. The DON or designee will review 100% of all incident reports daily to verify timely reporting and proper WellSky submission, using a monitoring tool to document compliance {doc #5}. Monitoring will continue daily for 3 weeks, then weekly for 4 weeks and monthly for 3 months after. If 100% compliance is maintained for three consecutive monthly audits, the correction will be considered effective and will be incorporated into the facility's QAPI program. The DON or designee will oversee and document monitoring and report findings to the Administrator during quarterly QAPI meetings.	

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F657 S/S D	**§483.21(b) Comprehensive Care Plans** **§483.21(b)(2) A comprehensive care plan must be—** **(i) Developed within 7 days after completion of the comprehensive assessment.** **(ii) Prepared by an interdisciplinary team, that includes but is not limited to—** **(A) The attending physician.** **(B) A registered nurse with responsibility for the resident.** **(C) A nurse aide with responsibility for the resident.** **(D) A member of food and nutrition services staff.** **(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.** **(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.** **(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.** **This requirement was not met as evidenced by:** A review of R1's clinical record revealed: 12/13/22 – R1 was admitted to the facility with diagnoses including, but not limited to, dementia and altered mental status.	**A.Individuals/Residents Impacted:** Residents identified as (R1) and (R2). The facility was unable to retroactively correct the deficient practice, as the residents involved have cognitive impairments and were unable to verbally confirm or refute the corrective actions implemented. **B.Identification of Other Residents with the Potential to be Affected:** All current residents and all future admissions were identified as having the potential to be affected by the deficient practice. **C.System Changes** Root Cause Analysis: The deficient practice was determined to have resulted from two primary factors: 1. Improper electronic updating of the behavioral care plan for (R1), which resulted in inaccurate intervention dating within the electronic health record. 2. Use of vague and ineffective behavioral care plan interventions that did not adequately prioritize resident safety or effectively address the risk of inappropriate behaviors. Following an incident on 10/22/2025, the behavioral care plan for (R1) was updated to include modification of the common area by distancing (R1)'s recliner from other recliners. During review, it was identified that instead of discontinuing the prior intervention	1/14/2025

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	5/19/25 5:45 PM – A facility incident report submitted to the State Agency documented that on 5/19/25 at 10:30 AM, R1 and R3 were sitting next to each other in the common room. R1 had put his hand on R3's breast, on the outside of her clothes. A CNA immediately redirected R1. 5/20/25 - R1's behavioral care plan interventions were updated to include: administer sertraline per MD order and monitor for effectiveness; if the resident is sitting next to a female resident in the dining room or common area, he is to be directly supervised; the resident must be supervised in common area due to behaviors; psych consult as needed; be firm, but kind when redirecting the resident, maintaining his dignity. 10/7/25 - A review of R1's clinical record, BIMS assessment documented R1 with a score of 6, indicating severe cognitive impairment. 10/23/25 10:59 AM – A facility incident report was submitted to the State Agency and documented that on 10/22/25 at 9:37 PM, R1 exited his room and sat in a chair next to R2 in the common room. After an unknown time, R1 was seen touching R2's breast, on the outside of her clothes. A nurse immediately redirected R1. There was insufficient evidence that the care plan for R1 was updated following the incident on 10/22/25. 10/29/25 - The facility's 5-day follow-up summary submitted to the State Agency documented that the recliner chairs in the common area were modified to prevent R1	and adding a new intervention, the previous intervention was overwritten. As a result, when intervention history was reviewed in the electronic chart, the new intervention carried a prior date of 5/20/2025, creating inaccurate documentation. To address this system issue, a procedure for updating care plans (Doc #6) has been developed to ensure: • Discontinuation of outdated interventions • Accurate dating of new interventions • Clear documentation of changes within the electronic record This procedure will be presented and reviewed at the Monthly Nurses' Meeting on 1/14/2026. Additionally, review of (R1)'s behavioral care plan revealed insufficient oversight and use of interventions that focused on behavior modification rather than resident safety, including the safety of other residents. The facility has re-emphasized that resident safety is the first priority. <u>Corrective Actions Implemented:</u> Behavioral care plans for (R1) and (R2) were revised to include clear, measurable, and safety-focused interventions:	

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	from having physical contact with other residents. 11/5/25 10:45 AM – During an interview E4 (CNA) stated that R2 is being redirected from sitting in the chair next to R1 because R2 continues to try to sit next to R1. 11/5/25 11:28 AM – During an interview, E5 (CNA) stated that after the incident on 10/22/25, R1 and R2 cannot sit next to each other anymore and are kept separated. 11/5/25 12:30 PM – During an interview, E6 (CNA) stated that they keep R1 and R2 separated and in different chairs, apart from each other. 11/7/25 at 9:55 AM – During an interview, E2 (DON) confirmed that R1's care plan did not reflect the changes that were in place to keep R1 and R2 separated. 11/7/25 1:30 PM - Findings reviewed with E1 (NHA), E2 and E3 (ADON) during the exit conference.	• (R1) is not permitted to sit with female residents, including during meals, activities, or in common areas. • (R1) has a designated chair in the common area that is distanced from other seating, with furniture and décor used as physical barriers to prevent reaching or touching other residents. • An infant monitor was added on 11/13/2025 to monitor (R1)'s room entry and exit. • (R2) is not permitted to sit with (R1). • (R2) was placed on 15-minute safety checks effective 10/29/2025, as she frequently seeks out (R1). • On 11/13/2025, (R2)'s family consented to a room change to the North Hallway, increasing physical separation between (R1) and (R2). The facility continues its established monitoring program to ensure that all common areas are supervised by staff whenever residents are present. A Care Plan Update Audit tool (Doc #7) was developed to ensure that when a change or occurrence is identified: • The resident's care plan is updated • New orders are obtained as needed • CNA instructions are revised • A progress note is completed	

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		These steps serve as formal communication methods to ensure staff are aware of changes in the plan of care. **D.Success Evaluation:** Expected Outcome: One hundred percent (100%) of residents will have an updated and accurate care plan when a change in condition or occurrence is identified, with interventions that prioritize resident safety. Monitoring Process: The DON or designee will audit all resident changes and occurrences using: • The Care Plan Update Audit tool • The 24-hour report • The incident report log Monitoring schedule: • Three (3) times weekly for one (1) month • If 100% compliance is achieved, then weekly for one (1) month • If 100% compliance is maintained, then monthly for three (3) months If 100% compliance is maintained for three consecutive months, the corrective system will be deemed effective and incorporated into the facility's QAPI program. The DON or designee will oversee the auditing process, document results, and report findings to the Administrator during quarterly QAPI meetings.	

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