

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 01/11/2024
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 - 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** 25232</p> <p>Based on interviews, record review, review of facility reported incidents (FRI), and review of the facility's policy, the facility failed to ensure residents were free from abuse for one of two residents reviewed for abuse (Resident (R) 2) out of a total sample of 26 residents.</p> <p>Findings include:</p> <p>Review of facility's policy titled, Freedom from Abuse, Neglect, Mistreatment, Serious Injury, Misappropriation of Property, Exploitation, Sexual Abuse, Injury of unknown origin and crime, dated ,d+[DATE], revealed [name of the facility] affirms that all persons admitted to the facility shall be treated with dignity and respect. Each resident is entitled to and shall receive appropriate and quality care, free of adverse preventable risks, consistent with their assessed needs and available resources. Staff shall be assured that resident care and treatment is administered in a safe, professional, and humane manner. Any instances of suspected, alleged, or witnessed resident abuse neglect mistreatment, serious injury, misappropriation of property, exploitation, sexual abuse, injury of unknown origin, and reasonable suspected crime must be reported by the covered individuals (owner, operator, employee, manager, agent or contractor of such long term care (LTC) facility) to facility administration or State survey agency and local law enforcement agency in the jurisdiction of the facility. Furthermore, not later than two hours after forming the suspicion if the event that causes the suspicion results in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. The nurse on duty at the time of the incident, or supervisor will submit an incident report to the office of long-term care residents' protection (OLTCRP) via their online portal.</p> <p>1. Review of R312's undated Face Sheet, located in the resident's electronic medical record (EMR) under the Profile tab revealed R312 was admitted to the facility on [DATE] with</p> <p>diagnoses which included Alzheimer's disease and anxiety.</p> <p>Review of an Incident Note (facility provided) dated [DATE] revealed Called to R312's room because he was very agitated, and staff reported he struck his roommate [R2] on the right side of his cheek. R312 continued to strike out at staff who finally calmed R312 and removed his roommate [R2] from the room.</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>Review of the facility provided Incident/Accident Report dated [DATE] revealed R312 noted with aggression and was reported that he hit his roommate [R2] on the face.</p> <p>2. Review of R2's undated Face Sheet, located in the resident's EMR under the Profile tab revealed R2 was readmitted to the facility on [DATE] with a diagnosis including dementia and major depressive disorder (MDD).</p> <p>Review of R2's Progress Note (facility provided) dated [DATE] revealed R2 was struck by R312 on the right cheek while sitting in his wheelchair at 07:15 AM [7:15 AM]. Staff immediately moved R2 to a safe location. Right cheek is reddened but R2 denied pain at the time. Team health notified through voicemail and are awaiting a call back.</p> <p>Review of facility provided Incident/Accident Report dated [DATE] revealed R2 was sitting in his wheelchair when R312 became agitated and struck him on right cheek. Area was reddened.</p> <p>Interview with R2 on [DATE] at 09:00 AM, alert yet confused, said that nobody has hit him while he has been at the facility. He had no evidence of bruising on his skin.</p> <p>Review of Incident Reporting Application (initial reporting) dated [DATE] revealed Received report R312 noted with physical aggression towards R2. R312 noted hitting R2 on his right cheek and mouth. Residents were separated, redirected, and given snacks to calm down. R312 was later sent to the hospital for further evaluation and treatment. R2 was noted with abrasion on the right cheek and bruise to the lip. First aid administered, R2 denied pain and stated he was okay.</p> <p>Review of Witness Statement for Registered Nurse (RN) 1, dated [DATE], revealed Called to resident's room after resident hit R2 on left cheek. R312 very agitated and trying to hit staff who were trying to calm him down.</p> <p>Review of Witness Statement for Certified Nursing Assistant (CNA) 1 dated [DATE] revealed At 07:15 AM [7:15 AM], I was in the dining room when I heard the R2 from room [R2's room] calling for help, help me, help me. I ran to see what was going on with the resident. As I got to the room door, I saw the nurse and another CNA trying to calm and redirect R312 who was being aggressive hitting his roommate [R2] in the face. I asked R2 why he was calling for help and he said that his roommate [R312] was hitting him. R312's face was read (sic). I, the nurse, and another CNA redirected R312 to his bed and offered him snacks while we took his R2 to the dining room for breakfast. The charge nurse/supervisor was notified.