STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085060	A. Building B. Wing	02/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foulk Living	1212 Foulk Road Wilmington, DE 19803

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 46134 Based on record review and interview, it was determined that for one (R42) out of one resident reviewed for hospitalization , the facility failed to notify the resident and the resident's representative in writing, of R42's transfer to the hospital, including the reason for the transfer. Findings include: Review of R42's clinical record revealed: 1/11/24 - R42 was admitted to the facility. 1/16/24 - R42 was transferred to the hospital because of a decline in physical and mental condition. R42 was admitted to the hospital and was discharged back to the facility on [DATE]. 2/22/24 2:20 PM - During an interview, E23 stated that she provided a verbal communication to R42's representative of R42's hospital transfer, including the reason for the transfer. E23 stated that a written communication was not provided. 2/26/24 3:15 PM - Finding was reviewed at the exit conference with E1 (DON, Interim NHA), E2 (ADON), and E4 (Clinical Specialist).

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. 47620 Based on record review and interview, it was determined that for one (R1) out of six residents reviewed for accident hazards and falls, the facility failed to ensure R1's received immediate medical attention following a bus accident that caused a fall from the wheelchair. Findings included: Cross refer F689 The facility policy titled Individual Safety Responsibilities: Authorized Driver Last revised 6/15/07 documented: 12. Traffic Accident: In the event of a traffic accident: Help anyone who is injured, call an ambulance if necessary . R1's record revealed: 9/8/21 - R1 was admitted to the facility with diagnoses including, but not limited to, cancer and difficulty in walking. 5/31/23 - A significant change MDS assessment documented that R1 was cognitively intact with a BIMS of 15. 6/28/23 - The facility's incident report and investigation revealed that after attending a social outing, R1 was being driven back to the facility when the transport van driver tapped the brake causing R1's wheelchair to propel forward and R1 to slide out of the wheelchair onto the van's floor. While resident was on the floor of the transportation van E19 (Housekeeping Manager) who was in the front passenger seat stated he saw that E18 (van driver, former employee) was in a panic, E19 asked E18 to stay with the resident while he drove back to the facility 1.3 miles away very slowly. E19 called the facility's receptionist and informed her they were in an accident and they would need help once they got to the facility. 6/28/23 3:00 PM - R1's facility progress note documented, At around 10:20 (AM) received a call from the receptionist that 'a resident fell in the van outside'. Rushed to the assisted living entrance and the transportation van pulled up and noticed [R1] lying on the foot bed of the van supine in front of her wheelchair. [R1] verbalized that she slid from the wheelchair during the van transport and that her legs hurt. Denies any LOC (loss of consciousness), or head injury. [R1] was awake and oriented to person, place, time and situation. Laceration noted laterally on bilateral shins. Scant amount of blood noted, no active bleeding noted. Nurse Practitioner [E30] in the building made aware, ordered to ok to send [R1] to the hospital. Emergency Service called and [R1] picked up by . fire company EMS (Emergency Medical Service). [R1's family member] . made aware of the incident and verbalized that she would meet [R1] at the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/26/24 10:23 AM - During an interview with E1 (DON, interim NHA), with E2 (ADON) and E4 (Corporate Clinical Specialist) present, On 6/28/23, we received a call from the front desk asking if nurses could come to the parking lot STAT. We went outside and I [E1] saw [R1] sitting in the van on the floor, the wheelchair was behind [R1] and [R1] was half lying and half sitting, and both legs were crooked and bleeding. I immediately called 911 and we tried to stop the bleeding. R1 was asked if she was in any pain and R1 denied pain. R1 did say that the van floor was hard on her back. I noticed that the wheelchair was stuck In the van and that R1 was not strapped in. I immediately asked the driver [E18] if he strapped [R1] in, he said that he did not and that he didn't know why he did not. I called her daughter . We did vital signs which were normal and wrapped her legs to stop the bleeding. The fire company was here quickly - they got here before the paramedics. Review of the incident report and facility investigation lacked evidence as to why the van driver did not call for emergency help at the time of the accident and instead drove back to the facility where emergency services were called. 2/26/24 3:15 PM - Findings were reviewed at the exit conference with E1, E2 and E4.