STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085057	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Center at Eden Hill, LLC	300 Banning Street Dover, DE 19904

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47114 Based on interview and record review, it has been determined that for one (R46) out of forty five residents reviewed for care plans, the facility failed to develop a care plan to address wax build up in the ears. Findings include: 5/18/24 - R46 was admitted to the facility. 5/31/24 11:00 AM - A physician's order written for R46 documented, Debrox Otic (relating to the ear) Solution 6.5% (Carbamide Peroxide) Otic instill five drop (sic) in both ears two times a day for earwax for five days flush with warm water on the fifth day. 6/7/24 10:53 AM - A physician's order written for R46 documented, Debrox Otic (relating to the ear) Solution 6.5% (Carbamide Peroxide) Otic instill five drop (sic) in both ears two times a day for earwax for five days flush with warm water on the fifth day. 6/13/24 10:30 AM - Further review of R46's clinical record lacked evidence that a person centered care plan had been created to address the wax build up in R46's ear. 6/13/24 10:45 AM - During an interview E19 (RN, UM) confirmed that a care plan had not been created for wax build up in R46's ear. Findings were reviewed during the exit conference on 6/13/24 at 2:30 PM with E1 (NHA) and E2 (DON) and representatives with the Ombudsman office.

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 47114 Based on observation, interview, and record review it was determined that for one (R3) out of three residents reviewed for ADL (Activities of Daily Living) the facility failed to provide nail care. Findings include: A facility policy and procedure titled, Dignity updated, 3/14/24 documented: Patients shall receive assistance with activities of daily living (ADLs) every shift, as appropriate. ADLs include bathing, grooming, dressing, eating, oral hygiene, ambulation, toilet activities and trimming of toenails. Review of R3's clinical record revealed: 5/15/24 - R3 was admitted to the facility. 5/15/24 - Review of R3's care plan for ADL's revised 5/26/24 documented interventions included provide assistance as needed with grooming, bathing, and personal hygiene and per patient's preferences and R3 required an assist of one for grooming and personal hygiene. Further review of R3's care plan lacked evidence that R3 had refused nail care. 5/17/24 - Review of R3's care plan for confusion/forgetfulness revised 5/26/24 documented interventions included assist as needed. 5/20/24 - An admission MDS assessment revealed R3 was moderately cognitively impaired. R3 required substantial maximum assist of one for showers and bathing and partial moderate assist of one for toileting. 6/6/24 10:30 AM - A random observation of R3's hands revealed dark encrusted debris underneath each fingernail on the right and left hand. Additionally, R3's fingernails were long and needed to be trimmed on both hands. 6/7/24 9:36 AM - During a telephone interview R3's FM1 stated, I have asked them a couple of times to cut them, but the staff just take their time doing things. 6/10/24 9:40 AM - A second observation revealed R3's fingernails on the right and left hand had not been cut and R3 continued to have dark encrusted debris underneath his fingernails. 6/10/24 10:52 AM - During an observation E20 (CNA) entered R3's room. E20 asked [R3], are you ready to get washed up. [R3] said, yes. E20 then left R3's room. 6/10/24 10:55 AM - E20 was observed entering R3's room to provide care. 6/10/24 11:09 AM - During an interview E20 stated, Usually I do nail care if I see that a resident's fingernails are physically dirty, and they need to be cut or if they ask me to while I am doing care, then I would do nail care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/10/24 2:10 PM - R3's fingernails remained long on both hands with dark encrusted debris underneath his fingernails on both hands. 6/11/24 8:30 AM - R3's fingernails had not been cut and continued to have dark encrusted debris underneath his fingernails on both hands. 