</p> <p>Review of Investigation Follow-Up dated [DATE] revealed R2 was dressed and ready to be sent to the dining room when R312 struck him on his face. R2 was asked what happened he stated I do not know, R312 just hit me. R312 is noted with a red mark on right cheek, no other injuries observed. R2 denied pain and stated that I am fine. Separate R312 from R2 and room change.</p> <p>Review of Follow Up (5-day report) dated [DATE] revealed Resident altercation between R312 and R2-not issues prior to the incident-one resident hit another with a one two punch. R312 who punched other R2 had behavior concerns and had demonstrated aggressive, hitting behaviors. R312 with aggressive behaviors sent to the hospital for evaluation and medical management (remains in the hospital at this time). R2 who was hit in face has no complaints of discomfort or pain. Currently investigating room change to separate the two residents. Resident rounding and rooms change when necessary.</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>Interview with Administrator on [DATE] at 10:30 AM, he said that R312 was sent out to the hospital for further evaluation after he hit R2 in the face. While R312 was at the hospital, R312 expired.</p> <p>Interview with CNA1 on [DATE] at 3:08 PM, she said that she did witness the incident when R312 hit R2. Said that R312 was walking on R2's side of the bedroom, staff redirected him several times without success, and R312 hit R2. Unable to recall where R2 was hit at. Said that R312 had a history of aggressive behavior toward staff, but not residents.</p> <p>During an interview on [DATE] at 3:15 PM, the Director of Nursing (DON) stated if there was a resident-to-resident altercation, she expected staff to intervene and separate the residents. After separating the residents, she expected staff to assess residents and give treatment to any resident that is hurt. The DON also stated she expected staff to send out the aggressive resident for evaluation. The DON further stated staff would notify her, so she could notify the appropriate agencies within two hours.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232</p> <p>26190</p> <p>Based on record review, interview and facility policy review, the facility failed to provide the resident and/or their responsible party a written transfer notice at the time the resident was transferred to the hospital; and failed to send a copy of the notice to the Long Term Care (LTC) Ombudsman for two residents (Resident (R) 54, and R312) of two reviewed for hospitalization s in a total sample of 26 residents.</p> <p>Findings include:</p> <p>Review of facility's updated policy titled, Discharge to Hospital/Another Long-Term Care (LTC) Facility, revealed To assure that comprehensive information regarding a resident's plan of care is communicated between facilities.</p> <p>Policy:</p> <ol style="list-style-type: none"> 1. Obtain transfer or discharge order from the physician. 2. Notify the family and administration. 3. Complete Interagency Form B. Place in an envelope with the resident's name and the name of the receiving facility. When a resident is being transferred to another LTC facility. Send a copy of the immunization record. 4. Arrange for transport (unless accepting facility has arranged). 5. Notify the receiving facility of the resident's transfer and explain the resident's condition. 6. When determination is made that the resident is to be admitted to another facility: <ol style="list-style-type: none"> a. Notify administration b. Notify dietary c. Notify pharmacy d. Notify housekeeping 7. Contact the business office: <ol style="list-style-type: none"> a. Bed being held-put resident's belongings away neatly in room <p>(continued on next page)</p>

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Bed not being held-Certified Nursing Assistant (CNA) to pack resident's belongings and check with the clothing sheet. Label all boxes, bags, suitcases with the resident's name and have maintenance put in storage until the family comes for the items. The policy did not entail being given written notices.</p> <p>1. Review of R54's undated Face Sheet, located under the Profile tab of the electronic medical record (EMR) revealed R54 was admitted to the facility on [DATE].</p> <p>Review of R54's Progress Notes located in the Progress Notes tab of the EMR revealed R54 was sent to the hospital on 10/15/23.</p> <p>Review of R54's EMR revealed no documented evidence that written notification regarding R54's transfer to the hospital was sent to R54's responsible party or sent to the Ombudsman.</p> <p>During an interview on 01/10/24 at 12:03 PM, the Long Term Care Ombudsman confirmed she had not received any notifications of the resident's transfer from the facility or any other resident transfer for the past year.</p> <p>During an interview on 01/10/24 at 1:00 PM, the Social Services Director (SSD) confirmed residents and/or resident's responsible party were not provided a written notice of transfer upon transfer to the hospital.