STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. Building B. Wing	02/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Castle Health and Rehabilitation Center	32 Buena Vista Drive New Castle, DE 19720

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 32810 Based on interview and record review it was determined that for one (R474) out of one resident reviewed for choices, the facility failed to ensure the right to self-determine when R474's preference for showers were not completed. Findings include: 1. Review of R474's clinical record revealed: 8/2/22 - A significant change MDS assessed R474 as cognitively intact and the preference to choose type of bathing as very important. Review of facility shower schedule revealed that R474 was scheduled to receive two showers a week initially on Tuesdays/Fridays then a change to Monday/Thursday on evening shift. Review of CNA Point of Care [POC] record revealed R474 had the following: June 2022 - Three showers received. July 2022 - One shower received. August 2022 - Two showers received. During an interview on 1/25/24 at 3:18 PM, E2 (DON) explained that residents are supposed to receive two showers a week based on their room location. E2 then confirmed that R474 had not received at least two showers a week. 1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON).

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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. 46134 Based on record review, interview and review of facility documentation, it was determined that for one (R524) out of two residents reviewed for discharge, the facility failed ensure that R524's discharge needs regarding his wound care were identified. Findings include: Review of R524's clinical record revealed: 8/20/23 - R524 was admitted to the facility for a five (5) day respite stay. 8/23/23 - The following orders and notes were written: - A progress note was written by E50 (RN) that the resident had a skin tear under his right 3rd toe while he was self-ambulating with non-skid socks on. - 9:25 AM - A physician order was written by E51 (Wound MD) for wound care that was to cleanse the right 3rd toe, pat dry, apply bacitracin (an antibiotic ointment) and leave open to air, every day shift. 8/25/23 7:53 AM - A discharge summary note was written by E7 (SW) that documented under the nursing section that no nursing education was provided, that a skin tear wound was currently present, and with the current wound care as described above. 1/18/24 3:00 PM - During an interview, E10 (RN) stated that according to the documentation in the EMR, R524's daughter was not shown R524's skin tear at the time of discharge. 1/24/24 3:00 PM - During an interview F2 (daughter/caregiver) stated that she was not shown the foot wound at the time of discharge. F2 stated that she took R524 to the hospital on 8/26/23 because the foot wound was swollen and painful. R524 was prescribed antibiotic medication for the foot wound. R524's wound was not shown to F2 and nursing education at the time of discharge to F2 about the wound care was not documented. 1/29/24 11:00 AM - Findings were reviewed E1 (NHA) and E2 (DON).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32810 Based on record review and interview it was determined that for one (R476) out of three residents reviewed for accidents the facility failed to ensure R476 received adequate supervision during a transfer. Findings include: Review of R476's clinical record revealed: R476' care plan for falls last reviewed 3/17/22 included the intervention to transfer the resident with assistance of two staff members. 4/4/22 - A physical therapy discharge summary documented, Staff reports consistent one person transfers, on average moderate assist fluctuates depending on patients level of motivation for the task. There was no documented change in R476's clinical record to change to one person assistance transfers. 8/29/22 - A quarterly MDS assessment documented R476 as being cognitively impaired and requiring total assistance of two staff members for transfers with impairment to one side. 11/21/22 - A quarterly MDS assessment documented R476 as being cognitively impaired and requiring extensive assistance of two staff members for transfers with impairment to one side. 11/30/22 - The facility reported an incident to the State Agency that, On 11/28/22 resident complained of pain in right knee. Area noted to be swollen NP made aware ordered x-ray. Transfer was appropriate per staff who assisted him .Aides suspended pending rule out abuse . 1/25//24 - A Review of the CNA Kardex [undated] indicated R476's transfer status as requiring assistance of two staff members. During an interview on 1/25/24 at 3:22 PM, E20 (CNA) confirmed that on 11/28/22 he transferred R476 from the wheelchair to the bed alone, without the assistance of another staff. E20 denied any fall or other adverse circumstance occurred during the transfer. E20 stated, that R476, was a one person assist. He just stood cried then sat on the bed. I changed him then I notified the nurse about it. During an interview on 1/25/24 at 1:31 PM, E2 (DON) confirmed R476's orders and care plan documented R476 required assistance of two staff members for transfers. During an interview on 1/29/24 at 8:56 AM, E12 (PT) stated residents should be transferred consistent with what the Kardex and careplan's. 1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON).

