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	05/06/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview and review of a clinical record and other documentation as indicated, it was determined that for one (R5) out of five residents reviewed for accidents, the facility failed to have evidence of a thorough investigation for a cognitively impaired resident who was identified at the hospital with multiple injuries of unknown origin. Findings include: Cross refer to F658 example 1 and F689 example 2 Review of R5's clinical record revealed: 3/20/25 - E4 (LPN) documented in a nurse's note that R5 fell while trying to sit on his chair in his room and had no injury. It should be noted that R5's 3/20/25 fall was witnessed and reported to the nurse by the assigned 1:1 CNA. R5's clinical record revealed that there were no other falls reported and documented after the 3/20/25 fall. 3/25/25 at 1:34 PM - The facility reported the following to the State Agency: On 3/24/25 [R5] was noted with a blood and tissue in his ear and he stated that he had scratched his ear. He was also noted with a change of condition, slurred speech with increased weakness. He was assessed by the NP [E5, contracted] who gave orders to send him out to the hospital for further evaluation. Resident had a CT scan completed which indicated Right temporal hemorrhagic contusion . 4/4/25 - The facility's five day follow-up report to the State Agency documented the following: - Describe any additional outcomes to the resident . No signs of psychological distress. [R5] was noted to have blood and tissue in his ear but did not express any psychological harm or distress. Resident scratched his ear. No additional mention is made regarding his perspective on any psychological distress. - Provide summary of information of investigation related to the incident from the resident's clinical record . The resident, [R5], was noted to have blood and tissue in his ear and a change of condition (slurred speech, increased weakness). After assessment, he was sent to the hospital, where a CT scan showed a Right temporal hemorrhagic contusion. - Description of conclusion: The investigation concluded that the incident likely resulted from [R5] fall a few days prior. The CT scan showed a Right temporal hemorrhagic contusion. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It should be noted that the facility failed to inform the State Agency in the five day follow-up report all of R5's injuries identified in his hospital records, including a right temporal hemorrhagic contusion, right temporal bone fracture, small epidural hematoma and right hip bruise. Upon request of the facility's investigation in response to R5's injuries of unknown origin, the surveyor was provided the following documents: - 3/20/25 Event Report for the witnessed fall and two statements from E4 (LPN) and E13 (assigned CNA for 1:1); and - Typed statements from eight staff, dated 3/25/25, from phone interviews. There was no evidence that the facility's investigation included: - interviews/statements from other staff present on the shift and/or who relieved the 1:1 CNAs when they were on their breaks/lunch from 3/20/25 through 3/24/25; - review of timecards to ensure 1:1 staff were present and observing R5 during the timeframe; and - review and identification of the lack of CNA documentation, including the Point of Care Report and the 1:1 Observation/Monitoring Tool, from the 3/20/25 fall through 3/24/25 when R5 was transferred to the hospital. 5/1/25 at 3:01 PM - During an interview, E4 (LPN) confirmed that E13 (CNA) told her that R5 had fallen on 3/20/25 and it was witnessed. E4 said she was told that R5 was trying to get out of his wheelchair and fell to his knees. E4 stated that R5 did not have any injury. E4 stated, There was no blood or injury. 5/5/25 at 5:15 PM - During an interview, E13 (CNA) confirmed that she was the assigned 1:1 CNA when R5 fell on 3/20/25. E13 stated that she never saw him hit his head against anything. 5/5/25 at 12:02 PM - Reviewed findings with E1 (NHA) and E2 (DON). The facility failed to thoroughly investigate R5's injuries of unknown origin after a change of condition and emergent transfer to the hospital on 3/24/25. 5/6/25 1:40 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (RUPO).

