**DELAWARE HEALTH AND SOCIAL SERVICES**
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

**STATE SURVEY REPORT**



**NAME OF FACILITY:** New Castle Health & Rehab

**DATE SURVEY COMPLETED:** February 1, 2024

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES |
|---|---|---|
| | An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from January 16, 2024 through February 1, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 115. The sample totaled 51 residents. | |
| 3201 | **Regulations for Skilled and Intermediate Care Facilities** | |
| 3201.1.0 | **Scope** | |
| 3201.1.2 | **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross Refer to the CMS 2567-L survey completed 2/01/24: F550, F561, F578, F604, F641, F644, F656, F660, F689, F690, F692, F697, F700, F712, F730, F758, F761 and F842.<br><br>Abbreviations/definitions used in this report are as follows:<br><br>BCC – Background Check Center;<br>CNA – Certified Nurses Aide; | |

Provider's Signature _____ Title Administrator Date 3/4/24

NAME OF FACILITY: New Castle Health & Rehab

DATE SURVEY COMPLETED: February 1, 2024

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES |
|---|---|---|
| **3201.5.0**<br><br>**3201.5.5**<br><br>**3201.5.5.1** | DON – Director of Nursing;<br>LPN – Licensed Practical Nurse;<br>NHA – Nursing Home Administrator;<br>RN – Registered Nurse.<br><br>**Personnel/Administrative**<br><br>**The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following:**<br><br>**Results of tuberculosis screening**<br><br>This requirement was not met as evidenced by:<br><br>Based on interview, record review and review of other facility documentation, it was determined that for nine (E30, E32, E34, E38, E39, E41, E42, E43, E44) out of 20 employees sampled, the facility lacked evidence of a two-step tuberculin test having been completed. Findings include:<br><br>1. 1/16/23 – E30 (RN) was hired. The facility lacked evidence of a first and second step Tuberculin test being completed.<br><br>2. 4/24/23 – E32 (RN) was hired. The facility lacked evidence of a first and second step Tuberculin test being completed.<br><br>3. 7/10/23 – E34 (LPN) was hired. The facility lacked evidence of a first and second step Tuberculin test being completed.<br><br>4. 1/23/23 – E38 (dietary) was hired. The facility lacked evidence of a first and second step Tuberculin test being completed. | Step 1: Unable to correct.<br>Step 2: All employees have the potential to be affected. Active employees' records reviewed. Screen forms will be completed on employees not having PPD in employee records. All new hires Since 1/15/24 have PPD uploaded in new software system.<br>Step 3: **RCA: Poor system for record keeping.**<br>To prevent the potential for reoccurrence company now has a new software system where employees cannot obtain a start date until information is completed.<br>Step 4: To monitor and maintain on-going compliance the NHA and/or Designee will randomly audit all new hires monthly to ensure PPD are uploaded times 3 months. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision.<br>Date 3/1/24 |

Provider's Signature _____ Title Administrator Date 3/4/24

NAME OF FACILITY: New Castle Health & Rehab

DATE SURVEY COMPLETED: February 1, 2024

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES |
|---|---|---|
| 3201.5.5.2 | 5. 4/10/23 – E39 (environmental services) was hired. The first step Tuberculin test was done 4/7/23. The facility lacked evidence of a second step Tuberculin test being completed.<br>6. 3/15/23 – E41 (CNA) was hired. The facility lacked evidence of a first and second step Tuberculin test being completed.<br>7. 2/5/23 – E42 (LPN) was hired. The facility lacked evidence of a first and second step Tuberculin test being completed.<br>8. 4/24/23 – E43 (receptionist) was hired. The facility lacked evidence of a first and second step Tuberculin test being completed.<br>9. 7/5/23 – E44 (dietary) was hired. The facility lacked evidence of a first and second step Tuberculin test being completed.<br>1/29/24 8:50 AM – Findings were confirmed during an interview with E1 (NHA) and E2 (DON).<br>1/29/24 – Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference beginning at 2:37 PM.<br>**Documentation of annual influenza vaccination or refusal**<br>This requirement was not met as evidenced by:<br>Based on interview, record review and review of other facility documentation, it was determined that for four (E23, E28, E39, E42) out of 11 employees sampled, the facil- | 5.5.2<br>Step 1: Current employees in sample have been offered the influenza vaccine.<br>Step 2: All employees have the potential to be affected. All employees have been offered the influenza vaccine.<br>Step 3: **RCA: Not all employees were offered influenza vaccine .**<br>To prevent the potential for reoccurrence the DON and/or designee educated IP and new staff educator on the importance of offering all employees the opportunity to request or decline the influenza vaccine.<br>Step 4: To monitor and maintain on-going compliance the NHA and/or Designee will randomly audit 2 employees for influenza vaccine documentation during flu season times 1 year. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision.<br>Date 3/1/24 |

Provider's Signature _____ Title Admin Asst Date 3/4/24

NAME OF FACILITY: New Castle Health & Rehab

DATE SURVEY COMPLETED: February 1, 2024

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES |
|---|---|---|
| 3201.5.5.3 | ity lacked evidence of annual influenza vaccination administration or refusal of the vaccination. Findings include:<br><br>The following employees were missing evidence of annual influenza vaccination administration or refusal of the vaccination:<br><br>1. E23 (CNA)<br>2. E28 (CNA)<br>3. E39 (environmental services)<br>4. E42 (LPN)<br><br>1/29/24 8:50 AM – Findings were confirmed during an interview with E1 (NHA) and E2 (DON).<br><br>1/29/24 – Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference beginning at 2:37 PM.<br><br>**Results of criminal background check**<br><br>This requirement was not met as evidenced by:<br>Based on interview, record review and review of other facility documentation, it was determined that for twenty (E23, E28, E30, E31, E32, E33, E34, E35, E36, E37, E38, E39, E40, E41, E42, E43, E44, E45, E46, E47) out of 20 employees sampled, the facility lacked evidence of criminal background checks. Findings include:<br><br>The following employees lacked evidence of criminal background checks:<br><br>1. E23 (CNA)<br>2. E28 (CNA)<br>3. E30 (RN)<br>4. E31 (dietary)<br>5. E32 (RN)<br>6. E33 (RN) | 5.5.3<br>Step 1: Active employees identified all have criminal background checks in the BBC and are eligible to work.<br>Step 2: All employees have the potential to be affected. All Active employees' records reviewed for background screen documentation. All are present.<br>Step 3: **RCA: BCC access was being set up during survey.** To prevent the potential for reoccurrence then NHA and BOM now have access along with the HR/payroll employee.<br>Step 4: To monitor and maintain on-going compliance the NHA and/or Designee will randomly audit new hires monthly to ensure backgrounds are in the BCC times 3 months. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision.<br><br>Date 3/1/24 |

