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	12/31/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48409 Based on interview, and record review, it was determined that for one (R2) out of three residents reviewed for accidents, the facility failed to provide a safe environment by having two staff members present to assist with turning when R2 received a shower on 10/25/24. R2 sustained harm due to the traumatic removal of the nephrostomy tube during care and needed to be transported to the hospital for emergency treatment. On 10/26/24, R2 was again sent to the emergency room for evaluation of the injuries to his face, torso and lower extremeties. Based on review of the facility's evidence to correct the non-compliance and the facility's substantial compliance at the time of the current survey, this deficiency was determined to be past non-compliance as of 10/29/24. Findings include: R2's clinical records revealed: 2/26/16 - R2 was admitted to the facility with diagnoses including traumatic brain injury, tracheostomy, enteral tube feeding and neuromuscular dysfunction of the bladder (which required the use of a nephrostomy tube for the drainage of urine from the bladder.) 2/29/16 - R2's care plan documented, . [R2] is totally dependent on staff to provide shower .totally dependent on staff for repositioning and turning 10/27/17 - R2's care plan documented, .2 person assist [assistance] with turning and repositioning . 4/16/19 - R2's clinical records documented, 2 person assist [assistance] with bed mobility and transfers. 6/10/24 - R2's Treatment Administration Records (TAR) documented, Nephrostomy Care every shift and PRN (as needed). 8/19/24 - R2's quarterly MDS documented, Dependent, on staff for all activities of daily living. 10/1/24 - R2's Activities of Daily Living (ADLs) documented, Bath/Shower x (times) 2 person assist. 10/25/24 9:32 AM - A clinical progress (E2 DON) documented, IDT (Interdisciplinary Team) note LATE ENTRY s/p [status post] potential fall in shower, that resident is to be a 2 person [assistance] during shower care. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	10/25/24 10:50 AM - R2's clinical records documented, Resident was assessed to have a dislodged Nephrostomy tube r/t repositioning during shower 10/25/24 11:48 AM - A clinical progress note (NP) documented, .Resident was receiving a shower when his nephrostomy tube got displaced, nursing staff also report that while turning patient inquired [acquired] multiple scratches to his feeding base [tube feeding site], mild abrasion. Will be sent out to the ER for replacement of tube. The facility failed to identify that R2's plan of care for two person assistance during his shower was implemented. 10/26/24 3:14 PM - R2's clinical records documented, . Family present with concerns of abrasions noted to residents left temple, forehead, above left eyebrow, and toes to b/l [bilateral] feet . mother and father expressed concerns of the number of staff present during shower, and appearance of shower bed . 10/26/24 6:38 PM - R2's clinical records documented, CNA today at around 1745 [5:45 PM] reported to the supervisor, that in the afternoon hours, she was told by the CNA who was taking care of resident yesterday, that resident fell in the shower room. resident noted with bruises and scratches on the left side of the face, right toes and right shoulders. immediately after receiving this information, On call for MD/POA made aware, new order to send resident to ER for evaluation. resident left facility via 911 ambulance to [NAME] hospital at 1815 [6:15 PM] pm . The facility's failure to ensure that R2's plan of care for two person assistance during the shower was implemented caused him to to go the emergency room twice, on 10/25/24 and 10/26/24. 10/26/24 7:05 PM - A facility reported incident submitted to the Division documented, A fall was reported that on 10/25 resident [R2] fell in the shower room and an aide picked him up without telling anyone. The facility's root cause analysis of the incident determined that the aide attempted to turn the resident to put a brief on him in the shower bed with the rails in the down position and R2 almost slid off. He hit the tiled wall of the shower and sustained the various injuries. 10/27/24 1:20 PM - R2's clinical records documented, . Nickel sizes bruise, yellow in color noted to left temporal [temple] area, abrasion to eyebrow 1.9 cm by 1 cm, abrasion to left cheekbone 2.7 cm by 3 cm, abrasion to right cheek 0.8 cm by 0.4 cm, abrasion to right knee 3.0 x 0.7 cm, abrasions to left second, third, fourth and fifth toes, nails to second and third toes [nails] broken, toes to right foot noted with then abrasions . 12/31/24 11:30 AM - During an interview E5 (CNA) stated, I helped [E7] put the resident [R2] on the shower bed. We used the Hoyer lift, and he [E7] took him to the shower room. I did not go into the shower room with him. 12/31/24 12:00 PM - During a telephone interview E6 (CNA) stated, E7 (CNA) asked me to bring some towels to the shower room. I brought the towels and took the dirty ones out. The Surveyor asked E6 if she helped E7 during R2's shower. E6 stated, No, I had my own residents to take care of. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	12/31/24 12:30 PM - During an interview E3 (LPN) stated, I was called to see the resident (R2) in the shower room because his toes and face were bleeding. I noticed that the nephrostomy tube looked longer than it usually looked. I told the aide to put him back to bed so I can look at it again. I then saw that the tube was laying on the bed, and I knew that he needed to go to the hospital to have another one put in. The Surveyor asked E3 if R2 was wearing a brief when he was assessed in the shower room. E3 stated, I don't think he was wearing a brief because I would have had to pull it down to see the nephrostomy tube site on his back. The facility failure to provide 2 persons assistance for R2, a completely dependent resident during the shower caused the nephrostomy tube to become dislodged. This required R2 to be sent to the hospital for a new nephrostomy tube placement. 12/31/24 2:30 PM - An interview with E1 (NHA) revealed that E7 was suspended pending the investigation and will be terminated upon return. The facility completed audits of all residents and verified their transfer statuses. The facility also had in-servicing training with signatures for the trainings that began on 10/26/24 and completed on 10/29/24. The facility's in-service training documentation included: Transfer mobility Kardex, shower gurney and siderails. Based on the review of the facility's investigation, documented response, documented completion of in-service training and audits, staff interviews and no further incidents related to injuries or accidents of residents who received showers with the required number of staff members, R2's accident was determined to be past non-compliance harm. The plan of correction was initiated on 10/26/24 and completed on 10/29/24. 12/31/24 3:17 PM - Findings were reviewed at the Exit conference with E1 (NHA), E7 (Corporate Director of Rehab) and E8 (RN Risk Manager).

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 47621 Based on record review, it was determined that for one (R5) out of three residents reviewed for Physician services, the facility failed to ensure the physician/provider completed the required Control Prescription [C2- a required form for any controlled (Drug Enforcement Administration's drug schedules II through V) medications that the pharmacy must have completed with the provider's signature and DEA number in order to release the medication to the facility)] form for three medication orders (lacosamide, clonazepam, perampanel) that were necessary for R5's immediate care. Findings include: The Drug Enforcement Administration (DEA)'s drug schedule classifies drugs into different groups based on their risk of abuse or harm. (www.dea.gov) Cross refer F755 Review of R5's clinical record revealed: 12/27/24 Friday 6:36 PM - R5 was admitted to the facility with diagnoses, including but were not limited to, seizures and anxiety. 12/27/24 - E10 (MD/Medical Director) ordered in R5's EMR, .clonazepam (anti-anxiety medication) 1 mg- give 1 tablet by mouth every 12 hours for anxiety .Fycomba (perampanel) (anti-seizure medication) 6 mg - give 1 tablet by mouth at bedtime for seizure prevention .lacosamide (anti-seizure medication) 200 mg - give 1 tablet by mouth two times a day for seizures . The admitting physician [E10], who also functions as the Medial Director for the facility, failed to complete the required C2 forms for clonazepam (schedule IV controlled anti-anxiety medication), lacosamide (schedule V controlled anti-seizure medication) and perampanel (schedule III controlled anti-seizure medication) when he placed the orders for these drugs in R5'e EMR on Friday,12/27/24, for R5's immediate care. 12/27/24 11:03 PM - E13 (RN) documented in R5's EMR health status note, .but no C2 forms were sent to pharmacy except for the oxycodone prescription. The pharmacy reported that they had not received prescriptions for the resident's seizure control medication. The on-call provider from [medical practice] was updated on the situation, and a review of the medications was conducted. The writer [E13, RN] provided the pharmacy's phone number and fax number to the provider so that the missing prescriptions could be sent to the pharmacy. The facility failed to ensure the physician (E10) /provider (E15) completed the C2 forms that were required upon admission for necessary medication for R5's immediate care. 12/29/24 6:24 PM - On Sunday evening, E12 (LPN) documented in R5's EMR health status note, [E15] NP (nurse practitioner) was called again regarding the following meds that need scripts, clonazepam, lacosamide, midazolam and Mycomba (sic). She stated that she called the pharm (pharmacy) and they sent the C2 form to complete and refax. She's unable to do that so she recommended the forms will be filled out in A.M. Resident made aware. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E15 (NP) failed to complete and return to the pharmacy the required C2 forms that were necessary to fill the orders for R5's clonazepam, lacosamide and perampanel medications despite being contacted two times by the facility nursing staff. For over sixty hours, the facility failed to have a physician/provider available on weekends with the capability to complete C2 forms. There was no documented explanation of why the provider (E15) was unable to complete and return the C2 form to meet R5's medication needs. R5 was in the facility for three days with active orders for three medications, which due to the lack of appropriate documentation, the pharmacy was unable to fill. Therefore, R5 missed five doses of clonazepam, three doses of Fycomba and five doses of lacosamide. 12/31/24 3:17 PM - Findings were reviewed at the Exit conference with E1 (NHA), E7 (Corporate Director of Rehab) and E8 (RN Risk Manager).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interview, it was determined that for one (R5) out of three residents reviewed for pharmacy services, the facility failed to obtain and administer three ordered medications (lacosamide, clonazepam, perampanel) to R5 from 12/27/24 to 12/29/24, which resulted in multiple missed doses of each medication. Findings include: Cross refer F710 R5's clinical record revealed: 12/27/24/ 11:14 AM - C1 (hospital physician assistant) documented in R5's interagency discharge orders, . Discharge Diagnoses: fracture of right radius (arm) . seizure . Medication Orders Upon Discharge: . lacosamide 200 mg - 1 tablet by mouth two times a day . perampanel (Fycomba) 6 mg - give 1 tablet by mouth at bedtime for seizure prevention . clonazepam 1 mg - take 1 tablet by mouth every 12 hours . 12/27/24 Friday - R5 was admitted to the facility with diagnoses, including but were not limited to, seizures and anxiety disorder. 12/27/24 - E10 (MD/ Medical Director) ordered in R5's EMR (electronic medical record), . clonazepam 1 mg- give 1 tablet by mouth every 12 hours for anxiety . Fycomba (perampanel) 6 mg - give 1 tablet by mouth at bedtime for seizure prevention . lacosamide 200 mg - give 1 tablet by mouth two times a day for seizures . 12/27/24 6:36 PM - E9 (agency RN) documented in R5's EMR, . Reason for admission- per resident/caregiver: Fracture to wrist, S/P (status post) fall at home . Review of R5's December 2024 Medication Administration Record (MAR) revealed the following medications were not administered to R5: - on Friday, 12/27/24, one dose of Fycomba, Clonazepam and Lacosamide; - on Saturday, 12/28/24, one dose of Fycomba, two doses of Clonazepam and two doses of Lacosamide; and - on Sunday, 12/29/24, one dose of Fycomba, two doses of Clonazepam and two doses of Lacosamide. Instead, E11 (LPN) and E12 (LPN) were documenting 9 or 3, which according to the MAR legend 9 means other/see nurses notes and 3 means out of the facility. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/27/2024 11:03 PM - E13 (RN) documented in R5's EMR health status note, . but no C2 (control prescription form) forms were sent to pharmacy except for the oxycodone prescription. The pharmacy reported that they had not received prescriptions for the resident's seizure control medication. The on-call provider from [medical practice] was updated on the situation, and a review of the medications was conducted. The writer [E13] provided the pharmacy's phone number and fax number to the provider so that the missing prescriptions could be sent to the pharmacy. The facility's failure to obtain and send the necessary C2 forms to the pharmacy to ensure delivery of these three medications during the weekend resulted in R5 missing three doses of Fycomba (anti-seizure medication), five doses of clonazepam (anti-anxiety medication) and five doses of lacosamide (anti-seizure medication). 12/29/2024 6:24 PM - E12 (LPN) documented in R5's EMR health status note, [name] NP (nurse practitioner) was called again regarding the following meds that need scripts, clonazepam, lacosamide, midazolam and Mycomba (sic). She stated that she called the pharm (pharmacy) and they sent the C2 form to complete and refax. She's unable to do that so she recommended the forms will be filled out in A.M. Resident made aware. Review of R5's C2 forms for Fycomba, Clonazepam and Lacosamide revealed the forms were completed and sent to the pharmacy on Monday, 12/30/24, on the fourth day after admission. The facility lacked evidence that the required C2 forms were completed upon R5's admission on 12/27/24. C2 forms are required to be completed and sent to the pharmacy with the prescriber's signature and DEA (Drug Enforcement Administration) number before medications can be delivered to the facility. 12/31/24 2:10 PM - During a telephone interview, C2 (pharmacy tech at [pharmacy]) confirmed that [pharmacy] received the C2 form via fax for clonazepam on 12/30/24 and lacosamide on 12/31/24. At the time of the call, the pharmacy did not have documentation of receiving the C2 form for Fycomba. 12/31/24 2:35 PM - During an interview, E1 (NHA) confirmed that the code 9 on the MAR legend stood for other/see nurse notes and that R5 had not received the medication. 12/31/24 3:17 PM - Findings were reviewed at the exit conference with E1 (NHA), E7 (Corporate Director of Rehab) and E8 (RN Risk Manager).