

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A020	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER Newark Manor Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 254 West Main Street Newark, DE 19711	

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 - 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>40264</p> <p>Based on interview, record review and review of other documentation as indicated, it was determined that for one (R462) out of three residents reviewed for abuse, the facility failed to ensure that R462 was free from physical abuse by R461 resulting in harm when R462 obtained a broken nose and laceration to the bridge of nose. Due to the facility's corrective measures completed on 5/28/24, the facility was notified that R462's incident was a harm past non-compliance. Findings include:</p> <p>Cross refer F684</p> <p>The facility's undated policy, titled, Freedom from Abuse, Neglect, Mistreatment, Serious Injury, Misappropriation of Property, Exploitation, Injury of Unknown Origin and Crime documented, .Definitions: 1. Abuse - the infliction of injury .with resulting physical harm, pain or mental anguish .and includes .a. Physical abuse - the unnecessary infliction of pain or injury . to a . resident . includes hitting, kicking, slapping .</p> <p>Review of R462's record revealed:</p> <p>3/6/24 - R462 was admitted to the facility with diagnoses including dementia.</p> <p>3/15/24 - R462's admission MDS assessment revealed that R462's cognition was severely impaired with a BIM's score of 6. R462 had no mood or behavioral symptoms exhibited during the review period.</p> <p>Review of R461's record revealed:</p> <p>5/6/24 - R461 was admitted to the facility with diagnoses including depression, insomnia and adult personality and behavior disorder.</p> <p>5/6/24 - R461 had a physician's order for safety checks every 2 hours every shift.</p> <p>5/7/24 - R461 was care planned for impaired thought process related to dementia with interventions including administering medications as ordered, cuing, reorienting and supervising as needed.</p> <p>5/10/24 - R461 was care planned for verbal and physical aggressive behavior towards staff related to dementia. R461's interventions included:</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 - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - R461's triggers for physical aggression are night shift hours .R461's behaviors are de-escalated by snacks and activities like using fidget books; - analyze times of day, places, circumstances, triggers, and what de-escalates behavior and document; - assess and address for contributing sensory deficits; - assess and anticipate R461's needs for food, thirst, toileting needs, comfort level, body positioning, pain, etc. - give the resident as many choices as possible about care and activities; - modify environment such as adjusting room temperature to comfortable level, reducing noise, dimming lights, placing familiar objects in room, keeping door closed, etc. and; - assess resident's coping skills and support system. - assess R461's understanding of the situation .allow time to express self and feelings towards the situation <p>5/10/24 - R461's care plan interventions for behavioral problems of paranoia and making false accusations included:</p> <ul style="list-style-type: none"> - anticipate and meet the resident's needs; - assist R461 to develop more appropriate methods of coping and interacting . encourage the resident to express feelings appropriately; - caregivers to provide opportunity for positive interaction, attention .stop and talk with him when passing by; - explain all procedures to R461 before starting and allowing the residents a few minutes to adjust to changes; - if reasonable, discuss the resident's behavior . explain/reinforce why behavior is inappropriate and/or unacceptable to the resident; - intervene as necessary to protect the rights and safety of others .approach/speak in a calm manner. divert attention .remove from situation and take to alternate location as needed. - praise any indication of the resident's progress/improvement in behavior and; - provide a program of activities that is of interest and accommodates residents' status. <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>5/16/24 - R461's Admission MDS revealed that R461 had a BIMS score of 6 with severe cognition impairment, was feeling down and depressed, tired and having little energy for 7-11 days. In addition, R461 displayed physical and verbal behavioral symptoms occurring 1-3 days and had significant risk of physical illness or injury interfering with his care, putting others at significant risk of physical injury and intrusion on the privacy or activity of others during the review period.</p> <p>5/16/24 - R461 had a physician's order for safety checks every 30 minutes while in bed . If resident awakes, allow him to exit room and offer preferred activities.</p> <p>5/16/24 - R461's physical aggression care plan intervention was updated to include safety checks every 30 minutes while resident is in bed .if [R461] wakes (sic), allow [R461] to get dressed if he desires to do so and allow [R461] to enter common area with preferred activities.</p> <p>5/18/24 11:20 PM - A nurse progress note documented, . (Registered Nurse) called (sic) to (room #) for resident [R462] altercation and noted to be seated in chair actively bleeding from face with roommate [R461] in front of him. Residents easily separated and this resident (sic) assessed. No c/o (complaints of pain) nose very swollen and bruised and lacerations noted on bridge of nose and below left eye .</p> <p>5/19/24 3:04 AM - A facility incident report submitted to the State Agency documented that on 5/18/24 at 11:20 PM, .found residents in altercation . CNA called for help and residents were separated. Both residents were sent to ED (Emergency Department) for further evaluation.</p> <p>5/19/24 12:25 AM - A hospital ED (Emergency)Teaching Physician Note documented, 82 - year old white male with dementia .now status post traumatic injury to his face by a punch from his roommate .has an injury to the nose .he did feel somewhat woozy (dizzy) . Impression: Laceration to the bridge of the nose/nasal fracture.</p> <p>5/23/24 - A facility 5 day follow up summary submitted to the State Agency documented, .the alleged perpetrator [R461] was striking the alleged victim and stated, "You were stealing my stuff" .Upon assessment . [R461] was actively bleeding from his face .Lacerations noted to the bridge of the nose and under the left eye.</p> <p>2/18/25 2:00 PM - In an interview, E2 (DON) stated that some information about R461's aggressive behaviors from outside facility was not relayed to them prior to R461's admission on 5/6/24.</p> <p>The facility failed to ensure that R462 was free from physical abuse by R461 when R461 struck 462 on the face which resulted in R462's broken nose and laceration to the bridge of nose.</p> <p>2/18/25 3:00 PM - During interview, FM1 (Family Member) stated, They (facility) advertised that they have a memory care unit. We checked the place before [R461's] admission and we were told that they will have somebody sit outside of the room and leave the door open to keep an eye on him specially when [R461] gets up and goes near the roommate. I don't know what the circumstance was when the hitting happened but I guess nobody was out there to keep an eye on him when he got up and became physically aggressive to his roommate .</p> <p>2/19/25 10:00 AM - Findings were discussed with E1 (NHA) and E2 (DON).</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>2/19/2 3:47 PM - In an email correspondence, E1 submitted to the Surveyor documentation of the corrective action plan with correction completed 5/28/24 at 3:00 PM.</p> <p>Corrective Actions:</p> <ol style="list-style-type: none"> 1. Education for staff began on 5/20/24 on Resident - to - Resident Mistreatment (RRM), which included risk factors of RRM, ways to de-escalate residents, documentation of behaviors, monitoring and provider notification. 2. QAPI 2nd quarter review. 3. Strengthen of the admission screening process: <p>Evaluating each potential resident for:</p> <ul style="list-style-type: none"> - History of aggression, violence and other behavioral issues. - Psychiatric diagnosis and treatments. - History of substance abuse or withdrawal symptoms. - Prior incidents of resident - to - resident aggression in other facilities. <p>Interdisciplinary Review Process:</p> <ul style="list-style-type: none"> - Admission team (including DON and social services) must review hospital discharge summaries, psychiatric evaluations, and legal history before approval or the last 6 months, or if potential admission has been in their current facility for < (less) 6 months, all notes available. - History of assault, involuntary psychiatric hospitalization s require further discussion before acceptance. <p>Enhanced Admission Documentation and Communication</p> <ul style="list-style-type: none"> - Improved Handoff Communication: Require detailed behavioral history reports from referral sources before admission approval, at least 6 months of notes or all notes available if resident at current facility < 6 months. -Admission Care Plan Implementation: Within 48 hours of admission, develop an individualized care plan that includes safety interventions for at - risk residents. <p>Monitoring and Compliance</p> <ul style="list-style-type: none"> - Admission Audits: Review 100% of admission, focusing on behavioral risk assessments and compliance with the new process. <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	No immediate action required related to facility correction and no further occurrences after the incident on 5/18/24. This was verified by interviews with staff about resident - to - resident physical abuse education, spot inspection for resident interactions and inspection of the facility abuse incident reports. 2/19/25 10:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>40264</p> <p>Based on record review and interview, it was determined that for one (R461) out of one sampled resident, the facility failed to ensure the physician's order to administer tamsulosin HCL, aripiprazole and escitalopram oxalate. Findings include:</p> <p>Cross refer F600</p> <p>5/6/24 - R461 had a physician's order for tamsulosin HCL give 2 capsules to equal 0.8 mg in the evening for enlarged prostate.</p> <p>5/6/24 (discontinued 5/13/24) - R461 had a physician's order for aripiprazole 5 mg give 2.5 mg (1/2 tablet) in the evening for depression.</p> <p>5/7/24 - R461 had a physician's order for escitalopram oxalate 10 mg 1 tablet in the morning for depression.</p> <p>5/13/24 - R461 had a physician's order for aripiprazole 5 mg 1 tablet by mouth at bedtime for depression.</p> <p>2/18/25 10:00 AM - A review of R461's May 2024 Medication Administration Record revealed the following missing medication doses:</p> <p>6 pm - tamsulosin HCL 0.8 mg - one out of 12 missed dose on 5/8/24;</p> <p>6 pm - aripiprazole 2.5 mg - four out of seven missed doses on 5/6/24-5/9/24;</p> <p>8 pm - aripiprazole 5 mg - five out of six missed doses on 5/13/24 - 5/17/24;</p> <p>8 am - escitalopram oxalate - two out of 11 missed doses on 5/15-17/24.</p> <p>2/18/25 10:20 AM - A review of nurse progress notes from 5/6/24 through 5/19/24 revealed the following:</p> <ul style="list-style-type: none"> - 5/6/24 7:39 PM - awaiting delivery from pharmacy, pharmacy notified; - 5/7/24 7:45 PM - awaiting pharmacy delivery; - 5/8/24 7:26 PM - awaiting delivery; - 5/8/24 7:29 PM - awaiting delivery; - 5/9/24 6:14 PM - awaiting delivery; - 5/13/24 7:55 PM - awaiting delivery; <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- 5/14/24 8:00 PM - awaiting delivery;</p> <p>- 5/15/24 8:57 AM - not available;</p> <p>- 5/15/24 10:08 PM - unavailable;</p> <p>- 5/16/24 8:58 AM - none available, attempted to order;</p> <p>- 5/16/24 6:05 PM - on order;</p> <p>- 5/17/24 7:35 PM - awaiting order.</p> <p>2/18/25 10:47 AM - In an interview, E3 (ADON) confirmed that R461 missed all those doses on the dates and times identified by the surveyor. E3 further stated that R461's son [FM1] signed a facility Pharmacy Services Agreement on 5/6/24 that R461's medications will be filled by the facility and that the facility pharmacy provider was not able to fill the medications as indicated.</p> <p>2/18/25 1:18 PM - During interview, E5 (RN, SW) stated that during R461's admission to the facility, .We were not aware that [R461's] prescriptions were to come from [Pharmacy 2], another provider with insurance issues which caused the delay in obtaining the scripts and availing the medications. I was calling [Pharmacy 2] almost everyday to follow up on [R461's] prescriptions because [Pharmacy 1], our facility pharmacy provider, could not fill due to insurance . [Pharmacy 2] finally sent the prescriptions to us by mail on 5/15/24 . When asked if the facility notified the attending physician regarding the delay in R461's medication delivery and that R461 was missing multiple doses, E5 stated, I spoke to the NP (E9) about it for the first time on 5/8/24. I asked her to write a script for [R461's] meds to be faxed to [Pharmacy 2]. When her script was sent over, we learned from the (Pharmacy 2) that the scripts were not accepted because the meds had to be prescribed by their [Pharmacy 2] physician [Physician 1] - so it was another cause of the delay because we had to look for [Physician 1] to write the scripts.</p> <p>2/19/25 10:00 AM - Findings were discussed with E1 (NHA) and E2 (DON).</p> <p>2/19/25 10:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.</p>