Provider's Signature _____ Title Administrator Date 3/4/24

NAME OF FACILITY: New Castle Health & Rehab

DATE SURVEY COMPLETED: February 1, 2024

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES |
|---|---|---|
| 3225.5.5.4 | 7. E34 (LPN)<br>8. E35 (LPN)<br>9. E36 (receptionist)<br>10. E37 (dietary)<br>11. E38 (dietary)<br>12. E39 (environmental services)<br>13. E40 (environmental services)<br>14. E41 (CNA)<br>15. E42 (LPN)<br>16. E43 (receptionist)<br>17. E44 (dietary)<br>18. E45 (environmental services)<br>19. E46 (RN)<br>20. E47 (environmental services)<br><br>1/26/24 3:45 PM – Per an interview with E1 (NHA) and E2 (DON), adult abuse registry results were unavailable, due to the facility not having access to the BCC system at this time.<br><br>1/29/24 – Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference beginning at 2:37 PM.<br><br>**Results of mandatory drug testing**<br><br>This requirement was not met as evidenced by:<br><br>Based on interview, record review and review of other facility documentation, it was determined that for nine (E28, E32, E34, E37, E39, E41, E43, E44, E47) out of 20 employees sampled for mandatory drug testing, the facility lacked evidence of mandatory drug testing. Findings include:<br><br>The following employees lacked evidence of mandatory drug testing:<br><br>1. E28 (CNA)<br>2. E32 (RN)<br>3. E34 (LPN) | 5.5.4<br>Step 1: Unable to correct.<br>Step 2: All employees have the potential to be affected. Active employees' records reviewed for completed drug screens. All new hires Since 1/15/24 have Drug screen results have been uploaded in BCC.<br>Step 3: **RCA: Poor system for record keeping.**<br>To prevent the potential for reoccurrence center will upload result in the BCC.<br>New HR/Payroll employee and BOM educated on uploading drug screens into the BCC.<br>Step 4: To monitor and maintain on-going compliance the NHA and/or Designee will randomly audit all new hires monthly to ensure Drug screens are uploaded times 3 months. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision.<br><br>Date 3/1/24 |

Provider's Signature _____ Title Administrator Date 3/4/24

NAME OF FACILITY: New Castle Health & Rehab

DATE SURVEY COMPLETED: February 1, 2024

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES |
|---|---|---|
| | 4. E37 (dietary)<br>5. E39 (environmental services)<br>6. E41 (CNA)<br>7. E43 (receptionist)<br>8. E44 (dietary)<br>9. E47 (environmental services) | 5.5.5<br>Step 1: Active employees identified all have abuse registry checks in their employee record and are eligible to work.<br>Step 2: All employees have the potential to be affected. All Active employees' records reviewed for abuse registry documentation. Issues that were identified were addressed.<br>Step 3: **RCA: BCC access was being set up during survey.** To prevent the potential for reoccurrence then NHA and BOM now have access along with the HR/payroll employee.<br>Step 4: To monitor and maintain on-going compliance the NHA and/or Designee will randomly audit new hires monthly to ensure abuse registry check have been completed times three months. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision.<br>Date 3/1/24 |
| **3201.5.5.5** | 1/29/24 – Findings were confirmed during an interview with E1 (NHA).<br><br>1/29/24 – Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference beginning at 2:37 PM.<br><br>**Results of Adult Abuse Registry Checks**<br><br>This requirement was not met as evidenced by:<br><br>Based on interview, record review and review of other facility documentation, it was determined that for twenty (E23, E28, E30, E31, E32, E33, E34, E35, E36, E37, E38, E39, E40, E41, E42, E43, E44, E45, E46, E47) out of 20 employees sampled, the facility lacked evidence of adult abuse registry checks. Findings include:<br><br>The following employees were missing evidence of adult abuse registry checks:<br><br>1. E23 (CNA)<br>2. E28 (CNA)<br>3. E30 (RN)<br>4. E31 (dietary)<br>5. E32 (RN)<br>6. E33 (RN)<br>7. E34 (LPN)<br>8. E35 (LPN)<br>9. E36 (receptionist)<br>10. E37 (dietary)<br>11. E38 (dietary)<br>12. E39 (environmental services) | |

Provider's Signature [signature] Title Administrator Date 3/4/24

**DELAWARE HEALTH AND SOCIAL SERVICES**
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

**STATE SURVEY REPORT**



**NAME OF FACILITY:** New Castle Health & Rehab

**DATE SURVEY COMPLETED:** February 1, 2024

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES |
|---|---|---|
| | 13. E40 (environmental services)<br>14. E41 (CNA)<br>15. E42 (LPN)<br>16. E43 (receptionist)<br>17. E44 (dietary)<br>18. E45 (environmental services)<br>19. E46 (RN)<br>20. E47 (environmental services)<br><br>1/26/24 3:45 PM – Per an interview with E1 (NHA) and E2 (DON), adult abuse registry results were unavailable, due to the facility not having access to the BCC system at this time.<br><br>1/29/24 – Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference beginning at 2:37 PM. | |
| | | |

Provider's Signature _____ Title Administrator Date 3/4/24

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility beginning 1/16/24 and ending 2/1/24, by the State of Delaware Division of Health Care Quality, Office of Long Term Care Residents Protection in accordance with 42 CFR 483.73. The facility census on the first day of the survey was 115.<br><br>For the Emergency Preparedness Survey, all contracts, operation plans, contact information, and annual emergency drills were up to date. No deficiencies were identified. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from January 16, 2024 through February 1, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 115. The sample totaled 53 residents.<br><br>Abbreviations/definitions used in this report are as follows:<br><br>ADON - Assistant Director of Nursing;<br>BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 to 15.<br>13-15: Cognitively intact<br>8-12: Moderately impaired<br>0- 7: Severe impairment;<br>Bioavailability - the extent a substance or drug becomes completely available; | F 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 02/22/2024

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 1 | F 000 | | |

BS - blood sugar;
CNA - Certified Nurse Aide;
DON - Director of Nursing;
DVT - deep vein thrombosis;
EMR - electronic medical record;
LPN - Licensed Practical Nurse;
MD - Medical Doctor;
MDS (Minimum Data Set) - a standardized set of assessments completed in nursing homes;
mg (milligrams);
NHA - Nursing Home Administrator;
NP - Nurse Practitioner;
PASARR - Preadmission Screening and Resident Review
PT - Physical Therapist;
SW - Social Worker;
RD - Registered Dietician;
RN - Registered Nurse;