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that for one (R5) out of three residents reviewed for discharge, the facility failed to allow R5 to return to the facility and also failed provide a 30 day discharge to his family representative. Findings include: The facility's Bed Hold Letter Policy - It is the policy of the facility to track Medicaid bed hold days and notify appropriate parties via Medicaid Bed Hold letter. Updated [DATE] The facility's admission Agreement- N. Bed Hold and Leave of Absence- . If Resident's primary pay source is Medicaid, and if the State within which the facility is located provides for paid hold/ leave days, the facility will hold the bed for the Resident up to _____. If the resident's absence from the facility exceeds the days provided during a calendar year or the State does not provide for paid hold/leave days, the facility shall not hold the bed and the Resident will be discharged from the facility effective the first day following the last paid Medicaid hold/leave or in-house day . Where a Resident's paid leave days for a calendar year have been exhausted or the State does not provide for paid hold/leave days, the Resident will be entitled to re-admission to the facility, if desired, to the Resident's previous room if available or immediately upon the first availability of a bed in a semi-private room, if the Resident: a). requires the services provided by the facility; and b). is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. Last revised [DATE] Review of R5's clinical record revealed: [DATE] - R5 was admitted to the facility with diagnoses including but not limited to vascular dementia with psychotic disturbances. [DATE] - R5's care plan for Behavioral Symptoms. Resident is a threat to self and/or others R/T (related to) episodes of aggression and elopement attempts was updated with an intervention for 1:1 observation for safety. [DATE] 10:25 AM - E6 (UM/LPN) documented in R5's EMR progress notes, Resident noted with increased confusion, need additional assist with ADLs and unsteady gait. Also note blood to right ear . [E5 NP] in house to evaluate with new order to send resident to ER for further eval (evaluation) . [DATE] 11:43 AM - E22 (hospital MD) documented in [hospital] ED (emergency department) Physician Record, XXX[AGE] year old male .presenting with altered mental status . [DATE] - The facility mailed copies of R5's Return to Facility Anticipated form dated [DATE] and Bed Hold Notice to F2 (R5's brother who lived in Puerto Rico). The Return to Facility form stated that the reason for R5's transfer was an immediate transfer or discharge is required by the resident's urgent medical needs. The facility provided the surveyor with copies of the addressed envelope and postage for this mailing to Puerto Rico. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 10:55 AM - C4 documented in R5's hospital EMR, Pt off restraints since 4/1 at 2345 (11:45 PM) . once 24 hours without restraints pt able to return to [facility]. [DATE] 11:30 AM - C5 (hospital case manager) documented in R5's hospital EMR, As per rounds, pt has a safety sitter at this time and is not in restraints. Patient's psych medications were adjusted .As per facility, patient will need insurance auth (authorization) and PASRR prior to return. [DATE] 12:48 PM - C5 (hospital case manager) documented in R5's hospital EMR, As per rounds, pt agitated and now has wrist restraints . [DATE] 3:19 PM - C5 documented in R5's hospital EMR, Spoke with Admissions at [facility], pt does not need to be sitter free for return to their facility, he needs to be out of restraints for 24 hours .PASRR approved and uploaded to facility via Ensocare. [DATE] 8:56 AM - C5 documented in R5's hospital EMR, .Spoke with [facility] yesterday, pt needs to be restraint free X 24 hours prior to acceptance. Received Ensocare message from [facility] Just to reiterate, patient has no bed hold and currently I don't have a bed . [DATE] 11:08 AM - C5 documented in R5's hospital EMR, As per rounds, pt has been restraint free since 1400 (2 PM) yesterday. Updates sent to [facility] with inquiry about bed availability later today vs tomorrow if pt remains restraint free . [DATE] 1:08 PM - C5 documented in R5's hospital EMR, [Facility] declined patient at this time . [DATE] 3:20 PM - C5 documented in R5's hospital EMR, Spoke with Admission, they report they declined pt because they do not have a bed available at this time and will contact this writer when a bed becomes available. Called DE (Delaware) Ombudsman office at [phone number]. [DATE] 8:12 Am - C5 documented in R5's hospital EMR stating that the facility staff said, I have no idea when we will have a bed available . This patient requires a private room and a room close to the nursing station, which