6/11/24 8:33 AM - During an interview and observation E19 (RN, UM) stated, Usually they do an assessment of the nails to see if they need to be cut or when the resident gets their shower. E20 confirmed R3's fingernails were dirty and needed to be cut. E20 updated the staff and requested that R3 be provided nail care. The facility failed to provide appropriate support and assistance for R3's personal hygiene and grooming when the facility failed to cut and trim R3's fingernails in accordance with R3's documented plan of care. Findings were reviewed during the exit conference on 6/13/24 at 2:30 PM with E1 (NHA) and E2 (DON) and representatives from the Ombudsman.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47114 Based on interview and record review it was determined that for one (R46) out of one resident reviewed for hearing the facility failed to administer ear drops as ordered by the physician for wax build up in R46's ears. Findings include: R46's clinical record revealed; 5/18/24 - R46 was admitted to the facility. 5/18/24 - A hospitalist progress note documented R46, had left ear pain deep-seated cerumen (wax build up) status post (treated) Debrox (ear wax removal drops). 5/20/24 - A physicians encounter note documented R46, had ear wax and was treated. 5/22/24 - An admission MDS (Minimum Data Set) revealed that R46 was cognitively intact. 5/31/24 11:00 AM - A physician's order written for R46 documented, Debrox Otic (relating to the ear) Solution 6.5% (Carbamide Peroxide) Otic instill five drop (sic) in both ears two times a day for earwax for five days flush with warm water on the fifth day. 6/6/24 11:38 AM - During an interview R46 stated, I have an ear infection and I can't sleep at night because of the pain in my left ear. R46 then said, I have told them, but they are not doing anything about it. 6/7/24 10:53 AM - A physician's order written for R46 documented, Debrox Otic (relating to the ear) Solution 6.5% (Carbamide Peroxide) Otic instill five drop (sic) in both ears two times a day for earwax for five days flush with warm water on the fifth day. 6/10/24 10:29 AM - During an interview E21 (RN) stated, [R46] complained about ear pain about two weeks ago, that was the last time I was here. E21 stated, [R46] has pain medication and he is on Debrox ear drops, now. E21 also stated, [R46] has Melatonin (Sleep Aid) to sleep at night. 6/11/24 11:00 AM - An interview with E19 (RN UM) confirmed R46 had not been administered Debrox ear drops as ordered 5/31/24 through 6/5/24. E19 confirmed the coding used on R46's MAR (Medication Administration Record) was not a code E19 was familiar with. E19 stated, When a medication has been administered by the nurse you will see the nurses' initial and a check mark on the MAR. Additionally, E19 stated, I do not recognize this chart code U-SA this is the first time I have seen this on a MAR. 6/12/24 12:11 PM - A telephone interview with CH1 (Consultant Pharmacist) revealed that Debrox ear drops were delivered to the facility for R46 on 5/31/24 and signed for at 6:24 PM. 6/12/24 1:00 PM - During an interview and observation E2 (DON) stated, I do not recognize the code U-SA on R46's MAR for Debrox ear drops. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/12/24 3:49 PM - Another interview with E2 confirmed, I can't provide you with the documentation that R46's ear drops were administered 5/31/24 through 6/5/24 as ordered. The facility failed to ensure that R46 received care and services to aid in the treatment of excessive wax build up and ear discomfort which affected the residents daily living. Findings were reviewed during the exit conference on 6/13/24 at 2:30 PM with E1 (NHA) and E2 (DON) and representatives with the Ombudsman office.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 40264 Based on observation, record review and interview, it was determined that for one (R51) out of one resident sampled for respiratory care, the facility failed to provide respiratory care consistent with professional standards of practice. Findings include: Review of R51's clinical record revealed: 5/1/24 - R51 was admitted to the facility with multiple diagnoses including a sudden onset of respiratory failure with hypoxia (low oxygen level reaching the body tissues). 5/6/24 - R51's Admission MDS assessments revealed that R51 was moderately cognitively impaired and was not on oxygen therapy. 