Advance Directive - a written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated;
Chronic Obstructive Pulmonary Disease - (COPD) difficulty breathing;
DMOST - Delaware Medical Orders for Scope of Treatment/separate from and is not an advance health-care directive. It expresses an individual's wishes regarding scope of treatment through medical orders. The DMOST form does not require an advance health-care directive. (Defined under Del. Code Title 16, Part II, Chapter 25 A);
Dementia - loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning;
Kardex - Summary of care needed for each resident to guide the CNA assigned to that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 2<br>resident.<br>Osteoarthritis - pain in the bones;<br>Pain Scale (0-10) - Pain is identified between zero (0) to 10, with 10 being the worst pain imaginable and 0 being no pain;<br>Parkinson's Disease - brain disorder affecting movement leading to shaking/tremors and difficulty walking;<br>Pulmonary Embolism - blood clot in the lungs;<br>Wedge compression fracture of thoracic vertebra- A vertebral wedge fracture is when one side of your vertebra collapses, usually the front side. | F 000 | | |
| F 550 SS=D | Resident Rights/Exercise of Rights<br>CFR(s): 483.10(a)(1)(2)(b)(1)(2)<br><br>§483.10(a) Resident Rights.<br>The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.<br><br>§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br><br>§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. | F 550 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 3<br>§483.10(b) Exercise of Rights.<br>The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.<br><br>§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.<br><br>§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and record review, it was determined that the facility failed to promote R2's dignity by keeping R2's urinary collection bag in a privacy bag. Findings include:<br><br>7/1/15 - R2 was admitted to the facility.<br><br>10/12/23 - R2 's care plan documented, "Requires urinary catheter for the diagnosis of retention with incomplete bladder emptying and obstructive uropathy".<br><br>12/28/23 - R2's physicians orders documented, "Ensure the Foley bag (urinary collection bag) is covered every shift".<br><br>1/17/24 - R2 was observed lying in her bed at 8:30 AM, 10:30 AM, 12:30 PM. The urinary collection bag was not in the privacy bag and was visible from the hallway. | F 550 | Step 1: R2 Urinary catheter bag was covered.<br>Step 2: All residents with urinary catheter bags have potential to be affected. The DON and/or designee reviewed all residents with urinary catheter bags. No additional issues were identified.<br>Step 3: RCA: Staff did not place urinary bag into privacy bag next to catheter bag. To prevent the potential for reoccurrence the DON and/or designee educated all nursing staff on covering urinary catheter bags.<br>Step 4: To monitor and maintain on-going compliance the DON and/or Designee will randomly observe of 1 residents urinary catheter bag 1 times a week for 3 months. Where necessary process corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 550 | Continued From page 4<br>1/17/23 12:45 PM - Findings were confirmed with E52 (UM).<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 550 | for continued review and revision. | |
| F 561 SS=D | Self-Determination<br>CFR(s): 483.10(f)(1)-(3)(8)<br><br>§483.10(f) Self-determination.<br>The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.<br><br>§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.<br><br>§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.<br><br>§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.<br><br>§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.<br>This REQUIREMENT is not met as evidenced by: | F 561 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 561 | Continued From page 5<br>Based on interview and record review it was determined that for one (R474) out of one resident reviewed for choices, the facility failed to ensure the right to self-determine when R474's preference for showers were not completed. Findings include:<br><br>1. Review of R474's clinical record revealed:<br><br>8/2/22 - A significant change MDS assessed R474 as cognitively intact and the preference to choose type of bathing as very important.<br><br>Review of facility shower schedule revealed that R474 was scheduled to receive two showers a week initially on Tuesdays/Fridays then a change to Monday/Thursday on evening shift.<br><br>Review of CNA Point of Care [POC] record revealed R474 had the following:<br>June 2022 - Three showers received.<br>July 2022 - One shower received.<br>August 2022 - Two showers received.<br><br>During an interview on 1/25/24 at 3:18 PM, E2 (DON) explained that residents are supposed to "receive two showers a week based on their room location." E2 then confirmed that R474 had not received at least two showers a week.<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 561 | Step 1: Resident R474 received a shower.<br>Step 2: All residents have a potential to be affected. The DON and/or designee reviewed all showers on date of survey. Issues that were identified were addressed.<br>Step 3: RCA: Direct care staff not consistently following the shower schedule.<br>To prevent the potential for reoccurrence the DON and/or designee educated all direct care staff on the shower schedule.<br>Step 4: To monitor and maintain on-going compliance the DON and/or Designee will randomly review shower documentation of 4 residents 3 times a week for 3 months. Where necessary process corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |
| F 578 SS=E | Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)<br><br>§483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to | F 578 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 578 | Continued From page 6<br>formulate an advance directive.<br><br>§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.<br><br>§483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).<br>(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.<br>(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.<br>(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.<br>(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.<br>(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was | F 578 | Step 1: R25, R29, R31, R 43, R56 and | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 578 | Continued From page 7<br>determined that for six (R25, R29, R31, R43, R56 and R119) out of six residents reviewed for advance directive, the facility failed to offer the opportunity to formulate an advance directive for each resident. Findings include:<br><br>1. R25's clinical record revealed:<br><br>5/4/23 - R25 was admitted to the facility.<br><br>5/11/23 - R25's admission MDS assessment documented the resident's BIMS as 11. While R25's initial mental status upon admission to the facility was moderately impaired, R25's BIMS was re-evaluated as a 14 on 8/1/23, 14 on 10/24/23 and 13 on 1/3/24, which reflected the resident was cognitively intact.<br><br>Review of R25's clinical record lacked documented evidence that the resident was offered to formulate an advance directive.<br><br>1/25/24 at 10:58 AM - During an interview with E6 (Regional) and E7 (SW), E6 stated that they (the facility) are "not doing it" (offering residents to formulate an advance directive).<br><br>2. R29's clinical record revealed:<br><br>5/19/23 - R29 was admitted to the facility.<br><br>5/24/23 - R29's admission MDS assessment documented the resident's BIMS as 13.<br><br>Review of R29's clinical record lacked documented evidence that the resident was offered to formulate an advance directive.<br><br>1/25/24 at 10:58 AM - During an interview with E6 | F 578 | R119 were offered the opportunity to formulate an Advance Directive.