

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085051	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Delaware Veterans Home		STREET ADDRESS, CITY, STATE, ZIP CODE 100 Delaware Veterans Blvd Milford, DE 19963	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36246</p> <p>Based on interview, record review, and policy review, the facility failed to protect two of three residents (Resident (R) 51, R63), reviewed for abuse, when facility nursing staff, a Certified Nurse Aide (CNA)4 used profanity toward R51 during care. In addition, when R39 sat on R63's bed and pushed down on R63's chest with his hands. Failure to protect residents from abuse has the potential to result in injury to residents.</p> <p>Findings include:</p> <p>1. Review of R51's Admission Record located in electronic medical record (EMR) under the Profile tab indicated R51 was admitted on [DATE] with diagnoses which included unspecified dementia, unspecified severity with agitation, and generalized anxiety.</p> <p>Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/03/23, found in the EMR under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of five out of 15, indicating a severe cognitive deficit.</p> <p>Review of the Investigation File, dated 01/19/24 indicated a written statement by Assistant Director of Nurses (ADON) 1 indicated he was informed that CNA2 witnessed CNA4, during resident care, using profanity toward R51. The statement indicated CNA4 was removed from the unit, asked to write a statement, questioned by ADON1, suspended, and terminated following investigation of the incident.</p> <p>Further review of the Investigation File indicated a Root Cause Analysis indicated the following: at approximately 6:00 AM on 01/19/24, staff (CNA2) witnessed another staff (CNA4) make inappropriate verbal remarks towards a resident (R51) during care. CNA4 stated that she became frustrated with the resident who was not being compliant with care and admitted that her tone was firm, and she may have used profanity words under her breath. CNA2, who came in to assist with care, overheard CNA4 using words of profanity toward R51.</p> <p>Review of CNA2's written statement indicated that while she was helping CNA4 provide care to R51 on 01/19/24, CNA4 was becoming verbally aggressive to him. The statement indicated CNA told R51 he was pissing her off. CNA2 said CNA4 wanted R51 to hold onto the sit to stand device, R51 was not being cooperative, and CNA4 told R51 to hold onto the fucking thing. CNA2 said CNA4 said, within earshot of R51. that he was fucking annoying her.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview, by telephone, with CNA2 on 04/24/24 at 7:47 PM, CNA2 said she witnessed CNA4 using foul language with R51. She said they were providing care, and he was not being cooperative, and CNA4 got frustrated with him. CNA2 said CNA4 was using the words fuck and fucking toward R51.</p> <p>During an interview, by telephone, with CNA4 on 04/25/24 at 2:19 PM, she said she was assigned to R51's unit that evening and was already mad because she had been floating and working different units all the time. She said she was providing care to R51 and providing peri care. She said he kept trying to pull up his pants before she was done, and she said she might have gotten loud because he was not hearing her but denied using profanity or being able to recall using profanity. She said she was accused of using profanity towards R51. She said she was removed from the unit and facility and has not been back.</p> <p>Review of CNA4's Personnel File indicated she received training on Abuse, Neglect and Exploitation on 09/12/23, and Dementia Care with the Hand in Hand program on 09/13/23.</p> <p>During an interview, by telephone on 04/25/24 at 10:04 AM, Registered Nurse (RN) 4 said she did not recall anyone reporting this incident of abuse to her because she would have reported it to ADON1. She said CNA2 did tell her that CNA4 was not applying R51's ted stockings so she told her R51 needed to have them, it was ordered so it must be done. RN4 said CNA2 told her that CNA4 told R51 you are making it hard for me to turn you or something, and had exhibited an attitude in general that night.</p> <p>During an interview on 04/25/24 at 9:39 AM, ADON1 said CNA2 reported that CNA4 became frustrated while providing care to R51 and used profanity toward R51. ADON1 said he interviewed staff that were on duty, removed CNA4 from the unit, asked her to write a statement, placed her on administrative leave and had her leave the facility. He said the abuse was substantiated and CNA4 was terminated. He said all staff were re-trained related to abuse. ADON1 said R51 exhibited no behavior changes and did not recall the incident.</p> <p>Review of the Social Worker (SW)3's statement dated 01/19/24 indicated she spoke with R51 and when asked how his day was going, R51 stated it was going great because he had been able to sleep late. The statement indicated that when asked if anything unusual happened, R51 said no, and denied anyone yelling at him or speaking to him in a mean way. The statement indicated R51 did not appear upset.</p> <p>2. Review of R39's Admission Record in the EMR under the Profile tab indicated R39 was admitted on [DATE] with diagnoses including Alzheimer's early onset, restlessness and agitation, major depressive disorder, and bipolar disorder.</p> <p>Review of R39's quarterly MDS with an ARD of 11/09/23 in the EMR under the MDS tab indicated a BIMS score was four out of 15, indicating a severe cognitive deficit.</p> <p>Review of R39's Care Plans in the EMR under the Care Plan tab indicated care plans in place at the time of the incident included R39's behaviors: aggressiveness, towards others, hallucinations, delusions, easily agitated, tearful episodes, purposeful intentions of sitting self on the floor related to dementia included the following intervention: when resident becomes agitated with staff and other residents encourage resident to go for a walk off the unit.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R63's Admission Record in R63's EMR under the Profile tab indicated R63 was admitted on [DATE] with diagnoses including anxiety, neurocognitive disorder with Lewy bodies, and post-traumatic stress disorder (PTSD).</p> <p>Review of the admission MDS with an ARD of 11/28/23 in the EMR under the MDS tab indicated the BIMS score was a six out of 15 indicating a severe cognitive deficit.</p> <p>Review of R39's Health Status Note, dated 01/23/2024 at 4:06 AM in the EMR under the Progress Note tab indicated staff heard a commotion and found R39 kneeling on R63's bed with one knee while his hands were around R63's crossed wrists, pressing against R63's chest. The Health Status Note indicated R63 remained lying in bed as if in shock, unable to defend himself. Staff removed R39 from the area and re-directed him.</p> <p>During an interview on 04/24/24 at 4:34 PM, the Unit Manager (UM) 1 stated that R39 has periods when he is up at night, and it was not unusual for him to be in the hallway where R63's room was located.</p> <p>During an interview on 04/25/24 at 9:41 AM, the ADON1 said R39 thought that it was his room and R63 was in his bed. ADON1 said R63 did not realize what was going on and R39 was removed and easily re-directed. ADON1 said R39 was placed on 1:1 supervision and transferred to an inpatient psychiatric facility on 01/26/24.</p> <p>The Investigation File indicated that when R39 was asked what he was doing, he stated that R63 was in his bed.</p> <p>Review of the facility's policy titled Abuse and Neglect dated 12/03/20 and recently revised on 04/04/24 indicated incidents of abuse will be investigated, reported, facility staff will be educated and trained, and incidents could be cause for immediate termination.</p>		