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47620 Based on record review and interview, it was determined that for one (R1) out of six residents reviewed for accident hazards and falls, the facility failed to ensure R1's environment was free from accident hazards as possible. On 6/28/23, while being driven back to the facility in a borrowed transport van from another facility, an accident occurred which resulted in R1 sustaining multiple fractures. The unsafe facility transport caused R1 harm. Based on review of the facility's evidence to correct the non-compliance and the facility's substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 7/5/23. Findings included: R1's record revealed: 9/8/21 - R1 was admitted to the facility with diagnoses including, but not limited to, cancer and difficulty in walking. 5/31/23 - A significant change MDS assessment documented that R1 was cognitively intact with a BIMS of 15. 6/28/23 - The facility's incident report and investigation revealed that after attending a social outing, R1 was being driven back to the facility when the transport van driver tapped the brake causing R1's wheelchair to propel forward and R1 to slide out of the wheelchair onto the van's floor. R1 was returned to the facility where 911 was called and fire company EMS (Emergency Medical Services) transported R1 to the hospital. 6/28/23 11:08 AM - Per C1's (hospital Forensic Nurse Examiner) notes, R1 arrived at the hospital after a motor vehicle collision with complaints of right and left leg pain. Reportedly R1 stated, I fell out of my wheelchair when the bus stopped short. 6/28/23 1:17 PM - The hospital record documented, [R1] was on a transportation van when it came to a sudden stop causing [R1] to fall out of [R1's] wheelchair striking [R1's] head and bilateral lower extremities. The record documented findings of a frontal contusion and abrasion no active bleeding left lower extremity medial aspect of calf large laceration with exposed adipose tissue measuring approximately 15 cm by 10 cm. [R1's] right lower extremity with 2 linear lacerations to the lateral aspect of [R1's] lower leg approximately 10 cm in length bleeding noted dressing applied .[R1] is complaining of significant pain to [R1's] left lower extremity with any movement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	6/28/23 3:00 PM - R1's facility progress note documented, At around 10:20 (AM) received a call from the receptionist that 'a resident fell in the van outside'. Rushed to the assisted living entrance and the transportation van pulled up and noticed [R1] lying on the foot bed of the van supine in front of her wheelchair. [R1] verbalized that she slid from the wheelchair during the van transport and that her legs hurt. Denies any LOC (loss of consciousness), or head injury. [R1] was awake and oriented to person, place, time and situation. Laceration noted laterally on bilateral shins. Scant amount of blood noted, no active bleeding noted. Nurse Practitioner [E30] in the building made aware, ordered to ok to send [R1] to the hospital. Emergency Service called and [R1] picked up by . fire company EMS (Emergency Medical Service). [R1's family member] . made aware of the incident and verbalized that she would meet [R1] at the hospital. 6/28/23 11:34 PM - Per the hospital record, R1 was transferred to another hospital after the previous facility noted bilateral open tibia-fibula fractures that occurred earlier that day when R1 was being transported in a wheelchair and not strapped in causing [R1] to fall out of the wheelchair. The hospital record documented a need for surgical repair. 6/28/23 - The facility's documented immediate actions in response to R1's transport accident included the following: - canceled all other appointments and resident transport for the day; - suspension of the driver [E18] because the preliminary investigation indicated that [E18] did not follow safety protocol .; - observation of the van and wheelchair immediately after the incident revealed that the shoulder strap was not fastened; - training initiated and completed by the plant manager [E21] on proper and safe medical transport; and - initiation of an investigation of the incident. 6/28/23 - The facility's in-service training documentation included the following: - Loading and Unloading Non-Ambulatory Wheelchair Passenger Policy (operating the wheelchair lift, positioning the wheelchair in the vehicle, attaching the two rear securement straps, attaching the two front securement straps, attaching the lap belt, attaching the shoulder belt); - Wheelchair Securement Checklist; and - Training (must include and frequency). The in-service training was completed on the same day, 6/28/23, of R1's accident. 6/29/23 - The hospital records documented that R1 was . going to the operating room for ORIF bilateral periprosthetic proximal tibia fractures today. 7/5/23 - R1 was readmitted to the facility from the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7/5/23 - The facility's documented plan of correction as a result of the investigation was: - the van driver [E18] was terminated; - root cause analysis - was determined to be related to driver's [E18] negligence by breaching his duty of care to the resident by not applying a restraint device when it was ordinary, prudent and reasonable. This action resulted in the resident sliding out of the wheelchair when the transportation van slowed down; - care plan changes - residents care plan was updated to include safe resident transport. Interventions for this goal was to have resident properly fastened in the wheelchair transportation vehicle; - systemic changes - trained drivers with best practices for loading and unloading non-ambulatory wheelchair passengers to safety. Specifically, all drivers returned demonstration of attaching the shoulder belt. Before each transport the driver must utilize wheelchair securement checklist to ensure residents are secured in transport vehicle. 