we do not have available. C5 also documented, F/u (follow up) with DE Ombudsman today due to facility declining pt return . [DATE] 2 :44 PM - C5 documented in R5's hospital EMR, CM (case management) received return call from Ombudsman's office, [C7] [phone number]. He reports he spoke with [facility]. Pt's bed hold expired and pt is planned for next available bed. [DATE] 10:49 AM - C5 documented in R5's hospital EMR, .Discussed during rounds, pt is back in restraints. Updates sent to [facility], no bed available at this time. Pt will need to be restraint free for 24 hours and will need room near nurse's station in order for facility to accept him back . [DATE] 10:33 AM - C5 documented in R5's hospital EMR, Discussed during rounds, pt will be out of restraints for 24 hours at 1400 (2 PM) today and is otherwise medically stable for return to [facility]. Updates sent to facility, facility continues to decline pt return due to no bed being available near the nurse's station. Called pt's LTSS case manager, she reports she is going to [facility] today and is requesting public guardianship for pt. [DATE] - R5's PASRR documented PASRR level I with no PASRR level II evaluation required. (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 1:55 PM - This surveyor identified that there were two empty male beds in the facility XXXB [room number] and XXXB [room number]. Additionally, XXXA [room number] bed was a private room near the nurse's station but was currently under a bed hold. [DATE] 3:28 PM - C8 (complex cases case manager) documented in R5's hospital EMR, .Per Liaison, they [facility] are not accepting the patient back as they cannot meet his care needs and feel he is a danger to the other residents. Per Liaison, Administrator [E1] spoke with Ombudsman [C9] regarding this patient and was advised that this patient was not appropriate for their facility. Per Liaison, Administrator states the Ombudsman [C9] advised that [hospital] work with the LTSS CM (case manager) to place patient in an out of state facility. CM to submit OSEC referral as [facility] is the patient's residence . [DATE] 4:14 PM - This surveyor informed E1(NHA) and E3 (RUPO) at the request of the State Agency that the facility would need to accept R5 back and proceed with the 30 day discharge notice process. [DATE] 2 29 PM - C8 documented in R5's hospital EMR, CM received call from [facility] Liaison asking, if per the request of the building, she can come in and have the patient sign the 30 day notice. CM stated that she would have to follow up with manager .However the patient has vascular dementia compounded with a TBI (traumatic brain injury) and that he is unable to sign. CM also stated to her knowledge, a 30 day notice cannot be given to a patient while they are in the hospital . [DATE] 11:23 AM - During an interview, E21 (business office manager) confirmed that Medicaid was R5's payor source. [DATE] 2:38 PM - During an interview, E1 (NHA) confirmed that envelope mailed to F2 (R5's brother) on [DATE] contained R5's DMOST, the bed hold policy and all the transfer paperwork. E1 stated that there was no discharge paperwork contained in the [DATE] mailing packet. E1 stated the facility's policy for Medicaid residents was a seven day bed hold. [DATE] 5:38 PM - C2 (hospital psychiatry NP) documented in R5's hospital EMR progress note, .From a psychiatric standpoint, there are no barriers to discharge back to a long-term care facility. [DATE] - Upon conclusion of the survey, R5 remained in the hospital. [DATE] 1:40 PM- Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (RUPO).

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview and record review, it was determined that for two (R1 and R5) out of five residents sampled for accidents, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of Practice by failing to have a registered nurse (RN) complete and document an RN admission assessment and post-fall assessment. Findings include: Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024 . RN . admission Assessments . Post Fall Assessment & Documentation . updated 10/11/24. 1. Review of R1's clinical record revealed: 11/6/24 - R1 was admitted to the facility with diagnosis including dementia. 11/6/24 11:35 AM - E10 (LPN) initiated R1's admission observations in the EMR. 11/6/24 12:30 PM - E10 (LPN) completed R1's admission observations in the EMR. 11/6/24 12:31 PM - E10 (LPN) completed R1's functional abilities assessment in the EMR. 11/6/24 12:39 PM - E10 (LPN) completed R1's TB (tuberculosis) screen in the EMR. 11/6/24 1:05 PM - E6 (LPN) completed R1's baseline care plan checklist in the EMR. 5/2/25 11:40 AM- A review of the EMR admission observations revealed the following information for each newly admitted resident were reviewed, assessed and documented on: language, hearing, speech and vision, nervous system, respiratory system, cardiovascular system, gastrointestinal system, genitourinary system, and musculoskeletal system, pain assessment, skin, infectious disease and resident preferences. Any section that included the word system had both a history and physical observation as part of the documentation. The facility failed to meet the professional standards of the Delaware State Board of Nursing by allowing LPNs to work outside of their scope of practice and complete R1's admission assessments. 