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 32810 Based on record review and interview it was determined that for one (R475) out of four residents reviewed for nutrition the facility failed to implement interventions related to risk for weight loss when the weekly weights were missed and percentage of supplement consumed was not documented. Findings include: The facility policy on Resident weights, last updated 12/12/23 indicated, Weights will be obtained routinely in order to monitor national health over time. Each residents weight will be determined upon admission/readmission to the facility, weekly for the first four weeks after admission/readmission and monthly or more often if risk is identified, or as ordered. Nursing is responsible for obtaining weights. Review of R475's clinical record revealed: 2/6/23 - 2/16/23 - Hospital records documented, Weight 122.75 pounds [55.8 KG] history and physical reports poor appetite and decreased intake .nutrition problem related to increased nutrient needs. Readmission risk moderate. 2/16/23 - R475 was admitted to the facility with multiple diagnosis including dementia and dysphagia. 2/17/23 - An admission MDS assessment documented R475 as having a poor appetite, weighing 118 pounds and receiving a mechanically altered therapeutic diet. 2/21/23 - A care plan for risk of nutrition was created that included interventions to monitor weight per protocol, monitor intakes, and Boost supplement nightly. 2/22/23 - A physicians order was written for weight on admission and then weekly for four weeks. 2/24/23 - A physicians order was written for house supplement 90 milliliters with meals. 3/3/23 - A physicians order was written for Boost supplement in the evening with dinner tray. Review of R475's weight's revealed the following: 2/16/23 - 118. 2/22/23 - 110. 3/2/23 - No weekly weight obtained. 3/6/23 - 101. February 2023 - Review of R475's MAR revealed amount of supplements consumed was not recorded. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/26/23 at 11:35 AM, E21 (RD) confirmed that supplement intakes for R475 should have been recorded and that one weekly weight was not obtained. 1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON).

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 46134 Based on interview, record review and review of other facility documentation, it was determined that for two (R525 and 274) out of five residents reviewed for pain, the facility failed to ensure that that adequate pain management was provided for R525 and R274 pain assessments were not conducted with a consistent scale for pre and post pain assessments. Findings include: The pain management standards were approved by the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. According to The National Library of Medicine (2008) pain should be reassessed after each intervention to evaluate the effect and determine whether modification is needed. Review of R525's clinical record revealed: 8/4/22 - R525 was admitted to the facility with multiple diagnoses including osteoarthritis and severe kidney disease. A physician's order was written for Tylenol 325 mg two tablets by mouth every six hours for pain. R525 did not have any other pain medications ordered. 8/5/22 - A review of R525's care plan revealed that R525 had the potential for pain and to notify the physician if the medication given was not effective. Review of R525's electronic medical record (EMR) medication administration record for August 2022 revealed that R525 had the following pain levels for which R525 received Tylenol: 8/6/22 7:49 AM - 6 out of 10. Tylenol was given and the post pain scale was assessed as unchanged. A post pain scale number was not documented. 8/6/22 8:30 PM - 9 out of 10. Tylenol was given and the post pain scale was assessed as effective. A post pain scale number was not documented. 8/7/22 3:30 AM - 8 out of 10. Tylenol was given and the post pain scale was assessed as effective. A post pain scale number was not documented. R525 experienced pain on 8/6/22 through 8/7/22 and her pain was not controlled as evidenced by the description of her pain levels as described above. Additionally, R525's pain was not assessed using a number scale after she was given Tylenol for pain. Tylenol was the only pain-relieving medication that R525 had ordered during her facility stay. A review of R525's EMR progress notes revealed the lack of documentation that the facility contacted the medical provider about R525's pain levels on 8/6/22 through 8/7/22, and to obtain further guidance for R525's uncontrolled pain. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). 46988 2. Review of R274's clinical record revealed: 10/30/21 - R274 was admitted to the facility with a diagnoses of cervical disc degeneration (a general term for age-related wear and tear affecting the spinal disks in your neck), wedge compression fracture of thoracic vertebra, and chronic low back pain. 11/2/21 - A baseline care plan initiated for potential for pain with a goal of pain to be controlled to an acceptable level. Interventions included: assess/ document pain per routine and prn, administer pain medications for pain prior to attending therapy sessions, procedures, dressing changes as needed; report and document complaints of pain and/or nonverbal signs of pain; reposition as needed for comfort; administer pharmacological interventions as indicated per physician; and non-pharmacological interventions such as distraction techniques, breathing and relaxation exercises, and music therapy. The baseline care plan failed to identify an acceptable pain level or pain scale to determine pain level. 11/5/21 - An admission MDS assessment documented that R274 was alert and oriented with a BIMS score of 15. Additionally, the MDS documented R274 had pain, that occurred frequently, limiting day to day activities, pain scale 7 (very severe) out of 10 over the last five days. November and December 2021 - R274's MAR revealed that a total of 197 doses of PRN pain medications were administered with a pre pain scale numerically and post scale noted as effective, ineffective, or unchanged. January 2022 - R274's emar revealed that 66 doses of PRN pain medication were administered with a pre pain scale numerically and the post scale noted as effective, ineffective, or unchanged. 2/1/24 11:32 AM - An interview with E27 (LPN) confirmed that a pain assessment records the numerical value for pre pain and effective, ineffective, or unchanged post pain. The review of R274's medical record revealed that the facility failed to monitor pain with a consistent scale. 2/1/24 3:40 PM - Findings were reviewed E1 (NHA) and E2 (DON).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46988 Based on record review and interview, it was determined for one (R274) out of five sampled residents for pain the facility failed to provide routine pharmaceutical services for acquiring and receiving medication. Findings include: Review of R274's clinical record revealed: [DATE] - R274 was admitted to the facility with a diagnoses of cervical disc degeneration, wedge compression fracture of thoracic vertebra, and chronic low back pain. [DATE] - An updated physician order was written for hydromorphone (narcotic pain medication) 2 mg give one tablet every eight hours as needed for severe pain. [DATE] 6:33 PM - A shipment detail form confirmed delivery of hydromorphone (15 tablets) by pharmacy to the facility. [DATE] 10:20 PM - A controlled substance log revealed that R274 received a dose of hydromorphone and the count resulted of zero of quantity. [DATE] 9:45 AM - A progress note revealed that R274 was out of hydromorphone 2 mg. E9 (LPN) notified pharmacy that medication was not available and requested to remove medication from the back up. The progress note revealed that the hydromorphone in the back up was expired. The pharmacy was to deliver medication during the evening delivery. [DATE] 6:35 PM - A shipment detail form confirmed delivery of hydromorphone (15 tablets) by pharmacy to the facility. [DATE] 6:06 PM - A controlled substance log revealed that R274 received a dose of hydromorphone and the count resulted of zero of quantity. [DATE] 11:04 AM - A shipment detail form confirmed delivery of hydromorphone (15 tablets) by pharmacy to the facility. [DATE] 9:30 AM - An interview with E8 (Pharmacist) confirmed the pharmacy delivered the medications on [DATE], [DATE], and [DATE]. E8 also confirmed the hydromorphone was expired in the back up pharmacy and was replaced on [DATE]. [DATE] 12:31 PM - An interview with E9 (LPN) confirmed R274 did not have hydromorphone available from [DATE] 10:30 PM utill [DATE] 6:30 PM. [DATE] 3:05 PM - An interview with E2 (DON) confirmed the hydromorphone was unavailable from [DATE] through [DATE]. The facility failed to order and receive a medication to meet resident's needs. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 3:40 PM - Findings were reviewed E1 (NHA) and E2 (DON).