2/26/24 10:23 AM - During an interview with E1 (DON, interim NHA), with E2 (ADON) and E4 (Corporate Clinical Specialist) present, On 6/28/23, we received a call from the front desk asking if nurses could come to the parking lot STAT. We went outside and I [E1] saw [R1] sitting in the van on the floor, the wheelchair was behind [R1] and [R1] was half lying and half sitting, and both legs were crooked and bleeding. I immediately called 911 and we tried to stop the bleeding. R1 was asked if she was in any pain and R1 denied pain. R1 did say that the van floor was hard on her back. I noticed that the wheelchair was stuck In the van and that R1 was not strapped in. I immediately asked the driver [E18] if he strapped [R1] in, he said that he did not and that he didn't know why he did not. I called her daughter . We did vital signs which were normal and wrapped her legs to stop the bleeding. The fire company was here quickly - they got here before the paramedics. 2/26/24 2:53 PM - During a follow-up interview with E1, with E2 and E4 present, the plan of correction was initiated on 6/28/23 and completed on 7/5/23. 2/26/24 at 2:55 PM - Based on the Surveyor's review of the facility's thorough investigation, documented response, completion of audits from 7/7/23 to 11/24/23, staff interviews and no further transportation incidents, R1's accident was determined to be past non-compliance harm. 2/26/24 3:15 PM - Findings were reviewed at the exit conference with E1, E2 and E4.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. 46134 Based on record review and interview, it was determined that for one (R195) out of one resident reviewed for physician services, the facility failed to ensure that R195 was seen for the required physician visits. Findings include: Review of R195's clinical record revealed: 4/30/2019 - R195 was admitted to the facility. Review of the electronic medical record (EMR), revealed the following alternating physician/ nurse practitioner visits were made to R195 from June 2022 thru February 3, 2023: 6/3/22 - E3 (MD) 8/3/22 - E30 (NP) 9/21/22 - E30 12/7/22 - E30 2/3/23 - E30. E3 did not visit the R195 in October 2022, which was the month R195 should have received a required physician visit. 2/26/24 3:15 PM - Finding was reviewed at the exit conference with E1 (DON, Interim NHA), E2 (ADON), and E4 (Clinical Specialist).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47620 Based on observation, interview and record review it was determined that for one (R36) out of twenty-six medication administration observations, the facility failed to provide accurate labeling to facilitate consideration of precautions and safe administration. For (R36), the medication label was not updated with the new order. Findings include: 2/23/24 8:31 AM - During an observation with E17 (LPN) for medication administration, the medication packet label for quetiapine Seroquel a medication used to treat certain mental/mood disorders was noted to read as quetiapine 25 MG tablet - give 1 tablet by mouth 3 times a day. However, the order and MAR (medication administration record) documented that the order was updated to be given two times a day beginning 1/29/24. During the observation E17 was interviewed and it was revealed the label should have been updated to reflect the change. E17 did confirm the new versus old order. 2/26/24 - During an interview E16 (LPN) revealed that when there is a medication change, the nurse who receives the communication would have been responsible for placing an FYI label on the medication packet. Then when it's time for a new blister pack, the medication will come from the pharmacy with a changed label. The change would also be documented in a communication log book and the change would be communicated to each shift and for multiple days until everyone knows about it. 2/26/24 3:15 PM - Findings were reviewed at the exit conference with E1 (DON, Interim NHA), E2 ADON, and E4 (Clinical Specialist).

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on observation and interview, it was determined that for one (R18) out of one reviewed for food, the facility failed to maintain appetizing food temperatures for food trays that are delivered to third floor residents in their rooms. Findings include: R18's clinical record revealed: 3/24/23 - R18 was admitted to the facility. 2/7/24 - E3 (MD) updated R18's diet order to regular diet, regular texture and regular/thin liquid consistency. 2/21/24 3:28 PM - During an interview, R18 stated that she takes all her meals in her room and her, food is delivered cold all the time. 2/23/24 11:30 AM - The Surveyor went to the kitchen to request a test lunch tray for the hot entree. 2/23/24 12:07 PM - The Surveyor observed food being plated for the third floor food truck. 2/23/24 12:35 PM - The third floor food truck arrived on the third floor. 2/23/24 12:36 PM- The Surveyor and E25 (Food Service Director) observed the CNAs delivering food trays to the residents in the dining room. 2/23/24 12:52 PM - The Surveyor and E25 observed food tray being delivered to room [ROOM NUMBER]. 2/23/24 12:55 PM - The Surveyor and E25 observed food tray being delivered to room [ROOM NUMBER]. 2/23/24 12:59 PM - The Surveyor and E25 observed food tray being delivered to R18's room. 2/23/24 12:59 PM - E25 obtained food temperatures for the test tray. The salmon tested at 121 degrees F (Fahrenheit), the rice at 118 degrees F, the soup at 123 degrees F and the vegetables at 127 degrees F. 2/23/24 1:00 PM - The Surveyor tasted the food tray. The food was presented in a very appetizing manner; however the salmon, rice and veggies was were very unpalatable as they were cool. The soup was also cool to taste and therefore, not enjoyable. 2/26/24 3:15 PM - Findings were reviewed at the exit conference with E1 (DON, Interim NHA), E2 (ADON) and E4 (Corporate Clinical Specialist).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32810 Based on observation, staff interview and review of other documentation, it was determined that the facility failed to ensure food was stored in a sanitary manner; failed to ensure the dishwasher operated at the correct temperature level to sanitize the residents' dishes; failed to maintain dishwasher temperature logs; failed to ensure food stored in a container was maintained in a clean and sanitary manner and failed to ensure the kitchen area was maintained in a sanitary condition, and failed to maintain refrigerator temperature logs. Findings include: Review of the facility policy for Preventing Foodborne Illness, last updated 2017 indicated, Food and nutrition employees will follow appropriate hygiene and sanitary procedures to prevent the spread of food borne illness .Employee's must wash their hands .Functioning of the refrigeration and food temperatures will be monitored. 1. During the follow up tour conducted on 2/20/24 at 11:30 AM the following was observed: -Empty soap dispenser at the hand washing sink in the food preparation area with slow drain and pooling water. -Wall adjacent to the hand washing sink in the food preparation area visible black substance on wall and wall and siding separating. -E25 (FSD) and E27 (cook) observed without beard restraints. -E26 (cook) wearing hair unsecured and on collar. -Flour handle inside bin, not on holder immediately confirmed by E28 (dietary staff) -February 2024 Production refrigerator near kitchen line temperature log last dated as completed on 2/8/24. 2. During a second follow up tour conducted 2/21/24 at 9:33 AM the following was observed: -E25 (FSD), E29 (dishwasher) and E27 (cook) observed without beard restraints. -E26 (cook) observed wearing hair unsecured and on collar. 3. During observation of the function of the facility's dish machine on 2/21/24 at 9:41 AM - 10:09 AM the facility dish machine failed to reach temperatures required for heat sanitization of 165 degrees. E25 confirmed that the facility used a high temperature process dish sanitization. E25 then reported that the dish machine function display screen has been malfunctioning off and on and that the facility did not have a maximum registering thermometer to run through the dish washing cycle. During repeated dish washing cycles the following was observed: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- 9:51 AM - 9:54 AM Wash cycle 133 degree's and rinse cycle 115 degree's. second wash 135 45 seconds. -9:55 AM -9:56 AM Wash cycle 126 degree's, rinse cycle 118 degrees with display screen readingwarning too low, wash cycle 126 degree warning too low, rinse cycle 113. -9:57 AM - 9:58 AM Wash cycle 131 degree's, rinse cycle 133 degree's. -9:59 AM - 10:01 AM Wash cycle 141 -139 degree fluctuation. -10:02 AM - 10:03 AM Wash cycle 149 -150 degree's, rinse cycle 155 - 157 degree's. -10:04 AM - 10:06 AM Wash cycle 156-159 degree fluctuation. -10:09 AM - E25 stated that When this happens repeatedly we sanitize again using chemicals. I'm going to call and try to get someone out. Observations from both follow up kitchen visits were discussed and E25 confirmed the findings. 2/21/24 11:07 AM - Review of maintenance records revealed service calls and completion of repairs to the facility's dish machine on the following dates: 10/2/23 ,11/7/23,11/16/23, 11/17/23 and 1/21/24. 2/21/24 11:30 AM - Review of dish machine temperature logs revealed the following: -December 2023 lacked evidence of log entries from 12/4/23 - 12/20/23, then 12/22/23-12/31/23. A hand handwritten note on the log indicated, Display Malfunctioning in the spaces without entries. -January 2024 lacked evidence of log entries on 1/4, 1/11, 1/12, 1/14 -1/21 and 1/23-1/31. -February 2024 lacked evidence of log entries from 2/1 - 2/15, 2/17 and 2/18. 2/21/24 1:51 PM - Kitchen tour findings were reviewed with E1 (DON) who reported maintenance workers have been contacted regarding dish washing machine repairs. 2/22/24 - A maintenance repair person repaired the facility dishwashing machine. The report documented Not hitting temperature, and rinse motor running constantly .replaced the main control board as it was faulty. Machine is now hitting temperature . 2/26/24 3:15 PM Findings were reviewed at the exit conference with E1 (DON, Interim NHA), E2 ADON, and E4 (Clinical Specialist).