DELAWARE HEALTH AND SOCIAL SERVICES

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

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

STATE SURVEY REPORT

NAME OF FACILITY: Wilmington Nursing and Rehabilitation **DATE SURVEY COMPLETED:** April 10, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced complaint and extended survey was conducted at this facility from April 5, 2024 through April 10, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documentation as indicated. The facility census on the first day of the survey was 123. The sample totaled six (6) residents. The facility was found to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities as of March 7, 2024. Cross Refer to the CMS 2567-L survey completed April 10, 2024: F580, F684, F690, F837, F838.	
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.**	
3201.9.0	**Records and Reports**	

Provider's Signature Renee Boyer Title LNHA Date 5/20/2024

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3201.9.6 3201.9.8 3201.9.8.4 3201.9.8.4.1	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. The method of reporting shall be as directed by the Division.** **Reportable incidents are as follows:** **Significant injuries.** **Injury from an incident of unknown source in which the initial investigation or evaluation supports the conclusion that the injury is suspicious. Circumstances which may cause an injury to be suspicious are: the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time.** **This require was not met as evidenced by:** Based on interview and record review, it was determined that for one (R3) out of one resident reviewed for injuries of unknown origin, the facility failed to report the injuries (right chin and upper lip bruises) to the State Agency within the required 8 hour timeframe. Findings include: Cross refer to F684, example 2a 4/5/24 at 1:35 PM – The facility's incident report by E18 (RN) documented, "... At (1:35 PM) after nurse (sic) was assisted back to bed, resident was noted with purple bruise on right side of chin and philtrum (upper lip). (R3) could not explained (sic) what happened...".	Cross refer 684 2a A. R3 still resides at the facility. Bruise was reported by Director of Nursing as soon as staff made her aware. B. All residents who have sustained an injury have the potential to be affected. An audit of the last 2 days of injuries of unknown origin was completed to ensure appropriate timely reporting was completed by the facility staff. C. Root cause determined that facility staff failed to notify the supervisor as soon as an injury was found on a resident. The DON/staff educator will educate all staff discovering an injury of unknown origin shall report the injury to a supervisor immediately. If the staff member is unsure if it is a new injury or existing, they are to contact the nurse for further clarification. D. The DON/nursing supervisor will complete an audit on any injuries reported daily to ensure a supervisor was notified immediately of discovery daily x 4 week until 100% compliance is achieved, then weekly x 4 weeks until 100% compliance is achieved and then monthly x 4 months until 100% compliance is achieved. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported x 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. Date of correction: 5/13/2024

Provider's Signature Renee Boyer Title LNHA Date 5/20/2024

NAME OF FACILITY: Wilmington Nursing and Rehabilitation **DATE SURVEY COMPLETED:** April 10, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	4/10/24 at 10:02 AM - During an interview, E15 (assigned LPN) that this was her first day off orientation and confirmed that she saw a small redness on R3's chin when she administered medications to R3 at 8:30 AM. E15 stated that she didn't think about reporting it. R3 was sitting up in her wheelchair. At 1:30 PM, E15 stated that she observed R3's purple bruises on her chin and upper lip. 4/5/24 at 7:31 PM – The facility reported R3's bruises of unknown origin to the State Agency, approximately 11 hours later. 4/10/24 at 4:30 PM – Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (RN RDCS).	Cross refer 684 2b A. R3 still resides at the facility. E19 was educated by the Director of Nursing on documenting post fall assessments. Unable to correct missing documentation of assessment. B. All residents have the potential to be affected by this deficient practice. The DON/nursing supervisor completed an audit of the last 48 hours of falls to verify an RN performed a post fall assessment and that assessment is documented in the medical record. Any assessment not documented will be entered into the medical record as a late entry. C. Root cause analysis was determined that the registered nurse completed the post fall assessment, but failed to enter that assessment into the medical record due to the belief that the assigned nurse could document that they were assessed by registered nurse. The DON/staff educator will educate licensed nurses and certified nursing aids that after a fall the resident is to be assessed by a registered nurse and that assessment is to be documented in the medical record. Once assessment is completed by the registered nurse and they deem the resident is safe to move, then the resident can be moved to appropriate location (bed, chair, etc). D. The DON/nursing supervisor will audit all falls daily to ensure an registered nurses assessment was completed and documented in the medical record and the resident wasn't moved until after the assessment was completed x 4 weeks until 100% compliance is achieved, then weekly x 4 weeks until 100% compliance is achieved, and then monthly x 4 months until 100% compliance is achieved. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported x 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. Date of correction: 5/13/24
3201.9.8.4.2	**Injury which results in transfer to an acute facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.** **This requirement was not met as evidenced by:** Based on review of the clinical record and other documentation as indicated, it was determined that for one (R3) out of one resident reviewed for injuries of unknown origin, the facility failed to report R3's fall on 4/5/24 in which the resident sustained a hematoma. Findings include: Cross refer to F684, example 2b 4/5/24 at 6:18 PM – The facility's incident report documented that R3 was found on the floor laying on her right side next to the bed with her right side of head against the nightstand. R3 was noted to have a hematoma on the right side of forehead and bruising to the left forehead.	

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	The nursing staff immediately initiated neuro-checks. The incident report lacked evidence that the State Agency was notified. The facility failed to report R3's fall on 4/5/24 to the State Agency as required. 4/10/24 at 4:30 PM – Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (RN RDCS).	

Provider's Signature Renee Boyer Title LNHA Date 5/20/2024

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	085028	A. BUILDING _____ B. WING _____	C 04/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD WILMINGTON, DE 19803

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F 000	INITIAL COMMENTS An unannounced Complaint and Extended Survey was conducted at this facility from April 5, 2024 through April 10, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 123. The sample totaled six (6) residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurses Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RDCS - Regional Director of Clinical Services; PTA - Physical therapy assistant; RN - Registered Nurse; TNA - Temporary Nurses Aide, also referred to as a non-certified nursing assistant by the facility; UM - Unit Manager; X - By Afib - atrial fibrillation (an irregular heart rhythm); CPR - cardiopulmonary resuscitation; EMS - emergency medical services; Hematoma - a pool of mostly clotted blood that forms in an organ, tissue, or body space; L/min - liters per minute; MDS - minimum data set; Neurological Checks - a physical examination to evaluate brain and nervous system functioning; Pulse ox - pulse oxymetry.	F 000		
F 580	Notify of Changes (Injury/Decline/Room, etc.)	F 580		5/13/24

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

Electronically Signed | 05/03/2024

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

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F 580 SS=D	Continued From page 1 CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident	F 580		

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F 580	Continued From page 2 representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and review of the clinical record and additional documentation as indicated, the facility failed to notify and update C5 (Optum NP) of changes to R3 after her fall on 4/5/24 to determine if further interventions were needed. Findings include: Cross refer to F684, example 2b 4/8/24 at 6:08 PM - C5's medical note documented, "... seen and evaluated s/p (status post) fall on 4/5/24. Nursing called provider after hours and reported fall from bed with minor injury-skin tear to left elbow and bruising to face. No bleeding noted and neurochecks were WNL (within normal limits). Today, resident noted with multiple bruising to face - right eye orbit bruised, right forehead, bruise to left (sic) chin and hematoma to left forehead... does not appear to be in pain...". 4/8/24 at 9:30 PM - An order note documented, "New orders received to hold ASA (aspirin) x 5 days, start Acetaminophen 650mg... BID (twice a day) and to apply cool compress to right eye TID (three times a day)...".	F 580	F580 A. Resident R3 still resides at the facility. Nurse practitioner was contacted on 4/5/24 around 1818 regarding the fall. Nurse practitioner completed an in house visit with resident on 4/8/24 around 1808 and new order to hold aspirin was immediately initiated. B. All residents who have sustained a fall with injuries have the potential to be affected. An audit of the last 7 days of falls was completed to identify any injuries sustained and/or any changes that occurred after the fall and verify notification of provider was completed. Any notification found not to be completed was completed and any changes in the plan of care were updated if applicable. Facility implemented the user of the Interact Fall CarePath after a fall to guide the nurse on targeted assessment and items to inform the provider about. C. Root cause of this deficient practice was that the nurse who notified the provider was not the same nurse who assessed/saw the resident after the fall.	

