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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/24/2025 |
| NAME OF PROVIDER OR SUPPLIER Delaware Hospital F/T Chronically Ill (Dhci) | | STREET ADDRESS, CITY, STATE, ZIP CODE 100 Sunnyside Road Smyrna, DE 19977 | |
| 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) | | |
| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48409</p> <p>Based on observation, interview, and record review, it was determined that for one (R1) out of three residents reviewed for accident hazards and falls, the facility failed to ensure that R1 received adequate hands-on assistance and supervision to prevent a fall to the extent possible. R1, a cognitively impaired and dependent resident sustained a fall on [DATE] when two staff members improperly used a mechanical lift to perform a transfer. The facility's failure caused R1 to suffer a subdural hematoma and two (2) lacerations to her scalp. R1 was sent emergently to the hospital. Due to this failure, an Immediate Jeopardy (IJ) was called at 10:30 AM on [DATE]. Findings include:</p> <p>The facility's fall policy dated 2023 and titled, Fall Prevention, included, .The facility will ensure that the resident environment is safe and free of hazards. That each resident receives adequate supervision to prevent falls or minimize the risk for fall related injuries .</p> <p>Review of R1's clinical record revealed:</p> <p>[DATE] - R1 was admitted to the facility with diagnoses including dementia, chronic kidney disease and weight loss.</p> <p>[DATE] - R1's fall care plan (revised [DATE]) documented, Transfer with the help of 2 people using a mechanical lift, using the appropriate size sling .</p> <p>[DATE] - R1's quarterly MDS documented a BIMS score of 00, indicating a severe cognitive impairment. R1's MDS also documented, Complete dependence on the staff for all activities of daily living, including eating, dressing and transfers.</p> <p>[DATE] - E5 (CNA) documented in a facility's investigative document titled and timed 12:30 PM, Employee Interview Statement, After I provided care for [R1] Me and the nurse (R4 LPN) were putting her [R1] in the chair, and she slid from her sling to the floor.</p> <p>(continued on next page)</p> | | |

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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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 085035 |
| | | If continuation sheet Page 1 of 3 |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>[DATE] - E4 documented in a facility's investigative document titled and timed 12:30 PM, Employee Interview Statement, .I was in the room .and started (the roommate's) tube feeding. After starting the feeding, I noticed [R1's] CNA come with a lift to get her up for lunch. I told her that since I'm already in the room, I will watch her while she put [R1] in her wheelchair. I watched [E5] connect all 4 hooks to the Hoyer lift. Then she lifted her (R1) up. I saw both of [R1's] legs of out of the sling, and I told [E5] that I will hold both legs so that they don't hit the wheelchair. I was not able to get to them in time. I heard [R1] fall on the floor. I ran immediately and called the unit manager in the dayroom.</p> <p>[DATE] 1:30 PM - E6 (NP) documented in R1's clinical record, Resident fell from the Hoyer lift a few minutes before we were called to the unit staff reports the fall was due to slipping while being transferred. Resident has bleeding of head, left hand, left leg pain .she repeated mumbled in distress .limited exam to her head because of diffuse bleeding and need to apply pressure to the laceration .</p> <p>[DATE] 2:44 PM - E4 (LPN) documented in R1's nursing progress notes, Resident fell at 1244 [12:44 PM] during 2 people transfer from her bed to her chair. She was noted with blood on the back of her head and her right shin. She was alert, treatment was provided. 911 was activated and was sent to the hospital.</p> <p>Of note, both E5 and E6's investigative statements documented that the fall occurred at 12:30 PM.</p> <p>[DATE] 12:15 PM - The facility's immediate action plan included training of E4 and E5 on the use of the mechanical lift.</p> <p>[DATE] 1:30 PM - During an interview, E5 (CNA) stated, The fall happened so sudden and fast. I provided her care, and she was ready to get up in the chair. The nurse (E4) was in the room was taking care of the other patient. The nurse said, I am already here, I will help you. The pad was under the resident [R1] and I hooked up the sling to the lift. The nurse was on the other side of bed. I raised the sling to get her [R1] off the bed and tried to straighten myself and it happened suddenly. I was behind the lift and tried to open the legs of the lift to put the resident above the chair. The nurse was around the side of the bed, but the resident slid out of the bed before she could reach her. The Surveyor asked E5 if the nurse Had hands on the resident while she was being lifted from the bed. E5 stated, The nurse was coming around the bed to reach the resident. It all happened so fast.</p> <p>[DATE] 12:30 PM - During an interview R4 (LPN) stated, I was putting the feeding up for the roommate and the aide [E5] was helping [R1] to get up for lunch. She finished getting her ready to get up and I told her that I would help her with the lift. I was on one side of the bed, and the aide was on the other side. She started to bring her around to the chair, and I saw her [R1's] legs hanging out of the sling. I said, Hold on, let me secure her legs so they don't hit the wheelchair. The resident was in the air already by the time I got around from the other side of the bed. And [E5] was backing up with the lift to put her in the chair. I came around to help put the resident in the chair, but she started to slide and fell before I could reach her. I did not get to reach her legs before she hit the floor.</p> <p>[DATE] 10:30 AM - An Immediate Jeopardy was called due to the seriousness of this incident.</p> <p>[DATE] 1:30 PM - A review of R1's hospital records revealed that she sustained the following:</p> <p>(continued on next page)</p> | | |

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| <p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p> | <p>- An intra cranial traumatic hemorrhage,</p> <p>- A 9 cm. laceration to the mid- scalp,</p> <p>- A 5 cm. laceration to the back of her scalp.</p> <p>R1 was placed on comfort care and expired at the hospital.</p> <p>The facility failed to provide the recommended use of two persons hands on assistance for R1 during the transfer from the bed to the wheelchair with the use of a mechanical lift. R1 sustained a traumatic fall which resulted in head injuries and expired at the hospital.</p> <p>[DATE] 3:30 PM - The facility's abatement plan was accepted.</p> <p>The facility's action plan included:</p> <ul style="list-style-type: none"> - All nursing staff will complete a mandatory in-service training on the proper use of mechanical lifts and the requirement for two-person assistance with hands on the resident while in the air when transferring residents. - A review of the facility protocols for safe transfers, including the use of mechanical lifts, a detailed explanation of the risks and potential injuries caused by improper transfers, emphasis on the importance of following the care plan for each resident and using the required number of staff for transfers; and hands-on resident training while in the air, on proper techniques and safety protocols for lifting and transferring residents while using mechanical lifts. - A full review of all residents' care plans requiring two-persons assistance for transfers. <p>[DATE] 1:00 PM - Based on the Surveyor's review of the facility's investigation, documented response, completion of audits from [DATE] to [DATE], staff interviews and no further mechanical lift fall or injuries, the IJ was considered abated on [DATE] at 7:00 AM.</p> <p>[DATE] 3:00 PM - Findings were reviewed at the exit conference with E1 (NHA), and E2 (ADON.)</p> | | |