<br>Step 2: All residents with the ability to make decisions for themselves has the potential to be affective. On 1/30/24 the Social Worker reviewed all advance directives with residents who make their own decisions. Ombudsman□s office was notice and met with residents on 2/16/24.<br>Step 3: RCA: Center was not aware of Title 16 Chapter 25.<br>To prevent the potential for reoccurrence the Social Worker was educated by the surveyor during survey and shared information with NHA. On admission and quarterly the Social worker will meet with resident who can make their own decisions and ensure they have the opportunity to formulate advance directives according to Title 16 Chapter 25.<br>Step 4: To monitor and maintain on-going compliance the Social Worker/or designee will randomly review the advance directives of 2 residents 1 time a week for 3 months to ensure at residents are offered to formulate advance directive. Where necessary process corrections will be made. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 578 | Continued From page 8<br>(Regional) and E7 (SW), E6 stated that they (the facility) are "not doing it" (offering residents to formulate an advance directive).<br><br>3. R31's clinical record revealed:<br><br>10/31/23 - R31 was admitted to the facility.<br><br>11/3/23 - R31's admission MDS assessment documented the resident's BIMS as 13.<br><br>Review of R31's clinical record lacked documented evidence that the resident was offered to formulate an advance directive.<br><br>1/25/24 at 10:58 AM - During an interview with E6 (Regional) and E7 (SW), E6 stated that they (the facility) are "not doing it" (offering residents to formulate an advance directive).<br><br>4. R43's clinical record revealed:<br><br>3/20/23 - R43 was readmitted to the facility.<br><br>7/11/23 - R43's annual MDS assessment documented the resident's BIMS as 15.<br><br>Review of R43's clinical record lacked documented evidence that the resident was offered to formulate an advance directive.<br><br>1/25/24 at 10:58 AM - During an interview with E6 (Regional) and E7 (SW), E6 stated that they (the facility) are "not doing it" (offering residents to formulate an advance directive).<br><br>5. R119's clinical record revealed:<br><br>11/10/23 - R119 was admitted to the facility. | F 578 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 578 | Continued From page 9<br><br>11/17/23 - R119's admission MDS assessment documented the resident's BIMS as 14.<br><br>Review of R119's clinical record lacked documented evidence that the resident was offered to formulate an advance directive.<br><br>1/25/24 at 10:58 AM - During an interview with E6 (Regional) and E7 (SW), E6 stated that they (the facility) are "not doing it" (offering residents to formulate an advance directive).<br><br>6. R56's clinical record revealed:<br><br>8/1/23 - R56 was admitted to the facility.<br><br>8/8/23 - R56's admission MDS assessment documented the resident's BIMS as 15.<br><br>1/25/24 at 9:55 AM - During an interview, R56 stated that she was not offered to formulate an advance directive.<br><br>1/25/24 at 10:03 AM - During an interview and when asked if she offered R56 to formulate an advance directive, E7 (SW) stated that she completed a DMOST form with R56. E7 stated that she does not coordinate with the Ombudsman's office regarding formulating advance directives for residents.<br><br>1/25/24 at 10:58 AM - During an interview with E6 (Regional) and E7 (SW), E6 stated that they (the facility) are "not doing it" (offering residents to formulate an advance directive).<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 578 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 604 SS=D | Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2)<br><br>§483.10(e) Respect and Dignity.<br>The resident has a right to be treated with respect and dignity, including:<br><br>§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).<br><br>§483.12<br>The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to ensure that R106 was free from side rails that were not required to treat the resident's medical condition. | F 604 | Step 1: R 106 Side rail was removed. Resident had half rails in place per family□s request.<br>Step 2: All residents have a potential to be affected. On 1/24/24 the DOR and | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 604 | Continued From page 11<br><br>A facility policy titled, "Bed rail policy", dated 3/10, and revised 4/24/23 documented, "The use of bed rails will be limited to circumstances where they are used to treat a medical condition and enhance the residents' functional abilities".<br><br>11/7/22 - R106 was admitted to the facility with diagnoses including muscles weakness, and seizure disorder.<br><br>11/7/22 - R106's admission side rail assessment documented, "No medical needs, and resident does not benefit from the use of side rails".<br><br>4/27/23 - R106's quarterly nursing side rail assessment documented, "No medical needs for bed rails, and resident does not benefit from side rails".<br><br>12/27/23 - R106's quarterly MDS assessment documented that R106 was completely dependent on staff for bed mobility and transfers.<br><br>1/1/24 R106's quarterly MDS documented, " No bed rails".<br><br>1/16/24 9:30 AM - R106 was observed lying in his bed with two long bed rails in the raised position.<br><br>1/16/24 11:30 AM - R106 was observed lying in his bed with two long bed rails in the raised position.<br><br>1/17/24 10:15 AM - R106 was observed lying in his bed with two long bed rails in the raised position.<br><br>1/24/24 9: 15 AM - A review of R106's physician's | F 604 | Restorative Nurse screen all residents for side rail use. Issues that were identified were addressed.<br>Step 3: RCA: Resident family insist on side rails.<br>To prevent the potential for reoccurrence the NHA will educated the family member on regulations, case studies on bed rail entrapment, involve the ombudsman and direct them to contact DHCQ. At the time of submitting this POC there is no resident in the center with side rails.<br>Step 4: To monitor and maintain on-going compliance the NHA and/or designee will randomly review side rails for 2 residents 1 time a month for 3 months. Where necessary process corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 604 | Continued From page 12<br>orders, and Kardex lacked documentation of physician's orders for the two side rails.<br><br>1/24/24 10:15 AM - During an interview, E52 (UM) stated, "R106 does not use the side rails for bed motility or transfers. He is completely dependent on staff for all his care". E52 (UM) confirmed the presence of the bed rails.<br><br>1/24/24 10:30 AM - During an interview E1 (NHA), stated that R106 does not use the bed rails for bed mobility.<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 604 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined for one (R106) out of three residents review for resident assessment the facility failed to accurately document R106's side rails on the MDS assessments.<br><br>11/7/22 - R106 was admitted to the facility with diagnoses including muscles weakness, and seizure disorder.<br><br>1/24/23 11:29 AM - R106's medical records documented, " ...[R106's] sister requested that side rails be placed on the bed ...care plan updated, nurse practitioner made aware". | F 641 | Step 1: R106 MDS was not coded for side rail under restraints because the RAI manuals definition of a restraint is: Any manual method, physical or mechanical device, material, or equipment attached to or adjacent to the residents body that the individual cannot remove easily which restricts freedom of movement or normal access to one body. Since R106 does not have the ability to reposition himself this would not be a restraint and would not be coded. The side rails were removed from the bed. No correction to the MDS is needed at this time.