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 32545 Based on record review and interview, it was determined that for eight (R25, R29, R31, R50, R56, R99, R123 and R276) out of thirty (30) residents clinical records reviewed, the facility failed to ensure that each residents' record was complete, accurately documented and readily accessible. Findings include: 1. R25's clinical record revealed: 8/21/23 at 11:20 AM - E4 (Physician) documented in a note, Patient seen and examined. Progress note to follow. As of 1/29/24, R25's clinical record lacked documented evidence of E4's 8/21/23 Physician completed progress note. 1/29/21 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record. 2. R29's clinical record revealed: 12/8/23 at 11:14 AM - E4 (Physician) documented in a note, Patient seen and examined. Progress note to follow. As of 1/29/24, R29's clinical record lacked documented evidence of E4's 12/8/23 Physician progress note. 1/29/21 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record. 3. R31's clinical record revealed: 11/3/23 at 9:53 AM - E4 (Physician) documented in a note, Patient seen and examined. Progress note to follow. Despite this note in R31's clinical record, review by the Surveyor on 1/29/24 revealed that R31's clinical record lacked documented evidence of R31's initial comprehensive note dated 11/3/23. 1/29/21 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record. 4. R50's clinical record revealed: 1a. On the following dates/times, E4 (Physician) documented in R50's clinical notes, Patient seen and examined. Progress note to follow. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/18/23 at 10:42 AM; - 7/24/23 at 1:34 PM. As of 1/29/24, R50's clinical record lacked documented evidence of both E4's 4/18/23 and 7/24/23 Physician progress notes. 1b. 8/3/23 - R50's physician orders by E4 (Physician) documented to discontinue INR (lab) check twice a week; and start INR check once a week. Review of R50's progress notes revealed that E5 (NP) documented to continue INR checks twice a week in three progress notes: 8/9/23, 9/22/23 and 11/27/23; and E4 (Physician) documented to continue INR checks twice a week in the 12/22/23 progress note. 1/29/21 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record. 5. R56's clinical record revealed: On the following dates/time, E4 (Physician) documented in the clinical notes, Patient seen and examined. Progress note to follow. - 10/19/23 at 10:49 AM; - 12/2/23 at 11:30 AM. As of 1/29/24, R56's clinical record lacked documented evidence of both E4's 10/19/23 and 12/2/23 Physician's progress notes. 1/29/21 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record. 6. R99's clinical record revealed: 6/5/23 at 2:03 PM - E4 (Physician) documented in a note, Patient seen and examined. Progress note to follow. As of 1/29/24, R99's clinical record lacked documented evidence of E4's 6/5/23 Physician progress note. 1/29/21 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record. 46988 7. Review of R276 clincal record revealed: 6/2/23 - R276 was admitted to the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/2/23 9:31 PM - An evalutation for continence and retraining schedule was completed for R276 indicating the need for a bowel and bladder diary to be completed. 8/29/23 3:36 PM - An evaluation for continence and retraining schedule was initiated for R276 with no outcome or score noted. 1/29/24 11:35 AM - An interview with E10 (RN) confirmed the evaluation was incomplete and inaccurate. 47621 8. R123's clinical record revealed: 10/31/23 - R123 was admitted to the facility with diagnoses including, but not limited to, stroke and diabetes. 11/1/23 - E4 (MD) ordered Rivaroxaban (anti-coagulation medicine) 2.5 mg (milligrams)- give 1 tablet by mouth two times a day for DVT (deep vein thrombosis) and Plavix (platelet aggregate inhibitor) oral tablet 75 mg- give 1 tablet by mouth one time a day for ischemic stroke. 11/19/23 5:00 AM - Incident report documented that R123 was found sitting on the floor with both feet resting on the bed and back against the wall and that he was getting stuff from his wheelchair. Resident was assessed for injury, none noted . Neuro check initiated . Due to a low blood sugar and the inability to effectively correct the blood sugar, R123 was transferred to the hospital at approximately 7:36 AM on 11/19/23. 11/19/23 7:36 AM - R123's Change in Condition evaluation stated that R123 was not on coumadin. In response to the statement, Resident/patient is on other anticoagulant (direct thrombin inhibitor or platelet inhibitor), the staff responded No. At the time, R123 was on both rivaroxaban and clopidogrel, a platelet aggregate inhibitor medicine. 1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON).