STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085035	A. Building B. Wing	10/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Hospital F/T Chronically Ill (Dhci)	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)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and other facility documentation, it was determined that for two (R1and R2) out of three residents sampled for accidents, the facility failed to ensure that R1 and R2 received adequate supervision to prevent accidents. R1, a severely cognitively impaired resident, was able to elope from the building on 9/26/25 during the 11:00 PM to 7:00 AM shift. R1 was found on 9/26/25 at 8:38 AM, approximately 17-20 miles from the facility. This failure put R1 at immediate risk for severe injury or death due to exposure to traffic and environmental hazards while walking on the road unsupervised. An immediate jeopardy (IJ) was called at 12:30 PM on10/1/25. The facility abated the IJ on 10/2/25 at 3:00 PM. R2, a completely dependent resident, sustained a right femur fracture from a fall from the bed to the floor while a staff member was providing care and the resident rolled off the bed. Findings include: 12/4/23 - A facility document entitled, Elopement of Resident, documented, .The facility provides a safe environment and adequate supervision that respects the residents' dignity and minimizes the residents' risk for accidents or harm. Residents identified as at risk for elopement requires the vigilance of all staff. Residents identified as being at risk for elopement will have person- centered interventions to monitor and manage their risk as reflected in the care plan.1. Review of R1's clinical records revealed:10/24/24 - R1 was admitted to the secured unit of the facility with diagnoses including but not limited to mild cognitive impairment, major neurocognitive disorder and impaired decision making. R1's elopement assessment documented a score of 4, indicating a high risk for elopement.10/30/24 - R1's admission MDS assessment documented a BIMS score of 99, indicating the inability to conduct a cognitive interview. 10/31/24 (revised 1/29/25) - R1's elopement care plan documented, . Unaware of safety risk.at risk for wandering and eloping. want to return to the community. The interventions included, .Complete frequent face to face checks.1/22/25 7:33 AM - R1's clinical record documented, Resident was noted to be up at the nurses' station, fully dressed, with his shoes on. Resident repeatedly asked to leave his unit so he could walk to [previous place of residence] to get his hair cut. Resident informed that we could cut his hair but refused, insisted that he needs to go to [previous place of residence.] Resident remained near the nurses' station repeatedly asking people to let him out so he can walk to [previous place of residence].1/22/25 7:46 AM - R1's clinical record documented, Resident standing in front of the unit manager's office pleading with all the staff that passed by to let him out of the door.1/23/25 12:28 PM - R1's clinical record entitled Plan of Care Note, included, Risk for elopement due to recent talk of going to [name of recent place of residence.]1/23/25 2:54 PM - R1's clinical record documented, .Stated multiple times.been a year. want to go to [name of previous residence.] Please help [R1's name.]8/12/25 10:19 AM - R1's clinical record documented, Resident pacing up and down the hallway. 8/15/25 4:44 PM - R1's clinical record documented, Resident was observed in the back hallway by the emergency exit door.9/4/25 12:02 PM - R1's clinical record documented, Resident expressed desire to leave the facility, per resident, it's been two years since he was taken to the hospital and then brought here. He stated, I am not sick, I want to go to [previous place of residence.]9/4/25 9:01 PM - R1's clinical record documented, Resident expressed desire to leave the facility to go [previous place of residence.]9/8/25 1:03 PM - R1's clinical record documented, Resident requested to speak with someone about getting out of this facility. Stated, I am not sick, I don't need to be here. Social Services came to speak with resident, reassured him that everything is being done to help him. Resident pulled out a piece of paper with his address written on it and stated, That's where I live. Resident spoke very clearly, explaining his experience in the hospital and how he got there and how he came to be at this facility. Resident expressed that he is very eager to get out of [name of current facility.]9/13/25 11:06 AM - R1's clinical record documented, Resident up out of his room, pacing around more than usual and expressing verbally the desire to leave, saying he's been here too long and wants to go back to where he used to live.9/14/25 8:53 PM - R1's clinical record documented, . Continues to stand in the hallway staring at the back and side doors.9/15/25 2:57 PM - R1's clinical record documented, Engaged in conversation with resident during which resident expressed his interest in going back to live the community.9/16/25 1:08 AM - R1's clinical record documented, . Ambulating back and forth in the hallway asking to go to [place of previous residence.]9/22/25 1:33 PM - R1's clinical record documented, . [R1] very vocal about his wants. Stated that he was brought to [name of facility] from the hospital and was supposed to stay here for a bit.9/23/25 - R1's annual MDS documented a BIMS score of 99, indicating the inability to conduct a cognitive interview 9/25/25 2:38 PM - R1's clinical record