<br>Step 2: All residents with orders for side | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 641 | Continued From page 13<br>1/24/24 9:00 AM - A review of R106's MDS assessments for the dates of 2/7/23, 2/24/23, 5/23/23, 7/25/23, 10/19/23, and 1/1/24 documented, "No bed rails". During an interview E52 (UM) stated, "I have been working here for about one and a half year, and he [R106] has had those side rails". During an interview with the E53 (LPN RNAC) stated, "I did not know that he [R106] had side rails".<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 641 | rails as a restraint have the potential to be affected. On 1/24/24 the DOR and/or designee reviewed all residents with side rails as a restraint none were found.<br>Step 3: RCA: Side rails were not a restraint.<br>To prevent the potential for reoccurrence family member will be educated on the regulation of side rails. At the time of survey and at this time the center does not have any other resident with side rails. If center does use side rails if in the future the center will ensure that the MDS is coded appropriately.<br>Step 4: To monitor and maintain on-going compliance the DOR and/or Designee will randomly review side rails and ensure the MDS is coded correctly on 1 residents a month for 3 months. Where necessary process corrections will be made, and the responsible a month party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |
| F 644 SS=D | Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2)<br><br>§483.20(e) Coordination.<br>A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:<br><br>§483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's | F 644 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 644 | Continued From page 14<br>assessment, care planning, and transitions of care.<br><br>§483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review it was determined that for one (R84) out of three residents reviewed for PASARR, the facility failed to ensure a referral for a new PASARR screening after changes to R84's mental health diagnoses. Findings include:<br><br>Review of R84's clinical record revealed:<br><br>10/8/20 - A Level II PASARR was completed for R84.<br><br>10/2/22 - A progress noted documented that R84 was being seen by psych for new mental health diagnoses including adjustment disorder with depressed mood, major depressive disorder severe with recurrent symptoms and delusional disorders.<br><br>1/24/24 1:00 PM - In an interview, E7 (SW) stated that R84 did not have an updated PASARR evaluation.<br><br>1/24/24 1:30 PM - During an interview, E1 (NHA) stated that E7 just started doing her PASARR audits.<br><br>1/24/23 4:03 PM - In an email correspondence, P1 (PASARR State Authority) confirmed that the | F 644 | Step 1: R84 PASARR was sent to Maximus and returned 2/7/24<br>Step 2: All residents have a potential to be affected. The Social Worker and/or designee reviewed all PASARR. Issues that were identified were addressed.<br>Step 3: RCA: Social Worker focus on PASARR accuracy.<br>To prevent the potential for reoccurrence NHA educated the social worker on PASARR accuracy and follow up with changes in mental health diagnosis and status changes.<br>Step 4: To monitor and maintain on-going compliance the NHA and/or designee will randomly check 2 PASARR 1 time weekly for 3 months to ensure no changes in mental health diagnosis/status changes occurred without generating a new PASARR. Where necessary process corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 644 | Continued From page 15<br>facility should have submitted a resident review for R84.<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 644 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)(3)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes. | F 656 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 16<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>§483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(iii) Be culturally-competent and trauma-informed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review for one (R106) out of three residents reviewed for careplans, it was determined that the facility failed to accurately develop and implement a comprehensive person-centered care plan for R106's use of bed rails. Findings include:<br><br>11/7/22 - R106 was admitted to the facility with diagnoses including muscles weakness, and seizure disorder.<br><br>1/24/23 11:29 AM - R106's medical records documented, " ...R106's sister requested that side rails be placed on the bed ...care plan updated, nurse practitioner made aware".<br><br>1/16/24 9:30 AM - R106 was observed laying on a concave mattress in bed with two long bed rails in the raised position.<br><br>1/16/24 11:30 AM - R106 was observed laying on a concave mattress in bed with two long bed rails in the raised position. | F 656 | Step 1: R 106 Side rail was removed. Resident had half rails in place per family□s request. Care plan is not needed at this time.<br>Step 2: All residents who have a side rails have a potential to be affected. On 1/24/24 the DOR and MDS nurse review all residents with side rail and care plans to ensure they matched. Issues that were identified were corrected.<br>Step 3: RCA: Care plan team did not care plan side rails related to family request. To prevent the potential for reoccurrence the DON/ designee has educated the care plan team on accuracy of care plans and ensuring if the center implements side rails they are care planned appropriately.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly review 2 care plan a week to ensure the care plan matches side rails being used. Where necessary process corrections will be made, and the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 656 | Continued From page 17<br><br>1/17/24 10:15 AM - R106 was observed laying in a concave mattress in bed with two long bed rails in the raised position.<br><br>1/24/24 9:15 AM - A review of R106's care plans lacked evidence for the use of the bed rails.<br><br>During an interview E52 (UM) stated, "I have been working here for about one and a half year, and he (R106) has had those side rails". During an interview with the E53 (LPN RNAC) stated, "I did not know that he (R106) had side rails".<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 656 | responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |
| F 660 SS=D | Discharge Planning Process<br>CFR(s): 483.21(c)(1)(i)-(ix)<br><br>§483.21(c)(1) Discharge Planning Process<br>The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and-<br>(i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.<br>(ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.<br>(iii) Involve the interdisciplinary team, as defined | F 660 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 660 | Continued From page 18<br>by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.<br>(iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.<br>(v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.<br>(vi) Address the resident's goals of care and treatment preferences.<br>(vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community.<br>(A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.<br>(B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.<br>(C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.<br>(viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient | F 660 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 660 | Continued From page 19<br>assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.<br>(ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, interview and review of facility documentation, it was determined that for one (R524) out of two residents reviewed for discharge, the facility failed ensure that R524's discharge needs regarding his wound care were identified. Findings include:<br><br>Review of R524's clinical record revealed:<br><br>8/20/23 - R524 was admitted to the facility for a five (5) day respite stay.