5/12/24 - R51 was care planned for alteration in respiratory status/difficulty in breathing related to sudden onset respiratory failure with hypoxia. Interventions including but not limited to providing oxygen as ordered. 5/29/24 12:31 PM - A nurse progress note documented, .patient is on 4L/min (liters/min) oxygen due to fluctuating O2 Sat (oxygen saturation or level) between 89% to 91% RA (room air) . 5/31/24 1:00 AM- A physician encounter note documented, Pulse Oximetry (measures blood oxygen saturation levels - desired range 94% to 100%) on RA was 97% on 5/31/24 8:25 PM, .Patient also requested to start titrating (continuously measure and adjust the oxygen flow rate) patient off of oxygen . 6/5/24 1:06 PM - Nurse progress notes documented R51 had a respiratory concern and shortness of breath with exertion and was on 2 L/min oxygen therapy. 6/6/24 10:53 AM - R51 was observed sitting in her wheelchair with oxygen in use at 3L/min via nasal canula. 6/8/24 2:54 PM - A nurse progress note documented that R51 had a respiratory concern and shortness of breath with exertion and was on 2 L/min oxygen therapy. 6/9/24 7:28 PM - A nurse progress note documented that R51 was on oxygen therapy at 4L/min. 6/10/24 10:54 AM - During a random observation, R51 was observed with oxygen in use at 4L/min via nasal canula. 6/10/24 - A review of R51's physician's order revealed a lack of evidence of R51's oxygen therapy via nasal cannula (NC). 6/10/24 11:56 AM - During an interview, E5 (LPN) confirmed that R51 did not have a physician's order for her oxygen therapy. In addition, E5 stated, .[R51] still requires oxygen therapy because her oxygen level at room air drops between 89%-90% when we titrate it .We will fix the physician's order and have it clarified. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/12/24 3:50 PM - Findings were discussed with E2 (DON). E2 confirmed that R51 did not have a physician's order for her oxygen therapy until the surveyor brought it to the facility's attention. E2 presented to the surveyor a copy of R51's new physician order for oxygen therapy dated 6/10/24. Findings were reviewed during the exit conference on 6/13/24 at 2:30 PM with E1 (NHA) and E2 (DON) and representatives with the Ombudsman office.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 32810 Based on record review and interview it was determined that for one (R40) out of five residents reviewed for unnecessary medication review the facility failed to ensure adequate monitoring of antipsychotic medication was completed. Findings include: The facility policy on antipsychotic medication use last updated 2/13/24 indicated, AIMS evaluation to be completed within 14 days of admission, then should also be evaluated for tardive dyskinesia at least every six months. 5/22/24 - R40 was admitted to the facility with multiple diagnoses including, unspecified dementia, psychotic disturbance, and mood disturbance. 5/22/24 - A physicians order was written for R40 to receive an AIMS testing/assessment every 180 days. 5/23/24 - An MRR was completed for R40 with a recommendation that indicated, resident is currently receiving an antipsychotic and requires an AIMS test at baseline and every six months thereafter. The MRR was signed as recognized the same date. 5/25/24 - An admission MDS assessment documented that R40 received antipsychotic medications. 6/1/24 - A care plan for use of antipsychotic medications was created for R40 that included the interventions to complete an AIMS test on admission and as needed. Monitor side effects as needed. 6/10/24 8:15 AM - The surveyor requested an copy of R40's most recent AIMS test. Simultaneously review of R40's medical record, including MAR and progress notes lacked evidence of daily side effect monitoring related to the use of antipsychotic medications. 6/10/24 10:25 AM - An AIMS assessment was completed for R40 and then submitted to the surveyor. During an interview on 6/10/24 at 12:14 PM, E19 (RN) and unit manager for R40's unit confirmed the finding. E19 stated that AIMS testing is completed, Close to admission then every six months. E19 visualized R40's MAR and confirmed daily monitoring for side effects related to antipsychotic medication was mistakenly absent. Findings were reviewed during the exit conference on 6/13/24 at 2:30 PM with E1 (NHA) and E2 (DON) and representatives with the Ombudsman office.