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F 580	Continued From page 3 4/10/24 at 10:49 AM - During an interview, C5 (Optum NP) stated that she was contacted by the facility staff after 5 PM on 4/5/24. C5 stated that she asked about bleeding, neurochecks and anticoagulants. C5 stated that she was not told about R3's hematoma nor was she told about R3's daily aspirin medication. C5 stated that she checked the on call log for the weekend and there were no calls made from facility staff regarding R3's medical status. 4/10/24 at 4:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (RN RDCS).	F 580	Facility implemented the use of the Interact Fall CarePath after a fall to guide the nurses on targeted assessments and items to inform the provider about. The DON/staff educator will educate licensed nurses on the Interact Fall CarePath reviewing that after a fall, the resident is to be assessed by a registered nurse utilizing the Interact Fall CarePath as a guide for assessment and targeted items to inform the provider of. After assessment is completed, the registered nurse will document in the medical records and either the nurse or the supervisor will notify the provider and report relevant medications the resident is taking. If the supervisor is notifying the provider, they will receive a fall report from the assessing nurse to ensure all injuries (if any) are reported accurately to the provider. In addition, if after a fall a resident is experiencing any changes (i.e., increased pain medication use, increased bruising) the provider is to be notified of the changes. D. The DON/nurse supervisor will audit falls to verify that a registered nurse assessed the resident, the provider was notified of any/all injuries, relevant medications the resident was taking and if any changes occurred after the fall that the provider was notified weekly x 4 weeks or until 100% compliance, then every 2-week x 4 or until 100% compliance and then monthly x 4 or until 100% compliance. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported x 4 months. The QAA committee will	

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F 580	Continued From page 4	F 580	determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of compliance 5/13/2024 Audit tool template sent via email to dhss_dhcq_poc@delaware.gov.	
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Post IDR 5/13/24 revision Based on observation, interview and review of clinical records and other documentation as indicated, it was determined that for two (R1 and R2) out of four residents reviewed for follow-up appointments, the facility failed to ensure that the correct resident (R1) was sent to a cardiology appointment on 4/3/24. R2, a newly admitted cognitively impaired resident, was sent with R1's medical paperwork and accompanied by a facility aide, who did not know the resident. At the appointment, R2 was slumped in a wheelchair with altered mental status and the facility aide did not know the resident's baseline. 911 was called	F 684	F684 1 A. R1 and R2 no longer reside at the facility. Unable to correct. -Facility was made aware on 4/3/24 at 1214 that R2 was at the doctor□s office instead of R1, and R2 was being sent to the hospital from the doctors office. -Nurse called the R2 wife to advise of his location and that R2 was being sent to the hospital 4/3/24 @ 1230 -Facility called the hospital to inform the hospital that the wrong resident was there and that R2 wife was there and could ID him. Facility obtained information from	5/13/24

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F 684	Continued From page 5 and R2 was emergently sent to the Emergency Room (ER) with R1's medical paperwork. In the ER, R2 was initially registered under R1's name until it was brought to the ER's attention. The facility's failure placed R2 at risk for a serious adverse outcome or death as R2 had the potential to receive treatment based on R1's medical paperwork provided to the Cardiologist's office, to the EMTs for transfer to the ER and to the ER staff with respect to the different code status, medications, allergies and treatments. Due to this failure, an Immediate Jeopardy (IJ) was called at 2:31 PM on 4/5/24. The IJ was abated on 4/5/24 at 4:30 PM. Also, for one (R3) out of one resident reviewed for injuries of unknown origin, the facility failed to ensure that nursing staff immediately reported an observed facial injury and implement interventions; failed to ensure that an RN documented her assessment after the resident's fall with a visible head injury; and failed to safely transfer the resident off the floor to protect the resident from further injury. Findings include: 1a. Review of R1 and R2's clinical records revealed: For R1: - admitted to the facility on 3/29/24 with diagnoses including, but not limited to, recent fall, supraventricular tachycardia, atrial fibrillation, acute kidney injury, hyperkalemia, cardiomyopathy, diabetes mellitus type 2; - full code status (requiring CPR); - no known allergies; - assigned room was XXX; and - the hospital Interagency Discharge Orders, dated 3/29/24 at 1:10 PM, documented that R1 had a follow-up cardiology appointment on 4/3/24	F 684	hospital to fax correct residents paperwork to ER on 4/3/24 @ 1240 B. Current residents residing in the facility have the potential of being affected by this practice. NHA went into calendar on EHR program and pulled up all upcoming appointments for the next 48 hours. She printed the appointments and the corresponding face sheets. These packets were put on each nursing station for staff who care for them on 4/3/24 @ 1930 C. Root cause was determined to be the facility did not have a validation process of identifying residents for appointments. -Staff present in facility were educated by NHA, DON or staff developer on below process change starting on 4/4/24 @ 0530 -Administration team was notified of incident by NHA on 4/4/24 @ 0945 to be on alert and informed of the new system change. -Receptionist were trained by NHA/DON to stop everyone at the front door to verify the correct resident is leaving for the appointment and verify resident with signed face sheet on 4/4/24 @ 0800 and 4/5/24 0830 -Each resident□s picture was uploaded into PCC by activities (except the 2 that were out at an appointment) completed by 4/4/24 by 1700. As of 4/5/24 @ 10am the remaining 2 residents and the 2 admission were uploaded in PCC. NHA and/or designee will educate staff starting on 4/4/24@ 0530 to ensure that the identification process for scheduled	

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F 684	Continued From page 6 at 10:00 AM. - admission MDS assessment, dated 4/4/24, documented the BIMS (Brief Interview of Mental Status) of 14, revealing that R1 was cognitively intact. For R2: - admitted to the facility on 3/19/24 with diagnoses including, but not limited to, recent fall, several facial fractures, dementia, carotid artery stenosis, diabetes mellitis type 2, morbid obesity, obstructive sleep apnea, dysphagia, hypernatremia and atrial fibrillation; - DNR (Do Not Resuscitate) code status; - allergy to Sulfa antibiotics; - assigned room was YYY; and - admission MDS assessment, dated 3/25/24, documented the BIMS of 3, revealing that R2 was cognitively impaired. 4/3/24 at 7:25 AM - An appointment form was completed and faxed to the transport company for R1's 10:00 AM appointment with a pick-up time of 9:00 AM. The patient information section documented R1's name, facility name, address, phone number and a room number. The room number documented was incorrect as it was R2's room number (YYY). 4/3/24 at 12:00 Noon - The facility's incident report documented the following: - "... [R2] was transported to a cardiologist appointment with [E6 TNA] as his escort. The appointment time and location was for a scheduled follow up but was intended for a different resident [R1].... During the exam, the resident had a change in condition and was transferred via EMS/911 to the (hospital) ED (emergency department)...".	F 684	appointments is per below. System changes to prevent reoccurrence: " All residents are to have a current photo uploaded into PCC at time of admission by the activities department and/or nursing supervisor. Nursing supervisor educated on uploading pictures into PCC at 4/5/24 at 1602. At times a resident will refuse, a second attempt to obtain a picture is to be made by management staff/designee immediately upon notification and if they still refuse the facility will place an ID bracelet. If they refuse the ID bracelet, staff will utilize verbalize identification to verify residents identify (i.e. name and date of birth). If the resident is confused or non-verbal identification of resident will be made with 2 staff members who are familiar with the resident. " All scheduled appointments must be entered into the calendar by unit clerk making appointment. This calendar will be printed out daily by the and given to the front desk. Along with this, there will be a printout of the individual□s face sheet. The night supervisor and or designee will be responsible to print these out. " Transportation companies are to be stopped at the receptionist desk and asked the name of patient/resident. Then they will be directed to the proper room. At which time a copy of the face sheet will be given to transport who will have a staffing member to verify identification. Validation made from photo, right name, and right appointment. Nursing staff will then sign the face sheet and direct transport back to the receptionist desk.	

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F 684	Continued From page 7 4/3/24 - The hospital record documented: - at 12:29 PM, the patient (R2) arrived at the ER; - upon arrival at the ER, R2 was registered under R1's name; - at 12:41 PM under R1's name, C4 (ED Physician) documented, "... 75-year-old gentleman history of ischemic cardiomyopathy with ejection fraction of 20 to 25%, atrial fibrillation/flutter on Eliquis, type 2 diabetes mellitus, chronic kidney disease stage III... reviewed discharge summary from March 29 when he was admitted to the hospital after a fall.... Coming into the emergency department from cardiology outpatient follow-up visit noted to be altered and hypotensive, reviewed the note from cardiology from today, apparently he had been altered for about 3 hours prior to presenting to the cardiology office but the nursing facility staff who was with him was unfamiliar with his baseline...". - at 2:06 PM, C3 (ED Physician) documented, "... 76-year-old male with past medical history of cognitive decline, HTN, HLD (hyperlipidemia), obesity, OSA (obstructive sleep apnea) on BiPAP, diabetes, A-fib previously on Eliquis who was discharged on 3/19 after admission for a fall. Patient is actually benign and presents from a cardiology office for altered mental status. Unfortunately patient was taken to the cardiology appointment that was for a different resident of his skilled nursing facility. That patient is reportedly alert and oriented x4 at baseline however (R2) has cognitive decline and is alert to only self at baseline. Patient was brought with documentation of the other patients (sic) that was unfortunately registered under that patient's name. Patient's (R2) wife did arrive with patient's actual chart from the skilled nursing facility. She	F 684	" The reception desk will collect the signed face sheet and document the time they left the building. " If the appointment doesn□t appear on the calendar, then a face sheet will not be printed. Facility will not release patient/resident until proper verification is made. DON and/or Administrator will also be notified. Education will be completed with nursing staff in person by NHA, DON, or staff developer on the above process by 4/5/24. A written notification was sent to all employees is Hosted Time with above education on 4/5/24 at 0915. Those educated via Hosted Time will receive education again in person prior to starting their next shift. The DON/staff developer will continue to educate new hires during new orientation on the appointment process. D. NHA and/or designee will conduct audits of scheduled medical appointments verifying that the correct resident and medical appointment match daily x 30 days until 100% compliance achieved, then weekly x 2 weeks until 100% compliance achieved and then monthly x 1 month until 100% compliance achieved. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported x 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 2a A. R3 still resides at the facility. Nurse practitioner was contacted on 4/5/24	

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F 684	Continued From page 8 was able to clear out his medical history for me. Patient is at his mental baseline currently. She states he has had no recent complaints and has heard nothing from the facility about changes in mental status, vitals, any new symptoms. She states that if he had not been sent out for the cardiology appointment today, he likely would not have ever ended up in the emergency department. Of note however patient was noted to be hypotensive on arrival into the 80s. He is a poor historian and is unable to answer any questions. Was noted to be into the upper 80s while lying flat... (at) 12:37 (blood pressure) 85/54... (at) 2:56 PM (blood pressure) 87/56... Pulse Ox:98%... Nasal Cannula 4 L/min (placed on oxygen)... was also noted to be hypoxic... Disposition: pending labs, CT (diagnostic test), anticipate admission...". 4/3/24 at 3:56 PM - C1 (PA) with the Cardiologist Office documented in a note, "I was scheduled for a hospital follow-up today with (R1's name and date of birth). Patient was brought in by aide from Wilmington rehab with the paperwork for (R1's name). Due to altered mental status patient was unable to provide his own name or date of birth. Patient was unable to respond to questions or follow commands. Aide stated she was not familiar with the patient but this had been his current mental status for the past 3 hours. I called (Cardiologist Physician name) to discuss clinical findings and new altered mental status compared to baseline. 911 was notified and on EMS arrival discussed patient's condition. After patient left via EMS patient's aide returned and stated they had brought the wrong patient to the office. Discussed over phone with (facility staff person) that the patient brought in was actually (R2's name and date of birth). At the Christiana ER patient had	F 684	around 1818 regarding the fall. Nurse practitioner completed an in house visit with resident on 4/8/24 around 1808 and new order to hold Aspirin was immediately initiated. B. All residents who have sustained an injury have the potential to be affected. An audit of the last 2 days of injuries was completed to ensure appropriate monitoring occurred and the appropriate reporting was completed. Any monitoring not completed or reporting not completed will be done upon discovery. C. Root cause determined that facility staff failed to complete a neurological assessment after an injury was found on a resident□s head due to lack of knowledge that any head injury needs a neurological assessment. The facility policy was updated to include examples of types of injury that require neurological checks. The DON/staff educator will educated licensed nurses on the updated head injury policy and that when there is an injury to the head, of known or unknown origin, a neurological assessment will be completed to ensure no changes in neurological status occur. If any changes are noted, the provider will be made aware for further directions. The DON/staff education will educate all staff discovering an injury of unknown origin shall report the injury to a supervisor immediately. If the staff member is unsure if it is a new injury or existing, they are to contact the nurse for further clarification. D. The DON/nursing supervisor will complete an audit on any injuries reported daily to ensure neurological checks were	

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F 684	Continued From page 9 been identified as (R1's name) and had no previous identification bracelet from rehab. Discussed with clerk who changed encounter to appropriate patient. Patient's wife arrived and identified that he was in fact (R2's name) and mental status was at baseline given history of dementia and fall last month. Case was discussed with ED resident who resumed care at that time...". The facility's investigative documentation provided to the Surveyor captured their immediate response: "(4/3/24 at 12:20 PM) Immediately upon notification of situation ... - (at 12:14 PM) Facility was made aware that it was the wrong resident at the doctor's (sic) office and he was sent to the hospital. - (at 12:30 PM) Nurse called the wife to advise of his location and that he was being sent to the hospital ... - (at 12:40 PM) Facility called the hospital to educate the hospital that the wrong resident was there and that his wife was there and could ID him and obtained information to fax correct residents paperwork to ER ...". On 4/3/24, the facility's investigation included the following typed and untimed statements: - E6 (TNA): "Around 8:30 AM I was asked to go on an escort with a resident named (R1's first name) and I was directed to his room on the Arcadia unit with the transport team. He was dressed and, in his wheelchair, ready to go. Shortly after getting him off the unit, I was approached by his wife, and she was asking where he was going because she wasn't informed of any appointments. She stated she was informed of an appointment for April 11th but	F 684	started if applicable and a supervisor was notified immediately of discovery daily x 4 week until 100% compliance is achieved, then weekly x 4 weeks until 100% compliance is achieved and then monthly x 4 months until 100% compliance is achieved. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported x 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. 2b A. R3 still resides at the facility. E19 was educated by the Director of Nursing on documenting post fall assessments. Unable to correct missing documentation of assessment. B. All residents have the potential to be affected by this deficient practice. The DON/nursing supervisor completed an audit of the last 48 hours of falls to verify an RN performed a post fall assessment and that assessment is documented in the medical record. Any assessment not documented will be entered into the medical record as a late entry. C. Root cause analysis was determined that the registered nurse completed the post fall assessment, but failed to enter that assessment into the medical record due to the belief that the assigned nurse could document that they were assessed by registered nurse. The DON/staff educator will educate licensed nurses and certified nursing aids that after a fall the resident is to be assessed by a registered nurse and that assessment is to be documented in the medical record. Once	

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F 684	Continued From page 10 not for today. I asked [E5, Unit Clerk] where the resident was going, and she said the cardiologist. I directed his wife to [E5] because I wasn't aware of any other information from the resident and knew [E5] could better answer her questions. After we left the facility, the transport company stopped and picked up another person from a different facility. This person was dropped off before (R1's first name) and we didn't arrive at the appointment until 11 AM. He was checked in with his name and birthday based on the paperwork I was giving them. The resident was brought to the exam room and seen by MOA (Medical Office Assistant) and a PA (Physician Assistant). During this time, he put his hand on his chest and stated, 'help me'. The PA nor the MOA could get a BP (blood pressure) on (R1's first name). In the exam room, he would be alert then in a state of disorientation like he was sleeping. The PA notified the cardiologist who usually sees the resident (R1's first name) and based on this information, the PA informed me they were calling 911 and sending him to the ED. This was around 12 PM. About 12:20 PM, [E5] called my cell phone to let me know the wrong resident was at the appointment. The resident I have is [R2]. She asked to speak to the nurse, so I took the phone to the PA." - E5 (Unit Clerk): "(R2's name) had left to go to the doctor's appointment when I realized it was the wrong resident. I checked the calendar and immediately called the Drs (Doctors) office. I let the staff know it was not (R1's name) but they had seen (R2's name). I let them know [R2] would be transported back to the facility. The nurse said he was a patient of theirs (sic) and they would see him. A few minutes later the TNA [E6] who escorted him called to let me know they	F 684	assessment is completed by the registered nurse and they deem the resident is safe to move, then the resident can be moved to appropriate location (bed, chair, etc). D. The DON/nursing supervisor will audit all falls daily to ensure an registered nurses assessment was completed and documented in the medical record and the resident wasn□t moved until after the assessment was completed x 4 weeks until 100% compliance is achieved, then weekly x 4 weeks until 100% compliance is achieved, and then monthly x 4 months until 100% compliance is achieved. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported x 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of compliance: 5/13/2024 Audit tool sent via email to dhss_dhcq_poc@delaware.gov.	

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were sending him to the ED. The nurse told me to send [R2's] info (information) to Christiana Care ED in Newark. I sent everything the nurse told me to send. I gave the cardiology number to his direct nurse then sent his entire chart. The nurse notified his wife."

- E7 (R2's Nurse): "The TNA [E6] was with the resident and the transport company was here to pick up resident. His name was not on the schedule, so I asked the TNA to check with [E5, Unit Clerk]. E5 said he had an appointment. [E6], the TNA left with [R2].... was working the morning (R2's name) was picked up for his appointment. The TNA [E6] reported to [E7] that the resident's wife was asking what the appointment was for as she had no knowledge of an appointment this week. [E7] directed the TNA [E6] to seek out clarification from [E5 Unit Clerk] who schedules the appointments...".

- E8 (Nurse): "[E5, Unit Clerk] was upset and reached out to me for help. She explained to me what had happened with the resident mix up. [E5] asked me to call the wife and let her know about the appointment, his change of condition, and he was being transported to... ED. At this time, [E5] was on the phone with the cardiology office. The wife called me [E8] back when she arrived at the ED. She was asking for [R2], and being told he was not a patient. I spoke with the ED nurse and explained what had occurred, verified the resident in their care is [R2] and his wife was there."

- E2 (DON): "Soon after I gathered information leading up to the event, I spoke with [E5, Unit Clerk] in the presence of [E1 NHA]. She [E5] recalled giving the TNA [E6]... the room number of [YYY], not the room number of the scheduled

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F 684	Continued From page 12 resident. She agrees the scheduled appointment was for [R1]... with his cardiologist. We discussed the chain of events that led up to her giving the incorrect room number. She had printed the correct resident information, and this envelope was passed to the TNA [E6]...". On 4/3/24, the facility documented the following actions taken: - (at 7:30 PM) NHA went into calendar on EHR (electronic health record) program and pulled up all upcoming appointments for the next 48 hours. She printed the appointments and the corresponding face sheets. These packets were put on each nursing station for staff who care for them ...". - (untimed) E2 (DON) documented an Employee Corrective Action for E5 (Unit Clerk) for "Resident placed in unfamiliar environment. Became anxious and agitated. Spouse was given incorrect information. Was put in an eventful situation causing emotional & (and) physical stress." In addition, E2 documented " ...Soon after I gathered information leading up to the event, I spoke with [name of E5] in the presence of the Administrator ... We discussed the chain of events that led up to her giving the incorrect room number ... Following our conversation, we implemented a plan of correction immediately and started educating all staff. This education was given to [name of E5], and she verbalized understanding and signed the documentation." On 4/4/24, the facility documented the following actions taken: - (at 5:30 AM) "Staff present were educated on below process change with staff education continuing on the following process. System changes to prevent reoccurrence:	F 684		

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F 684	Continued From page 13 * All residents are to have a current photo uploaded into PCC within 72 hours from admission. At times a resident will refuse, however a second attempt to obtain a picture is to be made. * All scheduled appointments must be entered into the calendar. This calendar will be printed out daily and given to the front desk. Along with this, there will be a printout of the individual's face sheet. The night supervisor and or designee will be responsible to print these out. * Transportation companies are to be stopped at the receptionist desk and asked the name of patient/resident. Then they will be directed to the proper room. At which time a copy of the face sheet will be given to transport who will have a staffing member to verify identification. Validation made from photo, right name, and right appointment. Nursing staff will then sign the face sheet and direct transport back to the receptionist desk. * The reception desk will collect the signed face sheet and document the time they left the building. * If the appointment doesn't appear on the calendar, then a face sheet will not be printed. Facility will not release patient/resident until proper verification is made. DON and/or Administrator will also be notified. Education will be completed with nursing staff on the above process by 4/5/24. - (at 8:00 AM) Receptionist was trained to stop everyone at the front door to verify the correct resident is leaving for the appointment and verify resident with signed face sheet." - (at 9:24 AM) The facility reported the following to the State Agency: "Incorrect resident was transported out of the facility to a follow up appointment scheduled for another resident." It	F 684		

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F 684	Continued From page 14 should be noted that despite the incident occurring on 4/3/24, the facility failed to report this incident within the required 8 hours per State Regulation and failed to disclose to the State Agency that the incorrect resident was emergently sent to the hospital from the appointment. - (at 9:45 AM) "Administration team was notified of incident to be on alert and informed of the new system change." An Ad Hoc QAPI sign-in sheet was dated 4/4/24. - (untimed) E2 (DON) documented an Employee Corrective Action for E7 (LPN) for "Resident placed in unfamiliar environment. Became anxious and agitated. Spouse was given incorrect information." In addition, E2 documented " ... In my conversation with [name of E7], I pointed out she, as the nurse, should seek clarification herself, so as not to have it go through multiple staff. She also was given the place of correction steps and education ...". 4/4/24 at 1:24 PM - During an interview with the Surveyor, C2 (Nurse Manager) with the cardiology office confirmed that R2 was not a patient of this cardiology practice. C2 stated that she observed the resident (R2) sitting in a wheelchair in an evaluation room slumped over to the right and was somnolent with the aide present. Surveyor observed that R1's paperwork printed for the office appointment did not have a identification picture of the resident (R1). 4/4/24 by 5:00 PM - The facility documented that each resident's picture was uploaded into PCC except the two that were out at an appointment. 4/5/24 at 8:30 AM - The facility documented that (second) receptionist was trained regarding the	F 684		

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F 684	Continued From page 15 new process. 4/5/24 at 9:15 AM - The facility documented that a written notification was sent to all employees through Hosted Time with the above education outlined on 4/4/24 at 5:30 AM. Those educated via Hosted Time will receive education again in person prior to starting their next shift. 4/5/24 at 10:00 AM - The facility documented that the "remaining two residents (pictures) and the two admissions were uploaded in PCC." 4/5/24 at 10:29 AM - During an interview with the Surveyor, F2 (R2's wife) stated the following: - On 4/3/24, F2 arrived at the facility for a visit at approximately 9 AM. - Transport personnel and E6 (TNA) were taking R2 out of the Arcadia unit. F2 asked "Where are you going?" F2 was told that R2 was going to a follow-up with the cardiologist. F2 said that she did not know about the appointment. F2 followed them up in the elevator. F2 stated that E5 wrote the address down. F2 asked if the appointment was at (name of building) and was told it was in Newark. (It should be noted that the building F2 named was also located in Newark.) F2 stated that she got into her car to follow the transport van. F2 stated that the transport van made a left hand turn onto to Foulk Road and both back doors of the van opened. The van stopped on Foulk Road and the back doors were closed from the inside. F2 stated that she could not follow the transport van and lost site of it. At 9:55 AM, F2 arrived at the cardiologist at the (name of building) and was told that R2 was not here. F2 stated that she went back to the car and looked at the paperwork with the cardiologist office address she was provided and went there. At	F 684		

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approximately 10:15 AM, F2 arrived at the address she was provided and was told there was no one here by that name (R2) nor scheduled. F2 stated that R2's vascular surgeon was located in the same building, so she went to that office and no one knew anything there. F2 stated that she even went to the 3rd floor cardiologist office, which is affiliated with the 2nd floor, and no one knew anything. At approximately 11:30 AM, F2 stated she called the facility to find out the location of my husband, R2. F2 stated that she believed she spoke with E14 (PTA) and was told that she would find out. At 11:50 AM, F2 stated that she went home to get changed because she was soaked from getting in and out of her car as it rained all morning and called her son. At approximately 12:30 PM, F2 stated that she received a call from a facility nurse (E8) that said her husband, R2, was taken to the ER for a heart attack. F2 stated that she called both kids about this. At approximately 1:20 to 1:30 PM, F2 arrived at the ER receptionist desk and explained that she was told her husband (R2) was brought here with a heart attack. F2 said that she was told by the ER receptionist desk that they do not have him (R2's name) in the system. F2 stated that she called the facility back to find out what was going on and was asked if she was at the (name of) ER. A facility staff person asked to speak to the ER receptionist. At approximately 2:10 PM, F2 said she was taken back by an ER nurse, where R2 said "What's up?" to F2 when she entered his ER room. F2 stated that R2 did not have a heart attack, but was later admitted and treated for a urinary tract infection.

4/5/24 at 11:30 AM - During an interview with the Surveyor, E14 (PTA) stated that she believed she

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received two calls from F2 (R2's wife) but could not recall the exact times. E14 stated that F2 called and said she could not find R2. E14 stated that she would check with E5 (Unit Clerk) and would get back to her. E14 then said that F2 called from the hospital and told her that no one was here by R2's name. E14 said she handed the phone over to E8 (Nurse).

4/5/24 at 11:45 AM - During an interview with the Surveyor, E5 (Unit Clerk) stated that there were two unit clerks about six months ago who were scheduling appointments for residents. Currently, E5 schedules appointments and arranges transportation, coordinates with the Scheduler for those residents who need an escort, and E14 had recently been assisting E5 with the scheduling appointments. E5 stated that she was not in the facility on 3/29/24, the day that R1 was admitted. E14 entered his appointment on the calendar (but did not arrange transportation). E5 stated that she did not completely open the facility's electronic appointment calendar to review all the details regarding the 4/3/24 appointment. E5 stated that she made a mistake thinking it was R2's name, but the calendar actually had R1's name on it. E5 went to the scheduler to ask for someone to go to the appointment with R2.

It should be noted that all appointments scheduled for the day are listed on the (name of electronic health record) electronic dashboard, which was accessible to all nursing staff.

4/5/24 at approximately 12:20 PM - During an interview with the Surveyor, E6 (TNA) stated she mainly does 1:1 observation, will help out in the kitchen and escorts residents to outside appointments (approximately 3 times since she

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started with the facility). E6 stated she was assigned a 1:1 with another resident on 4/3/24 when she reported to work at 7 AM. E6 stated that E5 (Unit Clerk) came a little after 9 AM to get me and take me to R2's room (YYY) and transport staff were already there in his room. E7 (Assigned Nurse) gave me the packet (medical records) for the appointment at the nurse's station. E6 stated that she asked where was R2 going and E7 checked the computer and could not find anything and told her to check with E5 (Unit Clerk). At approximately 9:20 AM, transport staff was taking R2 off the unit and we ran into R2's wife, who asked where was he going? E6 told F2 to the cardiologist and F2 asked where. E6 stated F2 then went to go talk to E5. E6 stated they left the facility at approximately 9:30 AM and confirmed that the two back doors of the transport van opened while turning left onto Foulk Road. E6 stated that the transport van stopped at another facility to pickup a second patient in a stretcher and dropped that patient off at the (name of location) at 10:30 AM. E6 stated that the transport driver called the cardiologist office because the 10:00 AM appointment was missed and cardiologist office stated they had another opening at 11:30 AM. E6 stated that they arrived at the cardiologist office and to check in she entered the resident's name and date of birth (R1) based on the paperwork she had with her. E6 stated that the cardiologist office medical assistant was trying to get a blood pressure reading and could not. The PA consulted with R1's cardiologist by phone and decided to send patient to the ER to be evaluated. E6 stated that she called the facility at approximately 11:45 AM and spoke to E5 (Unit Clerk) and was put on hold, then the phone hung up and she kept calling. E6 stated that the EMTs (emergency medical

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technicians) stated the patient was in 'aFib' and had low blood pressure. E6 stated that she handed the EMTs R1's paperwork, which included the medication list. At approximately 12:20 PM, E5 told me that it was the wrong resident and transport would be returning to pick her up and the resident's wheelchair. E6 stated that she gave the phone to the cardiology PA and then waited for transport to pick her up. E6 stated that some appointment packets have photos, but there was no photo on R1's packet.

4/5/24 at 12:56 PM - During an interview with the Surveyor, C1 (Cardiology PA) stated that the resident who was at the appointment was minimally responsive. C1 called R1's Cardiologist and the resident's presentation was not typical as R1 was fully alert. After consulting and based on the altered mental status, the office called 911. Resident was transferred to the ER. The facility escort came back into the office and C1 learned that the wrong resident was sent to the appointment. C1 stated that she went over to the hospital ER on 4/3/24 at approximately 1 PM and spoke with the ER Triage and bedside nurses and the Resident Physician to make sure the ER was aware that they had the correct patient information. C1 stated that she was present when R2's wife arrived.

4/5/24 at 2:31 PM - An Immediate Jeopardy was called with E1 (NHA), E2 (DON) and E3 (RN RDCS).

4/5/24 at 4:30 PM - E1 (NHA) submitted an acceptable Abatement Plan signed, dated and timed by E1 (NHA), as outlined below:
"System changes to prevent reoccurrence:
* All residents are to have a current photo

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F 684	Continued From page 20 uploaded into PCC at time of admission by the activities department and/or nursing supervisor. Nursing supervisor educated on uploading pictures into [name of EHR] at 4/5/24 at 1602 (4:02 PM). At times a resident will refuse, a second attempt to obtain a picture is to be made by management staff/designee immediately upon notification and if they still refuse the facility will place an ID bracelet. If they refuse the ID bracelet, staff will ... verbalize identification to verify residents identify (sic) (i.e. name and date of birth). If resident is confused or non-verbal identification of resident will be made with 2 staff members who are familiar with the resident. * All scheduled appointments must be entered into the calendar. This calendar will be printed out daily and given to the front desk. Along with this, there will be a printout of the individual's face sheet. The night supervisor and or designee will be responsible to print these out. * Transportation companies are to be stopped at the receptionist desk and asked the name of patient/resident. Then they will be directed to the proper room. At which time a copy of the face sheet will be given to transport who will have a staffing member to verify identification. Validation made from photo, right name, and right appointment. Nursing staff will then sign the face sheet and direct transport back to the receptionist desk. * The reception desk will collect the signed face sheet and document the time they left the building. * If the appointment doesn't appear on the calendar, then a face sheet will not be printed. Facility will not release patient/resident until proper verification is made. DON and/or Administrator will also be notified. Education will be completed with nursing staff in	F 684		

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F 684	Continued From page 21 person on the above process by 4/5/24 ...". Based on the facility's response to the 4/3/24 incident involving R2, interviews with staff and no further incidents observed where the incorrect resident was sent to the wrong appointment, the facility's IJ was abated on 4/5/24 at 4:30 PM. 1b. Observation of the facility's new process for resident's leaving the facility for appointments revealed: 4/9/24 at 9:30 AM - Surveyor's observation of the facility's abatement plan in action revealed that the Transport staff were in the lobby waiting to transport R6 to an appointment. However, R6's name was not on the Receptionist list of residents that had an appointment that day and was confirmed with E11 (Receptionist). 4/9/24 at 9:45 AM - Surveyor observed R6 being brought in a wheelchair to the reception desk along with E10 (LPN). 4/9/24 at 9:50 AM - During an interview, E10 stated she was aware that R6 had an appointment and had the paperwork. E10 verified that she confirmed the correct resident (R6) was sent out to the appointment using the resident identification process. 4/9/24 at 10:00 AM - During an interview, E1 (NHA) stated that she prints out the resident appointment list each day and provided it to the receptionist. E1 stated that R6 must have dropped off the list for an unknown reason. E1 stated that she had not verified that the names on the list matched up with the individual resident face sheets that were printed for each resident	F 684		

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that had an outside appointment that day. Going forward, E1 stated that she will have another person compare the resident's list with appointments each day with the face sheets of residents with appointments that are used for identification purposes.

2a. Review of R3's clinical record revealed:

1/10/17 - R3 was care planned for aspirin therapy and at risk for adverse effects with intervention that included: "report bruising." In addition, R3 was care planned for at risk for alteration in skin integrity with an intervention that included: "observe skin condition with ADL (activities of daily living) care daily; report abnormalities."

1/14/21 - An active physician's order documented to administer R3 Aspirin 81 MG every day for a diagnosis of coronary artery disease (CAD).

2/18/24 - The annual MDS assessment documented that R3 was rarely understood or understands; had short-term and long-term memory problems; was severely impaired for daily decision making; dependent for toileting, personal hygiene, showers and lower body dressing; and weighed 99 lbs.

4/2/24 at 11:21 AM - The Skin Observation Tool form by E18 (RN) documented that R3 had no skin alterations.

4/5/24 at 8:17 AM - E16 (CNA) documented in R3's clinical record that R3 was provided a shower.

4/5/24 at 1:35 PM - The facility's incident report by E18 (RN) documented, "... At (1:35 PM) after

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nurse (sic) was assisted back to bed, resident was noted with purple bruise on right side of chin and philtrum (upper lip). [R3] could not explained (sic) what happened... Assessment done body audit done no other abnormal bruise or cut noted. Resident denied any s/s (signs or symptoms) of pain. No swollen noted... Oriented to person... Family Member (notified) at (2:49 PM) and NP notified at (2 PM)...".

The facility's investigation included, but was not limited to, the following documented staff written statements:
- E15's (LPN) untimed/undated statement: "... What did you observe?... A bruise on resident chin... At 8:30 AM when I went to resident room to give morning medicine, I noted a small redness on her right chin. I did not tell my preceptor about it because I did not know the resident well...".

- E16's (CNA) untimed/undated statement: "... What did you observe?... Started my care with the resident. Overlook the bruise. I don't normally have (R3's name) as my resident, didn't notice it was abnormal...".

- E17's (CNA) 3:58 PM on 4/5/24 phone statement: "... What did you observe?... Cared for resident 3-11 & 11-7 (prior evening and night shifts on 4/4/24 through 4/5/24). Constantly check on her re (regarding) adjusting her in bed. Last provided care at 6:15 AM. No skin issues...".

Review of R3's clinical record lacked evidence that neurochecks were initiated and completed after injuries of unknown origin (right chin and upper lip bruises) were identified and monitoring for bleeding as R3 was administered aspirin daily.

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F 684	Continued From page 24 The facility failed to ensure that nursing staff immediately reported R3's injury of unknown origin (redness on the right chin) when identified at 8:30 AM and failed to initiate monitoring for bleeding and completing neurochecks. 4/9/24 at 9:52 AM - During an interview, E16 (CNA) stated that she came in on an off day on 4/5/24 and was pulled to the first floor on a different assignment as she usually works on the second floor. E16 stated that she provided care for R3 before, but not recently. E16 confirmed that she gave R3 a shower that morning, and the resident did not bump into anything. E16 stated that she noticed the purple bruise on the right chin, about the size of a quarter and the upper lip was swollen and light purple around 12 Noon. E16 stated that she reported it to the nurse. 4/10/24 at 9:17 AM - During an interview, E22 (RN) stated that she worked the 11 PM to 7 AMshift prior the 7 AM to 3 PM shift on 4/5/24. E22 stated that she applied a medication patch on R3's back between 5:30 AM and 6:00 AM and stated that R3 had no bruising on her face. 4/10/24 at 9:20 AM - During an interview, E17 (CNA) stated that she worked a double shift (3-11 PM and 11 PM to 7 AM) prior to the identification of R3's facial bruises. E17 stated that there was no bruises noted on R3 during her shifts. 4/10/24 at 10::02 AM - During an interview, E15 (assigned LPN) that this was her first day off orientation and confirmed that she saw a small redness on R3's chin when she administered medications to R3 at 8:30 AM. E15 stated that she didn't think about reporting it. R3 was sitting up in her wheelchair. At 1:30 PM, E15 stated that	F 684		

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F 684	Continued From page 25 she observed R3's purple bruises on her chin and upper lip. 2b. According to the State of Delaware's Division of Professional Regulation - Board of Nursing's website, the nursing scope of practice as outlined in the document entitled "RN, LPN and NA/UAP Duties 2023" stated that only a Registered Nurse (RN), not a Licensed Practical Nurse (LPN), are to perform Post Fall Assessment & (and) Documentation. The facility's policy and procedure entitled "Falls Management Program", last revised 1/29/24, stated, "... Fall Occurrence 1. Do not move or reposition patient until a licensed nurse has completed a physical and cognitive assessment. A licensed nurse will: -Assess, intervene, and promptly provide the necessary interventions for any patient experiencing a fall. -Notify the provider, responsible party, and/or EMS if indicated, as well as the supervisor/administrative personnel as appropriate. -Evaluate, monitor, and document patient response every shift for 72 hours post fall.... Follow-Up: 1. The Unit Manager or designee will review the Post-Fall Investigation and post fall follow-up documentation and communicate any necessary fall management interventions to direct care givers...". 3/3/23 - R3 was care planned for at risk for falls related to muscle weakness. Interventions included, but were not limited to: -Place bed in lowest position while resident is in bed;	F 684		

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F 684	Continued From page 26 -Place common items within reach of the resident. 4/5/24 - The facility's incident report completed by E19 (LPN) at 6:18 PM documented, "... called to pts room @ (at) 1715 (5:15 PM) by CNA (E20's name) to find pt laying on her right side next to bed with her right side of head against the nightstand. RN (E21's name) present in the room. 'falling leaf' announced over head by receptionist. Assessed for pain, no pain noted at time of fall, assessed for injuries. Hematoma noted to pts (patient's) right forehead, bruising noted to left forehead, skin tear on left elbow. Cleansed and dress, Unit manager aware, VS (Vital Signs) obtained. VS bp: (blood pressure) 180/108, p: (pulse) 90 rr: (respiratory rate) 18 pox: (pulse ox) 98%. (Company name) notified by unit manager. No new orders at this time. Pt (patient) was transferred back to bed via staff members. Tolieted (sic), bed low, call bell within reach. Message left for POA (Power of Attorney). Patient unable to give description... oriented to person... confused... impaired memory... Physician (notified)... 4/5/24 at (8:09 PM)." 4/5/24 at 5:40 PM - A nursing note documented that E19 (LPN) administered prn (as needed) Tylenol 650 MG for "head pain unrelieved by distraction and relaxation techniques." 4/5/24 at 5:41 PM - The facility's Skin Observation Tool completed by E19 (LPN) documented that R3 had sustained a left elbow skin tear 2 cm (centimeter) x 1 cm, face bruising and a hematoma on the face. No further description was captured. 4/5/24 at 8:11 PM - The facility's Post Fall	F 684		

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F 684	Continued From page 27 Investigation form completed by E19 (LPN) documented, "Date/time of the fall... 4/5/24 17:15 (5:15 PM)... Alert and Oriented (checked) No. 2. Confused/Disoriented (checked) Yes... Did resident hit their head? (checked) Unwitnessed...". 4/5/24 at 9:41 PM - An administration note documented that E19 (LPN) administered prn (as needed) Tylenol 650 MG for "elbow pain unrelieved by relaxation and deep breathing techniques." Review of the R3's clinical record and the facility incident report and post fall records lacked documented evidence of an RN assessment after the fall out of bed. The facility failed to ensure that the RN documented the post fall assessment. In addition, there was no further documentation regarding monitoring of R3's head injuries on 4/6/24 and 4/7/24 by nursing staff. 4/8/24 at approximately 2 PM - The Surveyor observed R3 sitting in her wheelchair outside of the activities/dining room across from the nurse's station. Surveyor observed R3's face to have significant facial bruising and a hematoma on her right forehead. Surveyor asked R3 if she had pain and R3 responded yes while closing her eyes. Surveyor immediately made contact with E1 (NHA) who was walking nearby and asked her what happened to R3. E1 stated that she fell. Surveyor asked E1 to walk over to where R3 was positioned at the time and in the presence of E1, Surveyor asked R3 about her pain again. E1 stated that she would escort R3 to her nurse for pain medication. 4/8/24 at 6:08 PM - C5 (company name NP)	F 684		

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F 684	Continued From page 28 documented, "... 88 year old female seen and evaluated s/p (status post) fall on 4/5/24. Nursing called provider after hours and reported fall from bed with minor injury- skin tear to the left elbow and bruising to face. No bleeding noted and neuro checks were WNL (within normal limits). Today, resident noted with multiple bruising to face- right eye orbit bruised, right forehead, bruise to left (sic) chin and hematoma to left forehead... does not appear to be in pain... Cognitively, she is at baseline, due to dementia, unable to answer most questions... Nursing advised to notify (company name) with changes in mental status-she remains DNR/I/H (Do Not Resuscitate/Do Not Intubate/Do Not Hospitalize)-resident is comfort care. Unable to reach POA... regarding fall... Plan:... Apply cool compress to right eye TID (three times a day) for 15min as tolerated. Continue Tylenol 650mg BID (twice a day). Monitor non-verbal s/sx (signs/symptoms) of pain- facial grimace, crying and guarding. Monitor progression of healing...". 4/9/24 at 3:15 PM - During an interview, E21 (RN) stated that she was the first nurse that responded to R3's room on 4/5/24 when she was found on the floor. E21 stated that R3 was perpendicular to the bed with the head against the dresser and laying on her right side. E21 stated that she assessed R3 on the floor and then the CNAs lifted R3 and placed on the bed. E21 confirmed that she did not document her assessment of R3 as the assigned nurse, E19 (LPN), took over. 4/10/24 at 9:45 AM - During an interview, E20 (CNA) stated that she was R3's assigned CNA on the evening shift (3 PM - 11 PM) on 4/5/24. E20 confirmed that R3 was transferred back to bed by lifting the resident up under her arms and feet.	F 684		

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F 684	Continued From page 29 4/10/24 at 10:10 AM - During an interview, E23 (RN) stated that she was the House Supervisor on 3 PM to 11 PM shift on 4/5/24. When asked what was her involvement with the fall, E23 stated that "nobody told me about the fall" involving R3. E23 stated that as House Supervisor she does rounds, receives calls and responds. E23 stated that she usually sits upstairs in the nurses station on the second floor. E23 stated that evening, she had a new admission after dinner. 4/10/24 at 1:56 PM - During a combined interview with E1 (NHA), E2 (DON) and E3 (RN RDCS), the Surveyor asked why wasn't E23, the House Supervisor, told about R3's fall. E2 stated that she was still present in the facility as well as E24 (LPN/UM) and were investigating R3's bruises identified earlier that day. 4/10/24 at 4:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (RN RDCS).	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690		5/13/24

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	085028	A. BUILDING _____ B. WING _____	C 04/10/2024

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F 690	Continued From page 30 (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and review of the clinical record and other documentation as indicated, it was determined that for one (R2) out of one resident reviewed for physician ordered bladder scanning, the facility failed to ensure that the resident, who was incontinent of bladder, received appropriate treatment and services to prevent an urinary tract infection. Findings include: According to the Lippincott Manual of Nursing Practice, 11th Edition, "Benign Prostatic Hyperplasia (BPH) is enlargement of the prostate that constricts the urethra, causing urinary symptoms... Clinical Manifestations:... 2.	F 690	F690 A. R2 no longer resides at the facility. Unable to correct. B. All residents who receive bladder scanning can be affected by this deficient practice. The DON/nursing supervisor completed an audit of all residents with a bladder scan order to ensure it was written accurately. Any clarifications needed were completed immediately. C. Root cause was identified to be that nurses failed to recognize the bladder scan order needing clarification. Bladder scan orders will include verbiage to instruct nurses to bladder scan after	

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F 690	Continued From page 31 Obstructive symptoms -... sensation of incomplete emptying of the bladder, urinary retention... Diagnostic Evaluation:... 6. Optional diagnostic studies for further evaluation:... b. Measurement of postvoid residual volume; by ultrasound or catherization...". According to the Cleveland Clinic website, last reviewed on 2/9/24, "... A post-void residual (PVR) test measures the amount of pee left in your bladder after you urinate. High PVR levels mean you have urinary retention, which could be caused by an underlying condition... There are a few different methods for measuring PVR. The two most common are: -Bladder catherization. A healthcare provider drains any pee left in your bladder after you urinate using a catheter (flexible tube). -Ultrasound. A provider can use a bladder scan... Your provider uses a probe on your belly to get images of your bladder with sound waves. Your provider can use these images to calculate the amount of pee left in your bladder... Just before the ultrasound, you'll go to the bathroom and empty your bladder as completely as possible...". (https://my.clevelandclinic.org/health//diagnostics/16423-postvoid-residual) R2's clinical record revealed: 3/19/24 - The hospital discharge orders included a new medication Flomax every day for a diagnosis of BPH and to "Bladder scan q6h (every six hours), straight cath for pvr> (greater than) 400ml (milliliters)." 3/19/24 - R2 was admitted to the facility with diagnoses including, but were not limited to, dementia and BPH.	F 690	voiding and document the post void residual. The DON/staff educator will educate licensed nurses on the bladder scanner user, including competency of use, orders should include to bladder scan after void and to document post void residual. D. The DON/nursing supervisor will audit all orders for bladder scanner to ensure they are written correctly, and the nursing staff is entering the correct supplemental documentation weekly x 4 week until 100% compliance is achieved, then every 2 weeks x 4 weeks until 100% compliance is achieved and then monthly x 4 months until 100% compliance is achieved. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported x 4 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 4 months. E. Date of compliance: 5/13/2024 Audit tool template sent via email to dhss_dhcq_poc@delaware.gov.	

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F 690	Continued From page 32 3/19/24 - R2 was care planned for being frequently incontinent of bladder... due to impaired functional mobility and inability to routinely communicate voiding needs to staff. The interventions included, but were not limited to: -one staff person to assist with toileting; -bladder scan and straight cath as ordered (dated 3/20/24); and -provide toileting hygiene with brief changes. 3/19/24 - A physician's order was entered as "Bladder Scan Q (every) shift and straight cath for PVR (post void residual) greater than 400 every shift for Urinary Retention." 3/25/24 - R2's admission MDS assessment documented that R2 had a BIMS of 3 (cognitively impaired), dependent for toileting hygiene, frequently incontinent of urine, and received a diuretic (water pill) medication. Review of R2's electronic Treatment Administration Record (eTAR) for March 2024 and April 2024 revealed the following documented nursing staff responses to the physician ordered bladder scan order: During 3/19/24 to 3/31/24: - 4 out of 37 shifts were blank; - 2 out of 37 shifts, nursing staff documented "1nco" under ML (milliliters); - 2 out of 37 shifts, nursing staff documented "void/voids" under ML. From 4/1/24 to 4/2/24: - 1 out of 6 shifts were blank; - 1 out of 6 shifts, nursing staff documented "voids" under ML.	F 690		

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F 690	Continued From page 33 4/3/24 - R2 was sent to the emergency room for an altered mental status. R2 was diagnosed and treated for a urinary tract infection. 4/8/24 at 4:45 PM - During a combined interview with E2 (DON) and E3 (RN RDCS), finding was discussed with R2's bladder scanning physician's order and documentation by nursing staff. 4/8/24 at 4:18 PM - During an interview, E13 (nurse) confirmed receiving training on bladder scanning in the past but was unable to provide an approximate date. For R2, the nurse stated that the bladder scanned amount of MLs was documented in R2's eTAR. It was unclear during the interview if the nurse understood the nursing practice of having a resident urinate first then bladder scanning the resident to obtain the PVR amount. 4/10/24 at 11:15 AM - During an interview, E12 (MD) discussed R2's dementia diagnosis and the bladder scan order. E12 acknowledged that R2's bladder scan physician order was not written correctly and it was confusing. 4/10/24 at 4:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (RN RDCS).	F 690		
F 837 SS=C	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and	F 837		5/13/24

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F 837	Continued From page 34 §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to update the facility Governing Body documents to remove the name of a governing body member who was no longer employed by the facility . Findings include: 4/8/24 - A review of the Vita Healthcare Governing Body Resolution document, updated 8/1/23, revealed that F1 (Registered Nurse, Director of Clinical Services, former employee) was listed as being appointed by the governing body as a person legally responsible for establishing and implementing policies regarding the management and operation of the facility. 4/10/24 3:1 5PM - During an interview, E1 confirmed that F1's name was still present on the Vita Healthcare Governing Body Resolution document provided to the surveyor. 4/10/23 4:30 PM Findings were reviewed with E1 (NHA), E2 (DON) and E3 (RN RDCS) during the exit conference.	F 837	F837 A. No residents were affected by the deficient practice. B. No residents have the potential to be affected by the deficient practice. C. A root cause analysis identified the facility failed to update the Governing Body due to one of the members no longer being employed by the facility. Facility has updated the Governing Body to reflect the new Governing Body Member. D. The Administrator/Designee will monitor the Governing Body to ensure all appropriate members have been updated monthly x 3 months until 100% compliance. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of compliance: 5/13/2024	
F 838 SS=D	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment.	F 838		5/13/24

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F 838	Continued From page 35 The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical);	F 838		

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F 838	Continued From page 36 (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on a review of the facility assessment, emails and interview, it was determined that the facility failed to update the facility assessment to include all personnel classifications which provide services to facility residents. Findings include: 4/8/24 - A review of the facility employee list revealed two employees with the job classification of "Non-Certified Nursing Assistant". 4/18/24 - A review of the "Facility Assessment - Wilmington Nursing and Rehab", updated 1/26/24, section 3.2 Staffing Plan, Position: "In addition to nursing staff, other staff needed for behavioral healthcare and services (list other staff positions/roles)" revealed the lack of a job position for a Non-Certified Nursing Assistant.	F 838	F838 A. No residents were affected by the deficient practice. B. All residents have the potential to be affected. The Facility Assessment was updated by the NHA on 4/16/24 to include a Non-Certified Nursing Assistant under Part 3: FACILITY RESOURCES NEEDED TO PROVIDE COMPETENT SUPPORT AND CARE. C. A root cause analysis identified the Facility failed to update Non-Certified Nursing Assistant position as a resource necessary to care for its residents during the facility□s annual update. The facility, NHA or Governing Body designee, will now update the Facility Assessment when changes in the facility occur instead of	

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F 838	Continued From page 37 4/9/24 3:48 PM - A review of an email from E1 regarding the job duties of a non-certified nursing assistant revealed the following response: "They don't provide care for the residents. They are used primarily for 1:1 and making beds. If we are doing any events in the building they help with activities". 4/10/24 3:30 PM - During an interview, E4 stated that Non-Certified Nursing Assistants provide services that do not involve direct care to residents, but could include services such escorting a resident outside the facility on medical appointments and also to provide one on one resident supervision if that was needed. 4/10/23 4:30 PM Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (RN RDCS).	F 838	waiting for annual review. The RDCS educated the NHA on updating the Facility Assessment as changes occur in the facility. D. The Administrator/Designee will monitor the Facility Assessment to ensure all appropriate resources necessary for care have been updated monthly x 3 months until 100% compliance. All audits will be submitted to the QAA committee monthly. The results of the audits will be reported X 3 months. The QAA committee will determine what, if any, additional intervention is needed at the end of the 3 months. E. Date of compliance: 5/13/2024 Audit and education sheets sent via email to dhss_dhcq_poc@delaware.gov.	