5/2/25 2:15 PM - During an interview, E2 (DON) confirmed that the above listed documentation was all part of the admission assessment and that for R1's 11/6/24 admission, there was not an RN involved in R1's admission assessment process. 5/2/25 2:202 PM - E1 (NHA) stated, Those are not assessments. They are labeled in the EMR as observations. The facility was unable to provide evidence of any other documentation that could be identified as an admission assessment that was performed by an RN. 2. Review of R5's clinical record revealed: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/20/25 3:23 PM - A nurse's note by E4 (LPN) documented, this writer was made aware by staff that resident fell and got himself back to sit in his chair. Pt (Patient) assess (sic) no apparent injury noted. Resident stated he was trying to sit on his chair. Pt denies injury upon assessment . 3/20/25 6:01 PM - The facility's event report for R5's fall was completed by E4 and documented the fall details, observations of pain and R5's body, neurological check, review of other body systems, possible contributing factors, interventions, therapy referral and vital signs. 5/2/25 at 2:19 PM - During an interview, E4 confirmed that after R5's 3/20/25 fall she completed the post fall assessment and documentation. The facility failed to ensure an RN performed and documented R5's 3/20/25 post-fall assessment. 5/6/25 1:40 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (RUPO).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. Cross refer to F610, F658 example 2 Review of R5's clinical record revealed: 1/20/23 - R5 was admitted to the facility for long term care. 1/18/25 - R5's care plan for Behavioral Symptoms. Resident is a threat to self and/or others R/T (related to) episodes of aggression and elopement attempts was updated with an intervention for 1:1 observation for safety. 2/11/25 - The quarterly MDS assessment documented that R5 was cognitively impaired with a BIMS score of 5; independent for toileting/showering/dressing/ambulating; active diagnoses included, but were not limited to: dementia, seizure disorder and depression; history of falls; current medications include antipsychotic, antidepressant and anticonvulsant; and the use of a wander/elopement alarm. 3/20/25 3:53 PM - A nurse's note by E4 (LPN) documented, this writer was made aware by staff that resident fell and got himself back to sit in his chair. Pt (Patient) assess (sic) no apparent injury noted. Resident stated he was trying to sit on his chair. Pt denies injury upon assessment . It should be noted that there was no documented evidence that R5 had another fall in the facility after 3/20/25. Review of the facility's 1:1 documentation for R5 that was provided to the surveyor lacked documented evidence of R5 being supervised by a staff person on Sunday, 3/23/25, from 7:00 AM through 3:00 PM and on Monday, 3/24/25, from 12 AM through 7:30 AM. 3/24/25 9:03 AM - A social services note documented, Resident observed attempting to leave the building by pushing and banging on the door. Resident continues to state to not like it her (sic) and wants to leave. Resident alert and verbal able to make needs known however has impaired cognition with a dx (diagnosis) of dementia. Resident was redirected by staff and brought back to his room where he remains on 1:1 for supervision. 3/24/25 9:59 AM - A progress note by E5 (NP) documented, . Patient was seen and examined . nursing staff concerned due to altered mental status and bloody drainage from the left ear. He is status post fall. No visible injury apart from bloody ear, which nursing staff reported that he scratched himself. He is unable to answer my questions at this time. Awake and sitting on a WC (wheelchair) . Plan: Perforated eardrum/ bloody drainage- Acute, suspected otoscopic exam revealed perforated eardrum . Since patient is post fall with AMS (altered mental status), will transfer to ED (emergency department) to more immediate imaging . Altered mental status- Acute . He is unable to answer and follow verbal commands . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3/24/25 10:25 AM - A nurse's note by E6 (UM/LPN) documented, Resident noted with increased confusion, need additional assist with adls (activities of daily living) and unsteady gait. Also note blood to right ear. Resident is s/p (status post) fall. [E5, NP] in house to evaluate with new order to send resident to ER for further eval (evaluation) . 3/24/25 11:04 AM (arrival time) - The hospital record documented, . Patient . presenting with AMS . was unable to answer orientation questions . ED provider called [facility] . Reported that since this AM he has not been acting like himself, reportedly able to ambulate although dragging his right leg . They stated he has been compliant on all his seizure medications and no seizure activity was noted today. Denied significant head trauma . Reportedly noted to have slurred speech . He was noted to have bleeding from his right ear, at which point a trauma alert was called . Dried blood in and around the R (right) ear . Head CT [CT scan results]: 1. Right temporal hemorrhagic contusion. 2. Right temporal bone fracture . with 7 mm epidural hematoma . and traumatic pneumocephalus . 3/25/25 10:37 AM - A progress note by E6 (UM/LPN) documented, IDT (Interdisciplinary team) met to review residents (sic) plan of care. Resident . with comorbities than (sic) include seizure disorder . dementia . alert and oriented with a BIMs of 5 . continent of bowel and bladder, self propels wheelchair and requires supervision for ADLs. On 3/20/25 resident sustained a witnessed fall during attempt to transfer from wheelchair. Per witness statement resident stood from wheelchair and fell to knees. Resident was able to independently get up from floor. No apparent injuries observed at this time . 3/25/25 6:49 PM - An IDT note by E2 (DON) documented, . Long-term care resident . past medical history of weakness, vascular dementia, MDD, CKD, Seizures, Neuropathic intracranial hemorrhage and hypotension. He is alert and orient (sic) he is able to make his needs known. He self-propels on a wheelchair. He is independed (sic) for ADLs. On 3/24/25 he was noted with blood and tissue in his ear, and he stated that he had scratched his ear. He was also noted with a change in condition, slurred speech with increased weakness. He was assessed by the NP who gave orders to send [R5] out to the hospital for further evaluation. Resident had a CT scan completed which indicated Right temporal hemorrhagic contusion . 5/2/25 2:49 PM - During an interview, E6 (UM/LPN) stated that she did not recall any complaints or issues with R5 on Friday, 3/21/25, the day after he fell (3/20/25). E6 stated that she did not work over the weekend. E6 stated on Monday dayshift, 3/24/25, when I came in, R5's 1:1 [E8, assigned CNA] pulled me into his room saying R5 was erratic and trying to hit her. E6 stated that R5 was on the toilet and he could not get up on his own, which is not how he normally is. E6 stated, I knew something was wrong. E6 stated that she was trying to put him in his wheelchair and she noticed blood on his ear. E6 stated that R5 told me that it was a scratch. E6 stated that R5 participated in the scheduled smoking breaks and he did not go out for the 8:30 AM scheduled smoking break. E6 stated Between us trying to get him settled and [E5, NP] seeing him and sending him out, R5 did not have time to got to the smoking break. Normally he went to every smoking break. That day he was not asking to go to the smoking break. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's timecard records revealed that E6 (UM/LPN) clocked in on Monday, 3/24/25, at 8:19 AM. The offgoing nightshift nurse, E9 (LPN), worked a double shift and was assigned to a different hallway for 3/24/25 dayshift. According to the facility's 7-3 C.N.A. Assignment Sheet Date: 3/24/25, E6 was the assigned nurse for the entire hallway where R5's room was located. 5/5/25 12:41 PM - During an interview, E8 (CNA) confirmed that she was the assigned 1:1 CNA for R5 on Monday dayshift, 3/24/25. E8 stated that she did not talk to anyone when she took over his care nor received report from previous CNA or a nurse. E8 stated there was nobody sitting outside his room from night shift. E8 stated that when R5 got up, he was kind of not himself and she noted his ear was bleeding. It was dried blood. E8 stated that From the beginning, he was talking about [name of country] . he wants to go home. E8 stated that [R5] walked to the front door by pushing his wheelchair. When he got to the front door, [R5] went off. [R5] threw the wheelchair at me. Someone opened the front door because they did not see him. Then three of us pulled the door closed and [R5] came back at me. E8 stated that [R5] was not himself . he was out of it and aggressive. E8 stated that after the front door, he walked himself back and sat down on his bed. The nurse [E6, UM/LPN] cleaned his ear again. Then the [NP] came and saw him and sent him out. E8 stated that the first time [R5] had his ear cleaned up was before the door incident and the second time it was cleaned up was after the door incident. E8 stated that when [R5] acts up, he kicks and uses his hands. E8 stated that she has never seen him bang his head. According to the facility's timecard records, E7 (assigned 1:1 CNA for Sunday nightshift, 3/23/25-3/24/25) clocked out on Monday, 3/24/25, at 7:00 AM. E8 (assigned 1:1 CNA for dayshift) clocked in on Monday, 3/24/25, at 7:21 AM. The facility lacked evidence that R5 had 1:1 supervision. 