<br><br>8/23/23 - The following orders and notes were written:<br><br>- A progress note was written by E50 (RN) that the resident had a skin tear under his right 3rd toe while he was self-ambulating with non-skid socks on.<br><br>- 9:25 AM - A physician order was written by E51 (Wound MD) for wound care that was to cleanse the right 3rd toe, pat dry, apply bacitracin (an | F 660 | Step 1: R524 is discharged. Unable to correct.<br>Step 2: All residents who will discharge have the potential to be affected. All resident who need wound care, residents/care giver discharge will be shown and taught wound care. The wound nurse and/or designee reviewed all discharges. Issues that were identified were addressed.<br>Step 3: RCA: Nurse did not do wound care teaching with resident.<br>To prevent the potential for reoccurrence Wound Care Nurse educated all nurses on wound care teaching for discharge residents/care giver and ensured documentation is included in the medical record.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly check discharge residents 1 time weekly for 3 months to ensure wound care, care giver sees wound on discharge | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 660 | Continued From page 20<br>antibiotic ointment) and leave open to air, every day shift.<br><br>8/25/23 7:53 AM - A discharge summary note was written by E7 (SW) that documented under the nursing section that no nursing education was provided, that a skin tear wound was currently present, and with the current wound care as described above.<br><br>1/18/24 3:00 PM - During an interview, E10 (RN) stated that according to the documentation in the EMR, R524's daughter was not shown R524's skin tear at the time of discharge.<br><br>1/24/24 3:00 PM - During an interview F2 (daughter/caregiver) stated that she was not shown the foot wound at the time of discharge. F2 stated that she took R524 to the hospital on 8/26/23 because the foot wound was swollen and painful. R524 was prescribed antibiotic medication for the foot wound.<br><br>R524's wound was not shown to F2 and nursing education at the time of discharge to F2 about the wound care was not documented.<br><br>1/29/24 11:00 AM - Findings were reviewed E1 (NHA) and E2 (DON). | F 660 | and documentation is in the medical record. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate | F 689 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 21<br>supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview it was determined that for one (R476) out of three residents reviewed for accidents the facility failed to ensure R476 received adequate supervision during a transfer. Findings include:<br><br>Review of R476's clinical record revealed:<br><br>R476' care plan for falls last reviewed 3/17/22 included the intervention to transfer the resident with assistance of two staff members.<br><br>4/4/22 - A physical therapy discharge summary documented, "Staff reports consistent one person transfers, on average moderate assist fluctuates depending on patients level of motivation for the task." There was no documented change in R476's clinical record to change to one person assistance transfers.<br><br>8/29/22 - A quarterly MDS assessment documented R476 as being cognitively impaired and requiring total assistance of two staff members for transfers with impairment to one side.<br><br>11/21/22 - A quarterly MDS assessment documented R476 as being cognitively impaired and requiring extensive assistance of two staff members for transfers with impairment to one side.<br><br>11/30/22 - The facility reported an incident to the State Agency that, "On 11/28/22 resident complained of pain in right knee. Area noted to be | F 689 | Step 1: R 476 is discharged.<br>Step 2: All residents who have transfer have the potential to be affected. The DOR/designee reviewed all residents who transfer and ensure clinical record reflects correct number of staff assisted needed. Issues that were identified were corrected.<br>Step 3: RCA: Clinical record did not reflect correct number of staff assisted needed. To prevent the potential for reoccurrence the DON/ designee has educated the Clinical staff on clinical record reflecting correct number of assist need on transfer including C.NA Kardex.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly review 2 clinical records to ensure correct number of assists is documented in the clinical record and is on the C.NA Kardex. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 689 | Continued From page 22<br>swollen NP made aware ordered x-ray. Transfer was appropriate per staff who assisted him ...Aides suspended pending rule out abuse ..."<br><br>1/25//24 - A Review of the CNA Kardex [undated] indicated R476's transfer status as requiring assistance of two staff members.<br><br>During an interview on 1/25/24 at 3:22 PM, E20 (CNA) confirmed that on 11/28/22 he transferred R476 from the wheelchair to the bed alone, without the assistance of another staff. E20 denied any fall or other adverse circumstance occurred during the transfer. E20 stated, that R476, "was a one person assist. He just stood cried then sat on the bed. I changed him then I notified the nurse about it."<br><br>During an interview on 1/25/24 at 1:31 PM, E2 (DON) confirmed R476's orders and care plan documented R476 required assistance of two staff members for transfers.<br><br>During an interview on 1/29/24 at 8:56 AM, E12 (PT) stated residents should be transferred "consistent with what the Kardex and careplan's".<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 689 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is | F 690 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 23<br>not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that for one (R31) out of three residents reviewed for bowel and bladder, the facility failed to ensure that R31 was appropriately assessed on admission to ensure that treatment and services were provided to promote continence of bladder and bowel to the extent possible. | F 690 | Step 1: R31 assessed for continence of bladder and bowel.<br>Step 2: All residents have the potential to be affected. The DON/designee reviewed all residents for bladder and bowel continence. Issues that were identified were addressed.<br>Step 3: RCA: Toileting program was not established after assessment. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 24<br>10/31/23 - R31 was admitted to the facility with diagnoses including muscle weakness gait abnormality and diabetes.<br><br>10/31/23 - R31's admission bowel and bladder assessment lacked documentation of whether she was continent or incontinent of bowel. R31's bladder assessment documented, "no altered bladder elimination".<br><br>10/31/23 - R31's Kardex (electronic record for care givers for resident's care) documented, "Assist of one (1) with mobility, provide incontinence care as needed".<br><br>11/3/23 - R31's admission MDS documented a BIMS score of 13 indicating cognitively intact.<br><br>11/7/23 - R31's urinary care plan documented, "[R31] is incontinent of bowel and bladder", with interventions including, "Check and change as needed".<br><br>1/7/24 - R31's admission MDS documented, "No trial toileting program...has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission? (No)....and frequently incontinent of bowel and bladder".<br><br>1/17/24 11:30 AM - During an interview with R31 in her room about bowel and bladder continence, R31 stated, " I did not wear this kind of thing (pulling at her pants and pointing to the top of a plastic brief) when I was at home. I used to go on the toilet when I wanted to pee. Sometimes I did not make it to the toilet to poop on time, but I am wet a lot now. Look, I am wet now". During an interview with E54 (CNA) stated she was not | F 690 | To prevent the potential for reoccurrence DON/designee educated all nurses on establish a toileting plan after bladder and bowel assessment. Resident will be reviewed on admission and quarterly.