STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. Building B. Wing	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Veterans Home	100 Delaware Veterans Blvd Milford, DE 19963

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36246 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. Findings include: 1. Review of R51'sAdmission 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. 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. 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. 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. 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. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. 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. 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. 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. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R63'sAdmission 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). 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. 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. 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. 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. The Investigation File indicated that when R39 was asked what he was doing, he stated that R63 was in his bed. 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.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 35693 36246 39540 Based on interview, record review, and policy review, the facility failed to ensure resident, and resident's representatives were notified at time of discharge of the location and reason for the discharge for a sample of four of four residents (Resident (R)13, R19. R12 and R39) reviewed for hospitalization . As a result of this deficient practice, residents had the potential for location of residents not known to families or resident representatives. Findings include: 1. Review of R13's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed an admitted [DATE] and readmission on 12/21/23 with medical diagnoses that included chronic obstructive pulmonary disease and adult failure to thrive. Review of R13's Significant Change Minimum Data Set (MDS) located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 01/17/24, revealed a Brief Interview for Mental Status (BIMS) score of 3 out of 15, indicating R13 was severely cognitively impaired. Review of the Misc tab in the EMR revealed a bed hold agreements dated 12/02/23 and 12/17/23 as date of transfer and lacked information about the reason or destination of the transfer of the resident. Review of the Progress Notes tab in the EMR documented Social Services entry on 12/04/23 and 12/18/23 revealed Note Text: Bed hold notice to Ombudsman/MCO/Family/POA [Power of Attorney] and lacked documentation of where the resident was transferred to or why transfer was needed, 2. Review of R19's undated Admission Record, located in the Profile tab of the EMR revealed R19 was initially admitted to the facility on [DATE] with diagnoses of chronic kidney disease, stage 3, diabetes mellitus, essential hypertension, and hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Review of a quarterly MDS located in the EMR under the MDS tab, with an ARD of 01/21/24 indicated R19 had a BIMS score of 10 out of 15 which indicated R19 was moderately cognitively impaired. Review of a document titled DVH Bed Hold Notice at Time of Transfer dated 03/06/24, located in the EMR under the Misc tab, revealed R19's representative received a bed hold notice upon R19's transfer. The document did not indicate where R19 was transferred too. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R19's Social Services progress notes located in the EMR under the Progress Notes tab, dated 03/05/24 indicated social services had sent a bed hold notice to R19's power of attorney (POA). Review of a Social Services progress note dated 03/06/24 indicated the facility had received a signed bed hold notice from R19's POA. Neither note indicated the POA had received written notice of the location of R19's transfer. Review of a document titled DVH Bed Hold Notice at Time of Transfer dated 04/23/24, located in the EMR under the Misc tab, revealed R19's representative received a bed hold notice upon R19's transfer. The document did not reveal where R19 was transferred too. Review of R19's Social Services progress notes located in the EMR under the Progress Notes tab, dated 04/23/24 indicated social services had sent a bed hold notice to R19's POA. The note did not indicate the POA had received written notice of the location of R19's transfer. 3. Review of R12's Admission Record, located in the EMR under the Profile tab revealed R12 was initially admitted on [DATE] and most recently readmitted on [DATE] with diagnoses that included chronic atrial fibrillation, asthma, atherosclerotic heart disease of natural coronary artery without angina pectoris, and retention of urine. Review of the quarterly MDS with an ARD of 02/27/24 revealed a BIMS score of nine out of 15 indicating R12 was moderately cognitively impaired. Review of the Census located in the EMR under the Clinical tab revealed R12 was hospitalized from 11/30/23 to 12/13/23. Review of the Progress Notes located in the EMR under the Clinical tab revealed no written evidence a Bed Hold notification with the location or reason for the transfer/discharge was provided to the resident and resident's representative for the two identified hospitalization s. 4. Review of the Admission Record, found in R39's EMR under the Profile tab indicated R39 was admitted on [DATE]. The Admission Record indicated diagnoses included Alzheimer's disease, depression, restlessness and agitation, and bipolar disorder. Review of the MDS with an ARD of 11/09/23, found in R39's EMR under the MDS tab indicated R39's BIMS score was four out of 15, indicating a severe cognitive deficit. Review of the Health Status Note, found in R39's EMR under the Progress Notes tab, dated 01/23/24 at 4:06 AM indicated R39 was seen physically aggressing another resident while that resident was in bed asleep. The Health Status Note indicated R39 was discovered kneeling on the other resident's bed with one knee while his hands were around the other resident's crossed wrists, pressing against the chest of the other resident. Review of R39's Health Status Note, found in the EMR under the Progress Notes tab, dated 01/26/24 at 3:04 PM indicated R39 left the facility, accompanied by a unit manager, and was transported to Meadowood (an inpatient psychiatric facility). Review of R39'sSocial Service note found in EMR under the Progress Notes tab, dated 01/29/24 at 3:00 PM indicated the Bed-hold Notice at Time of Transfer was sent to the Responsible Party. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R39'sBed-Hold Notice at Time of Transfer, found in the EMR, under the Misc tab dated 01/26/24, indicated the Bed-Hold Notice at Time of Transfer, did not include the name of the facility that he was being transferred to and did not include in writing the reason for the transfer/discharge. During an interview on 04/24/24 at 2:26 PM, the Social Work Consultant (SW2) explained the process was to notify family or resident representative within 24 hours with the bed hold information. A note was made in the EMR progress note to indicate the notification was made and the bed hold information was mailed out. During an interview on 04/25/24 at 10:44 AM, the Administrator confirmed the bed hold information sent out to the resident or resident's representatives lacked information about the reason or location where the resident was discharged to and confirmed the information was missing on the form sent to the resident or resident's representative. Review of the facility policy titled Bed Hold Policy dated 01/04/24 revealed, At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. When a Transfer/Discharge policy was requested, the Bed Hold Policy was provided and lacked information about the reason or location of the transfer of the resident to be provided to the family or resident representative.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 11599 Based on observation, interviews, record review, policy and procedure review, the facility failed to follow infection control procedures during a dressing change for one of three residents (R)4 reviewed. Specifically, the Registered Nurse (RN)1 failed to clean the over the bed table or place a barrier on the table before placing clean wound supplies on the table. Also, RN1 failed to perform hand hygiene when she returned to the room after obtaining a dressing from the treatment cart. The failure created the potential for an infection to develop in R4's wounds. Findings include: Review of the facility's policy titled Skin Integrity/Wound Care dated 03/08/23, revealed .A resident with skin impairment will receive treatment and services, consistent with professional standards of practice, to promote healing . Review of the facility's procedure titled Wound Treatment Competency Audit provided by the Administrator on 04/25/24 revealed the following criteria for all nurses to utilize .7. Assembles necessary equipment &[and] places on clean, accessible surface 8. Places date, time, and initials on dressing. 9. Hand hygiene performed prior to and after the treatment of each wound . 10. Puts on gloves . 12. Soiled dressing gently removed & placed in a small waste bag. 13. Removes gloves and places in trash receptacle 14. Hand hygiene l 5. Prepares dressing, without contamination 16. Hand hygiene, put on clean gloves and cleanse site 17. Applies treatment as ordered .21. Hand hygiene prior to returning equipment to cart .STEPS MUST BE FOLLOWED FOR THE TREATMENT OF EACH WOUND Review of R4's Admission Record, located in the electronic medical record (EMR) under the Profile tab revealed R4 was admitted on [DATE] with diagnoses that included chronic atrial fibrillation, unspecified cardiovascular and coagulations; post-traumatic stress disorder, chronic; idiopathic progressive neuropathy, and acute neurologic. Review of the quarterly Minimum Data Set (MDS) assessment with an assessment reference date of (ARD) of 04/03/24 revealed a Brief Interview for Mental Status (BIMS) score of 99 indicating R4 was unable to participate in the assessment due to severe cognitive impairment. Review of the Progress Notes located in the EMR under the Clinical tab revealed R4 was identified to have two open areas on 04/16/23 which indicated, Nurse notified by aid in reference to two open areas noted behind resident's left knee with measurements of 5.5 centimeters (cm) x 1.3 cm and 1.0 cm x 1.0 cm . Review of the Physician's Orders dated 04/18/24, located under the Clinical tab in the EMR, revealed a treatment order for wound care left posterior knee: cleanse with Normal Saline Solution (NSS), pat dry. Apply calcium alginate and cover with .dry dressing as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 9:13 AM, RN1 was observed to perform R4's dressing change to the left posterior knee. RN1 obtained the required materials from the treatment cart and proceeded to R4's room. RN1 placed the items on an overbed table and performed hand hygiene. RN1 did not clean the table or place a clean covering over the table before placing the items on the table. RN1 performed hand hygiene, donned gloves and removed the dressing from the resident's left posterior knee. RN1 doffed the gloves, donned clean gloves and cleaned the wounds with a sterile saline wipe. RN1 dropped the calcium alginate dressing in the trash, left the room to retrieve another calcium alginate from the treatment cart located down the hall from R4's room. RN1 returned to R4's room, without performing hand hygiene donned a new pair of gloves, placed the calcium alginate on the left posterior knee and then a dry dressing. During an interview with RN1 and Unit Manager (UM2) on 04/24/24 at 10:35 AM, RN1 confirmed that she did not perform hand hygiene when she returned to the room after obtaining a calcium alginate from the treatment cart before donning a clean pair of gloves. RN1 confirmed that she did not date the dressing per facility protocol. UM2 stated, the expectation would be to clean the overbed table and wash hands again when returning to the room. In an interview on 04/25/24 at 10:28 AM, the Administrator stated, I retrained everyone on handwashing on 04/24/24 and I personally retrained RN1 on wound care criteria as well.