5/5/25 12:02 PM - Finding was reviewed with E1 (NHA) and E2 (DON). 5/6/25 1:40 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (RUPO). Based on interview and review of clinical records, hospital records and facility documentation as indicated, it was determined that for two (R1 and R5) out of five residents reviewed for accidents, the facility failed to ensure the environment remained as free of accident hazards as was possible and each resident received adequate supervision. For R1, the facility failed to ensure R1, a resident with cognitive impairment and care planned to wear a wandering device, received adequate supervision and assistive devices to prevent an elopement. On 4/21/25 at approximately 9:30 PM, R1 eloped from the facility via the facility front door. R1 remained unaccounted for until 10:20 PM when the police located and returned R1 to the facility. An IJ was called on 5/1/25 at 1:30 PM. The IJ was abated on 5/1/25 at 3:54 PM For R5, the facility failed to supervise a cognitively impaired resident who was on 1:1 (one to one) supervision for safety/behaviors. On 3/24/25, R5 was emergently transferred to the hospital for a change in condition and upon examination was identified with multiple injuries of unknown origin, including a non-displaced temporal bone fracture and small epidural hematoma. R5 was harmed. Findings include: (continued on next page)

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	085039	A. Building B. Wing	05/06/2025

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. The facility's Elopement/Unauthorized Absence Policy: The facility will identify residents with potential and/or actual risk factors for elopement and protect the resident through development and implementation of safety interventions. In the event of a resident elopement, the facility will implement its policies and procedures promptly to locate the resident in a timely manner . Assessment: 1. All residents will be assessed for the risk of elopement using the Elopement Observation on admission, quarterly and as needed. The facility's Resident Observation Policy, last revised 5/28/21, stated, . B) DON will assign a staff member to complete appropriate observation/interventions which may include but are not limited to: every 15 or 30 minutes checks or 1:1 monitoring. Staff members will complete the observation/monitoring tool as follows: . C) If resident is on 1:1 monitoring, additional staff member assigned will remain with the resident in view at all times. Should the assigned staff member need to leave the area they are responsible to ensure the resident is directly observed during their absence by another staff member. Interim staff member will utilize observation/monitoring tool as above . [Manufacturer] Code Alert Wander Management User Manual - Resident Generated Alarms - Do not rely exclusively on resident generated alarms for resident care and safety . The most reliable method of resident monitoring combines close personal surveillance with correct operation of monitoring equipment .The transmitter is placed on the wrist or ankle of the resident. If a transmitter is detected in an Exit Alarm Zone and the door is open, an alarm sounds at the exit. Depending upon which equipment you have installed, the Wander management Solution can automatically lock doors and deactivate elevators . The Wander management solution, by itself, cannot prevent the elopement of residents .Signal Strength 2. An alarm must occur when the transmitter is within 4-feet of the monitored door. If applicable, the door should also lock . [Manufacturer's] Technology, 2018. 1. Review of R1's clinical record revealed: Cross refer F658 example 1 and F842. 11/6/24 - R1 was admitted to the facility with diagnosis including but not limited to, dementia. 11/6/24 11:35 AM - E10 (LPN) documented on the admission elopement observation, No- clinically not at risk for elopement .No identified risks for elopement. 11/7/24 1:56 PM - R1's admission Minimum Data Set (MDS) assessment documented a Basic Inventory of Mental Status (BIMS) score of 9, which was reflective of moderate cognitive impairment. 11/19/24 - R1's baseline care plan documented Problem- Resident experiences wandering . Approach - . Safety/Wanderguard: electronic bracelet for safety - check placement every shift . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	12/2/24 10:35 AM - E11 (MD) and E12 (Social Work Director) completed the DSAMH (Division of Substance Abuse and Mental Health) 24-hour Emergency Detention form on behalf of R1 stating that R1 was dangerous to self as evidenced by .exhibiting increasing delusions paranoia. He believes he has been kidnapped by the Russians. He refers to the staff as [NAME] .frequently combative. Physically aggressive with staff . The facility failed to complete a re-assessment of R1's elopement risk at this time. 1/19/25 9:21 PM - E17 (RN) documented in R1's EMR progress notes, Pt (patient) was seeing (sic) holding security band cut and in hand. Pt keeps band in closet in dirty clothes bin. Pt is refusing to wear band. Writer is unsure how pt was able to remove band. Incoming nurse to be informed, hopefully band can be reapplied during sleep . 2/3/25 -R1's quarterly MDS assessment documented a BIMS score of 00, which reflected severe cognitive impairment. Review of the March 2025 MAR (Medication Administration Record) on nineteen different occasions E18 (RN), E19 (RN) and E20 (RN) (out of a potential ninety-three shifts) documented that R1 had removed his wander guard during the month of March. 3/13/25 - The Court of Chancery (a Delaware court of equity that assigns guardianships) assigned R1 a guardian, stating R1 was a person with a disability by reason of mental or physical incapacity . and is in danger of substantially endangering his health . The facility failed to complete a re-assessment of R1's elopement risk at this time. Review of the April 2025 MAR on five different occasions E18 (RN) (out of a potential sixty-two shifts) documented that R1 had removed his wander guard prior to the 4/21/25 elopement. 4/21/25 at approximately 9:30 PM - R1 eloped from the facility by exiting via the unattended, alarmed front door of the facility per the report that the facility filed with the State Agency. Review of the facility's abatement plan revealed that the facility took the following immediate measures: - 4/21/25 9:30 PM - facility immediately initiated Code Green- elopement protocol. Staff searched the facility both inside and outside the facility. - 4/21/25 9:45 PM - the local police were called and made aware of the missing resident. Staff members continued searching the area by car. - 4/21/25 10:20 PM - R1 was located and returned to the facility by the [local] Police. R1 was found seated on the ground on the adjacent complex parking lot behind the facility. - 4/21/25 10:20 PM - Once in the facility, R1 placed on 1:1 supervision indefinitely. NP and Guardian notified of the elopement. - 4/21/25 - R1's care plan was updated for elopement. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- 4/21/25 10:30 PM - DON (E2) entered the facility and checked exit doors ensuring that the door locking mechanism was properly functioning. A head count of all residents in the facility was also completed by the DON. - 4/21/25 10:45 PM - House wide education was initiated regarding elopement was initiated by the DON and continued until all staff were educated. - 4/22/25 2:30 PM- The Staff development nurse called all staff not scheduled and provided elopement education via the telephone. This was completed by 2:30 PM. - 4/22/25 - Elopement drills were completed on all 3 shifts. - 4/22/25 - Maintenance director audited all exit doors. - 4/22/25 - R1 evaluated by NP and Psych provider. - 4/22/25 - An Ad Hoc QAPI meeting to discuss the elopement incident was held. - 4/23/25 6:30 AM -The last elopement drill was completed with night shift. 4/22/25 6:12 PM - E2 (DON) reported to the State Agency, On 4/21/25 at approximately 9:30 PM, staff noticed that the front door alarm was going off. Staff immediately responded to the alarm and noted the wheelchair of [R1] in the lobby; staff quickly looked outside and did not note the resident. Elopement protocol initiated; the staff immediately completed a house wide search of the resident and he was not located. External search of the facility initiated and police were notified to assist in the search . Police officers located the resident in the neighboring apartment complex compound, seated on the ground and was returned to the facility by officers at approximately 10:20 PM . The facility failed to provide adequate supervision of R1 to prevent an elopement. R1 was outside the facility without supervision at night for approximately 50 minutes. 4/23/25 6:30 AM - The last elopement drill was completed with the night shift. 4/29/24 8:24 AM - During an interview, E13 (front desk receptionist) stated, The (front) door is locked 24/7. You have to be buzzed to be let in. 4/29/25 10:10 AM - During an interview, E2 stated that the facility does not have video footage of the elopement incident at the front doorway. 