</p> <p>During an interview on 01/10/24 at 1:50 PM, the Director of Nursing (DON) was asked about written notification of transfer being provided to R54's responsible party and the Ombudsman. The DON stated, upon resident transfer, nursing notified the resident's responsible party by telephone. The DON stated she was not aware of written resident transfer notifications being sent to the ombudsman. The DON said she did not know written notification of transfer needed to be completed and provided to the residents' responsible party and the ombudsman.</p> <p>2. Review of R312's undated Face Sheet, provided by the facility, revealed R312 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and anxiety.</p> <p>Review of Incident Reporting Application (initial reporting) dated 12/09/22 revealed Received report R312 noted with physical aggression towards R2 .R312 was later sent to the hospital for further evaluation and treatment.</p> <p>Review of R312's electronic medical record (EMR) and thinned medical record revealed no documented evidence that a written transfer notice was provided to R312, R312's family, and/or Ombudsman.</p> <p>During an interview on 01/10/24 at 1:00 PM, the Social Service Director (SSD) confirmed the resident, family, and/or resident representative (RP) were not given a written notice of transfer. The SSD also indicated the Ombudsman is not notified of residents' transfers to the hospital.</p> <p>During an interview on 01/10/24 at 1:50 PM, the Director of Nursing (DON) confirmed that the facility's policy did not address providing written notification of transfer to the resident, family and/or RP. The DON also confirmed the policy did not address notification to the Ombudsman.</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25232</p> <p>Based on record review, interview, and facility policy review, the facility failed to provide written information regarding the facility's bed hold policy to the resident and the resident's responsible party at the time of transfer or within 24 hours of the transfer for two of three residents (Resident (R) 54 and 312) reviewed for hospitalizations of a total sample of 26 residents.</p> <p>Findings include:</p> <p>Review of facility policy titled, Bed Hold (BH) Policy, (admission package) undated, revealed, A. Medical Assistance/Medicaid Residents. If the resident is transferred to a hospital by the order of a physician, [name of facility] will hold resident's bed for up to seven days commencing on the first day of leave, in accordance with Medicaid bed-hold policy. If a patient or resident is transferred out of a facility to an acute care facility or other specialized treatment facility, the facility must accept the patient or resident back into the facility when the resident no longer needs acute or specialized care and there is space available in the facility. If no space is available, the resident shall be accepted into the next available bed. B. Private Pay Residents. BH payment will be \$150.00 per day.</p> <p>1. Review of R312's undated Face Sheet, provided by the facility revealed R312 was admitted to the facility on [DATE] with diagnoses including Alzheimer's disease and anxiety.</p> <p>Review of Incident Reporting Application (initial reporting) dated 12/09/22 revealed Received report R312 noted with physical aggression towards R2 .R312 was later sent to the hospital for further evaluation and treatment.</p> <p>No evidence in the electronic medical record (EMR) and/or thinned chart revealed that a bed hold notice was given to R312 and/or R312's family upon transfer to the hospital on 12/09/22.</p> <p>2. Review of R54's undated Face Sheet located under the Profile tab of the electronic medical record (EMR) revealed R54 was admitted to the facility on [DATE].</p> <p>Review of R54's Progress Notes located in the Progress Notes tab of the EMR revealed R54 was sent to the hospital on 10/15/23. Review of R54's EMR revealed no documented evidence that the facility provided written information regarding the facility's bed hold policy to the resident and the resident's responsible party at the time of transfer or within 24 hours of the transfer.</p> <p>During an interview on 01/10/24 at 12:03 PM, the Long-Term Care Ombudsman stated she had concerns regarding the facility not sending her bed hold notices for the past year.</p> <p>Interview with Social Services Director (SSD) on 01/10/24 at 1:00 PM, confirmed no bed hold notices were given at time of transfer or within 24 hours of the transfer.</p> <p>(continued on next page)</p>		

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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 01/10/24 at 1:50 PM, the Director of Nursing (DON) stated residents and their responsible parties were provided written information regarding the facility's bed hold policy upon admission. The DON stated information about the facility's bed hold policy had not been provided to residents and their responsible parties upon the resident's transfer to the hospital. At 2:30 PM, the DON stated the facility was using the bed hold policy for 30 days, not seven.</p> <p>26190</p>