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly check 2 residents 1 time weekly for 3 months to ensure resident assessed and in need for a toileting program is in place. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 690 | Continued From page 25<br>aware of any residents on a toileting program. E54 stated, "I check them during my shift and change them if they are wet". During another interview with E55 (CNA) stated, "I don't know anything about a toileting program. I check to see if they are wet and change them".<br><br>1/18/24 12:15 PM - During an interview E2 (DON) stated, the facility does not have a policy for bowel and bladder assessment for new residents, and residents that might have had a change in continence status. E2 stated, "The nurses use the bowel and bladder records to evaluate the residents' toileting for the first 3 days after admission, and a care plan is formed based on that information".<br><br>1/23/24 8:15 AM - A review of R31's bowel records from 12/25/23 -1/20/24 (a total of twenty-seven days) revealed 14 episodes of continence, and 42 episodes of incontinence. R31's bladder records revealed 23 episodes of continence, and 58 episodes of incontinence.<br><br>1/24/24 10:15 AM - During an interview with E53 (MDS LPN) stated, "The nurses do the assessments on the floors, and I do the MDS assessments, and care plans based on the flowsheets".<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 690 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and | F 692 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 692 | Continued From page 26<br>percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview it was determined that for one ( R475) out of four residents reviewed for nutrition the facility failed to implement interventions related to risk for weight loss when the weekly weights were missed and percentage of supplement consumed was not documented. Findings include:<br><br>The facility policy on Resident weights, last updated 12/12/23 indicated, "Weights will be obtained routinely in order to monitor national health over time. Each residents weight will be determined upon admission/readmission to the facility, weekly for the first four weeks after admission/readmission and monthly or more often if risk is identified, or as ordered. Nursing is responsible for obtaining weights.<br><br>Review of R475's clinical record revealed: | F 692 | Step 1: R 475 is discharged.<br>Step 2: All residents have the potential to be affected. The DON/designee reviewed all residents to ensure weekly weights are completed and percentage of supplements consumed is documented. Issues that were identified were corrected.<br>Step 3: RCA: Nursing staff did not record weekly weight or percentage of supplement consumed.<br>To prevent the potential for reoccurrence the DON/ designee has educated the Clinical staff on clinical record documentation related to weekly weights and supplement percentage documentation. Weekly weight documentation/and supplement orders will be reviewed in clinical meeting to ensure documentation of each is recorded in the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 692 | Continued From page 27<br><br>2/6/23 - 2/16/23 - Hospital records documented, "Weight 122.75 pounds [55.8 KG] history and physical reports poor appetite and decreased intake ...nutrition problem related to increased nutrient needs. Readmission risk moderate."<br><br>2/16/23 - R475 was admitted to the facility with multiple diagnosis including dementia and dysphagia.<br><br>2/17/23 - An admission MDS assessment documented R475 as having a poor appetite, weighing 118 pounds and receiving a mechanically altered therapeutic diet.<br><br>2/21/23 - A care plan for risk of nutrition was created that included interventions to monitor weight per protocol, monitor intakes, and Boost supplement nightly.<br><br>2/22/23 - A physicians order was written for weight on admission and then weekly for four weeks.<br><br>2/24/23 - A physicians order was written for house supplement 90 milliliters with meals.<br><br>3/3/23 - A physicians order was written for Boost supplement in the evening with dinner tray.<br><br>Review of R475's weight's revealed the following:<br>2/16/23 - 118.<br>2/22/23 - 110.<br>3/2/23 - No weekly weight obtained.<br>3/6/23 - 101.<br><br>February 2023 - Review of R475's MAR revealed amount of supplements consumed was not | F 692 | medical record.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly review 2 clinical records to ensure weekly weights are documented and percentage of supplement consumed. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 692 | Continued From page 28<br>recorded.<br><br>During an interview on 1/26/23 at 11:35 AM, E21 (RD) confirmed that supplement intakes for R475 should have been recorded and that one weekly weight was not obtained.<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 692 | | |
| F 697 SS=D | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, record review and review of other facility documentation, it was determined that for two (R525 and 274) out of five residents reviewed for pain, the facility failed to ensure that that adequate pain management was provided for R525 and R274 pain assessments were not conducted with a consistent scale for pre and post pain assessments. Findings include:<br><br>The pain management standards were approved by the American Geriatrics Society in April 2002 which included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and | F 697 | Step 1: R525 and R 274 are discharged.<br>Step 2: All residents receiving pain medication have the potential to be affected. The DON/designee reviewed all residents for a consistent scale for pre and post pain assessment. If issues were identified they were addressed.<br>Step 3: RCA: Inconsistent pre and post pain assessment scale.<br>To prevent the potential for reoccurrence DON/designee educated all nurses consistent pre and post scale assessment. Centers new EMR system has consistent pain scales the user can not change them.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly check 2 residents 1 time weekly | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 697 | Continued From page 29<br>appropriateness of pain management.<br><br>According to The National Library of Medicine (2008) "pain should be reassessed after each intervention to evaluate the effect and determine whether modification is needed".<br><br>Review of R525's clinical record revealed:<br><br>8/4/22 - R525 was admitted to the facility with multiple diagnoses including osteoarthritis and severe kidney disease. A physician's order was written for Tylenol 325 mg two tablets by mouth every six hours for pain. R525 did not have any other pain medications ordered.<br><br>8/5/22 - A review of R525's care plan revealed that R525 had the potential for pain and to notify the physician if the medication given was not effective.<br><br>Review of R525's electronic medical record (EMR) medication administration record for August 2022 revealed that R525 had the following pain levels for which R525 received Tylenol:<br><br>8/6/22 7:49 AM - 6 out of 10. Tylenol was given and the post pain scale was assessed as "unchanged". A post pain scale number was not documented.<br><br>8/6/22 8:30 PM - 9 out of 10. Tylenol was given and the post pain scale was assessed as "effective". A post pain scale number was not documented.<br><br>8/7/22 3:30 AM - 8 out of 10. Tylenol was given and the post pain scale was assessed as "effective". A post pain scale number was not | F 697 | for 3 months to ensure resident assessed and consistent pre and post scale is in use. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 697 | Continued From page 30 | F 697 | | |