4/29/25 11:10 AM - During an interview, E14 (receptionist) stated, You need a code to get in and out. I work day shift. I typically arrive around 6:30 AM and stay until 3 PM. Then there is a part-time worker who is here until 7 PM. After 7 PM, to get in a person has to ring the doorbell and then a nurse or aide has to let them in. To get out you have to have the code to open the door. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4/29/25 7:02 PM - During a telephone interview, E15 (RN/ evening shift supervisor) stated, I was working as the supervisor. I was on the southside unit. The resident was on the northside unit. Two CNAs told me that he [R1] had eloped. I started a search. I told everyone to search the rooms. One of the nurse aides saw that the wheelchair was in the main lobby and that he [R1] was missing. I notified the police and then the DON. A couple of the CNAs got in their cars and drove around looking for him. One of the CNAs went to the Wawa area. The police came and I gave a description. We did not have picture because he refused a picture. Within 40 minutes he was located. When he was back in the building, he was really agitated. He did say that he fell. He refused everything. [E16, LPN] is regularly assigned to him. He was very disrespectful to her and he got in her space. No I don't remember hearing the alarm, I was in a little office on the Southside . I had no idea that he could walk that fast. Every time I saw him, he was pushing a WC. He is up walking at all times. He did have a Wanderguard on. Wanderguard should be checked every shift. I believe it was on his ankle. 4/30/25 10:26 AM - During an interview, E6 (LPN/unit manager) stated, [R1] had an order for the Wanderguard device . He would take it off a lot. He was not an exit seeker prior to that night. 5/1/25 11:39 AM - The surveyor with E1 (NHA) and E2 (DON) performed a demonstration of the front door locking system. Without a Wanderguard device, when the surveyor put pressure on the door handle, an alarm had an immediate two beeps and then beep approximately every second for 15 seconds continuously. Then at 15 seconds, the door lock released and the door could be opened. With the Wanderguard device, when the surveyor put pressure on the door handle, an alarm had an immediate two beeps and then beep approximately every second for 20 seconds continuously. Then at 20 seconds, the door lock released and the door could be opened. For this demonstration , E2 (DON) held the Wanderguard device and E1 (NHA) timed the alarm. Of note, the door alarm did not trigger an alarm when the Wanderguard device came within four feet of the sensors on the door. 5/1/25 1:30 PM - An IJ was called. 5/1/25 3:54 PM - The abatement plan that the facility would have staff at the front door 24 hours until the door locks could be adjusted, was accepted by the State Agency. 5/2/25 11:30 AM - The surveyor confirmed the abatement by reviewing the schedule and interviewing the day shift front desk personnel.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, it was determined that for one (R1) out of four residents reviewed for accidents, the facility failed to have his advanced directive and copy of his DPOA (Durable Power of Attorney) readily accessible on his EMR during his 11/6/24 admission. Findings include: Review of R1's clinical record revealed: 6/21/23 - During a previous Facility admission, E5 (NP) completed the DMOST (Delaware Medical Orders for Scope of Treatment) form with R1, which stated Do not attempt resuscitation/DNAR. 11/6/24 - R1 was admitted to the facility with diagnosis including dementia. 11/6/24 11:48 AM - E6 (LPN) entered into R1's EMR a DNR (do not resuscitate) order. 11/7/24 9:44 AM - E11 (MD) signed the DNR order in R1's EMR. 11/7/24 1:56 PM - R1's admission Minimum Data Set (MDS) assessment documented a Basic Inventory of Mental Status (BIMS) score of 9, which was reflective of moderate cognitive impairment. 4/30/25 9:10 AM - A review of R1's EMR revealed no evidence of the DMOST form or the financial power of attorney document in R1's EMR. 4/30/25 10:35 AM - During an interview, E12 (SW director) stated, At admission, we were notified that R1 had a financial PO [person's name]. We did not get a copy of the Advanced Directive from the hospital or assisted living facility. 4/30/25 10:47 AM - During an interview, E21 (business office manager) stated, We never got a copy of the POA (power of attorney) since [financial POA] was paying the bill. He told us that he was applying for guardianship. The facility failed to obtain proof of R1's financial POA and R1's completed DMOST form. 5/6/25 1:40 PM - Finding was reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (RUPO).