STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. Building B. Wing	10/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Healthcare & Rehab Center	801 N. Broom Street Wilmington, DE 19806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 47621 Based on record review and interview, it was determined that the facility failed to report R1's allegation of sexual abuse to the Administrator or the State Agency within two hours when it became known on the weekend of 10/5/24. The facility reported the allegation on 10/8/24. Findings include: The facility's policy entitled Abuse, Neglect, Exploitation or Misappropriation- Reporting and Investigating, last revised September 2022, stated, . 1. If resident abuse . is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law . 3. 'Immediately' is defined as: a. within two hours of an allegation involving abuse . Review of R1's clinical record revealed: 11/16/22 - R1 was admitted to the facility with diagnoses, including but was not limited to, stroke with left-sided weakness. 8/15/24 - R1's quarterly Minimum Data Set (MDS) assessment documented R1's Basic Inventory of Mental Status (BIMS) score of 14, which was reflective of normal cognitive function. 10/8/24 10:40 AM - During an interview, R1 stated that the encounter of alleged inappropriate touch happened before the summer. R1 stated that he wears an incontinence brief and the incident occurred when he was being changed for bed. R1 also stated that he reported this incident to E8 (former Social Work Director) shortly after it occurred. R1 also stated that this type of behavior occurred multiple times. Review of E8's employee file revealed that E8 (former Social Work Director) was terminated from the facility on 7/7/23 for not a good fit. 10/8/24 11:15 AM - E1 (NHA) was notified by S1 (State Investigator) of R1's abuse allegation. 10/8/24 11:40 AM - E1 (NHA) stated that neither he nor E2 (DON) had been aware that E6 (CNA) was not caring for R1 or that R1 had made an abuse allegation involving E6. 10/8/24 12:20 PM - E2 (DON) called the State Agency to report R1's sexual abuse allegation. This was 3 days after the nursing supervisor E9 was made aware of R1's allegation on 10/5/24. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/8/24 1:07 PM - During an interview, E6 (CNA) stated that approximately April of 2024 another resident (R5) told him that R1 was claiming that E6 had given him (R1) a hand job. E6 stated that he immediately told the nurse [E7, LPN], who told him not to take care of him any more. I reported it to my supervisor [E7]. The aides report things to the nurses all the time but they don't do anything about it a lot of the time. My nurse is my chain of command. Review of E7's Employee file revealed that E7 was terminated on 5/29/24 from the facility for falsifying records. Attempts to contact E7 were unsuccessful as the phone number that the facility provided was no longer in service. 10/8/24 2:28 PM - During an interview, E9 (RN/Nursing Supervisor) stated that on Saturday, October 5th E10 (CNA) told me that E6 (CNA) could not have R1 in his assignment. E9 proceeded to ask why E6 could not have R1 and was informed that R1 had accused E6 of stroking his penis while he was giving care. So he [E6] had not taken care of R1 in a long-time. The aides had been swapping assignments. I wasn't aware of this information prior to that. E9 (RN/Nursing Supervisor) then asked E6 about the allegation and he [E6] said the nurses knew about it. E9 stated, I assumed everyone else knew. I just started working as a supervisor in September 2024 . It did strike me as odd. But the CNAs said they have been swapping assignments for months . I don't know why I did not report it. I thought management knew. This was the first that I learned of it [the allegation]. 10/9/24 12:45 PM - During a telephone interview, E10 (CNA) stated, I was working on Saturday [10/5/24]. When the supervisor asked why E6 could not take care of R1, E6 said he could not have him [R1] because he [R1] has accused me of jerking him [R1] off during care. E6 said he told management. He [E6] never took care of R1 again. It is hard to work when E6 is on the schedule. The switches have been going on for months. The CNAs have to do a lot of switches because there are several residents that don't want E6 to care for them or E6 does not want to care for . I was standing right there and heard what E6 said. E6 said it right in front of E9 (Nursing Supervisor) . The supervisors make the assignments and the unit clerks switches the rooms if swaps are needed . I have been inserviced by [the facility] regarding abuse and neglect. You have to tell your supervisor as soon as you hear it [an allegation]. 10/9/24 1:15 PM - During an interview regarding the exclusion of E6 not caring for R1, E2 stated, Until yesterday [10/8/24], I knew nothing about it. E2 also confirmed that when staffing exclusions are made, it has to be verified by the unit managers/nursing supervisors. E2 also confirmed that multiple in-person inservices are given to the staff throughout the year regarding abuse and neglect. 10/9/24 2:15 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON), E3 (Corporate Risk Manager) and E4 (Corporate Director of Clinical).