documented.

R525 experienced pain on 8/6/22 through 8/7/22 and her pain was not controlled as evidenced by the description of her pain levels as described above. Additionally, R525's pain was not assessed using a number scale after she was given Tylenol for pain.

Tylenol was the only pain-relieving medication that R525 had ordered during her facility stay. A review of R525's EMR progress notes revealed the lack of documentation that the facility contacted the medical provider about R525's pain levels on 8/6/22 through 8/7/22, and to obtain further guidance for R525's uncontrolled pain.

1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON).

2. Review of R274's clinical record revealed:

10/30/21 - R274 was admitted to the facility with a diagnoses of cervical disc degeneration (a general term for age-related wear and tear affecting the spinal disks in your neck), wedge compression fracture of thoracic vertebra, and chronic low back pain.

11/2/21 - A baseline care plan initiated for "potential for pain with a goal of pain to be controlled to an acceptable level. Interventions included: assess/ document pain per routine and prn, administer pain medications for pain prior to attending therapy sessions, procedures, dressing changes as needed; report and document complaints of pain and/or nonverbal signs of pain; reposition as needed for comfort; administer pharmacological interventions as indicated per

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 697 | Continued From page 31<br>physician; and non-pharmacological interventions such as distraction techniques, breathing and relaxation exercises, and music therapy." The baseline care plan failed to identify an acceptable pain level or pain scale to determine pain level.<br><br>11/5/21 - An admission MDS assessment documented that R274 was alert and oriented with a BIMS score of 15. Additionally, the MDS documented R274 had "pain, that occurred frequently, limiting day to day activities, pain scale 7 (very severe) out of 10 over the last five days."<br><br>November and December 2021 - R274's MAR revealed that a total of 197 doses of PRN pain medications were administered with a pre pain scale numerically and post scale noted as "effective, ineffective, or unchanged."<br><br>January 2022 - R274's emar revealed that 66 doses of PRN pain medication were administered with a pre pain scale numerically and the post scale noted as "effective, ineffective, or unchanged."<br><br>2/1/24 11:32 AM - An interview with E27 (LPN) confirmed that a pain assessment records the numerical value for pre pain and "effective, ineffective, or unchanged" post pain.<br><br>The review of R274's medical record revealed that the facility failed to monitor pain with a consistent scale.<br><br>2/1/24 3:40 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 697 | | |
| F 700 SS=D | Bedrails<br>CFR(s): 483.25(n)(1)-(4) | F 700 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 700 | Continued From page 32<br><br>§483.25(n) Bed Rails.<br>The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>§483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation.<br><br>§483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>§483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br><br>§483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to accurately assess R106's medical condition for the necessary use of two (2) bed rails. Additionally, the facility failed to ensure the bed rail padding was provided on the bed rails as documented in R106's medical records. Findings include:<br><br>A facility policy titled, "Bed rail policy", dated 3/10, and revised 4/24/23 documented, "The use of bed rails will be limited to circumstances where they are used to treat a medical condition and enhance the residents' functional abilities". | F 700 | Step 1: R 106 bed rails that the family requested on having were removed and padding discontinued.<br>Step 2: All residents who have side rails have the potential to be affected. On 1/24/24 the DOR and MDS nurse assessed all residents for side rails and padding. Issues that were identified were corrected. There are no other side rails in use in the center.<br>Step 3: RCA: Resident family requested siderails.<br>To prevent the potential for reoccurrence the DON/ designee has educated the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 700 | Continued From page 33<br>11/7/22 - R106 was admitted to the facility with diagnoses including muscles weakness, and seizure disorder.<br><br>11/7/22 - R106's admission side rail assessment documented, "No medical needs, and resident does not benefit from the use of bed rails".<br><br>4/27/23 - R106's quarterly nursing side rail assessment documented, "No medical needs for bed rails, and resident does not benefit from bed rails".<br><br>6/29/23 - R106's Kardex, and care plan documented, "Bed rail padding".<br><br>12/27/23 - R106's quarterly MDS assessment documented that R106 was completely dependent on staff for bed mobility and transfers.<br><br>1/1/24 - R106's quarterly MDS documented, " No bed rails".<br><br>1/16/24 9:30 AM - R106 was observed lying on a concave mattress in bed with two long bed rails in the raised position. The bed rails padding was not observed.<br><br>1/16/24 11:30 AM - R106 was observed lying on a concave mattress in bed with two long bed rails in the raised position. The bed rails padding was not observed.<br><br>1/17/24 10:15 AM - R106 was observed lying in a concave mattress in bed with two long bed rails in the raised position. The bed rails padding was not observed.<br><br>1/24/24 9:15 AM - A review of R106's physician's | F 700 | Clinical staff on assessment of siderails and ensuring padding is in place. The center has no side rails in use at this time.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly review 2 residents to ensure if side rails are in use side rail assessments have been completed and if padding is ordered it is in place. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 700 | Continued From page 34<br>orders lacked documentation of orders for bed rails, the bed rails padding, and the concave mattress. R106's Kardex lacked documentation of the two bed rails.<br><br>1/24/24 10:15 AM - During an interview, E52 (UM) stated, "R106 does not use the bed rails for bed motility or transfers. He is completely dependent on staff for all his care". E52 (UM) confirmed the presence of the bed rails, and the lack of the bed rail padding.<br><br>1/24/24 10:30 AM - During an interview E1 (NHA), stated that R106 does not use the bed rails for bed mobility. E1 confirmed the absence of padding on the bed rails.<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 700 | | |
| F 712 SS=E | Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4)<br><br>§483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter.<br><br>§483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.<br><br>§483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally.<br><br>§483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may | F 712 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 712 | Continued From page 35<br>alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for three (R29, R43 and R99) out of six residents reviewed for physician services, the facility failed to ensure each resident was seen for the required physician visits. Findings include:<br><br>1. R29's clinical record revealed:<br><br>5/19/23 - R29 was admitted to the facility.<br><br>5/25/23 - R29 was seen by E4 (Physician) for the initial comprehensive visit.<br><br>Review of R29's physician visits revealed that the resident was seen on 7/26/23 by E5 (NP) and the next documented visit was on 11/8/23 by E5 (NP), approximately 104 days later. The nineth day visit was missed.<br><br>1/29/24 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), E4 stated that they are catching up on their visits and that going forward they are going to keep a log to ensure that the required visits are completed.<br><br>2. R43's clinical record revealed:<br><br>1/5/18 - R43 was admitted to the facility.<br><br>12/14/22 at 4:28 PM - A progress note documented that R43 was seen by E17 (Physician) for a routine visit. This was the last | F 712 | Step 1: R29, R43 and R99 were seen by physician.<br>Step 2: All residents have the potential to be affected. The DON/designee reviewed all residents to ensure resident has been seen by a physician per regulation. Issues that were identified were addressed.<br>Step 3: RCA: Physician not alternating visits with NP.<br>To prevent the potential for reoccurrence NHA/designee educated the Physician and NP□s on regulations and the need to be in compliance with regulation.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly check 2 residents 1 time month for 3 months to ensure has been seen by a physician and visits are in compliance with the regulations. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 712 | Continued From page 36<br>documented Physician visit until 11/3/23, approximately 324 days later.<br><br>3/15/23 to 3/20/23 - R43 was hospitalized for COPD exacerbation and urinary tract infection.<br><br>Review of R43's clinical record lacked documented evidence that he was seen by the physician for a comprehensive visit upon readmission to the facility on 3/20/23.<br><br>While R43 was seen and evaluated by E5 (NP) on 5/22/23, 6/14/23, 8/9/23 and 10/4/23, he was not seen by a Physician on every 120 days.<br><br>10/23/23 to 10/31/23 - R43 was hospitalized for pulmonary embolism. R43 was seen by E4 (Physician) on 11/3/23 upon his readmission to the facility.<br><br>1/29/24 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), E4 stated that they are catching up on their visits and that going forward they are going to keep a log to ensure that the required visits are completed.<br><br>3. R99's clinical record revealed:<br><br>2/11/22 - R99 was admitted to the facility.<br><br>6/23/23 at 8:43 AM - A progress note documented that R99 was seen by E5 (NP) for follow-up of mood and Parkinson's. This note was the last time R99 was seen for the required visits until 12/11/23 by E4 (Physician), approximately 170 days later. R99 missed two 60 day visits: one in August 2023 and one in October 2023.<br><br>1/29/24 at 12:01 PM - During an interview with E4 | F 712 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 712 | Continued From page 37<br>(Physician), E5 (NP) and E1 (NHA), E4 stated that they are catching up on their visits and that going forward they are going to keep a log to ensure that the required visits are completed.<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 712 | | |
| F 730 SS=E | Nurse Aide Peform Review-12 hr/yr In-Service<br>CFR(s): 483.35(d)(7)<br><br>§483.35(d)(7) Regular in-service education.<br>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview it was determined that for five (E19, E22, E23, E24 and E25) out of five CNAs (certified nurse's aides) reviewed, the facility failed to provide proof of annual performance reviews. Findings included:<br><br>1. E19 was hired on 6/27/22. The facility lacked evidence of a yearly performance evaluation.<br><br>2. E22 was hired on 8/1/22. The facility lacked evidence of a yearly performance evaluation.<br><br>3. E23 was hired on 7/12/22. The facility lacked evidence of a yearly performance evaluation.<br><br>4. E24 was hired on 8/1/18. The facility lacked evidence of a yearly performance evaluation.<br><br>5. E25 was hired on 8/3/22. The facility lacked | F 730 | Step 1: E19, E22, E23, E24 and E25 evaluations completed.<br>Step 2: All C.NA have to potential to be affected. The NHA/designee reviewed all C/NAs file for evaluations. Issues that were identified were addressed.<br>Step 3: RCA: Clinical team not consistently doing C.NA evaluations.<br>To prevent the potential for reoccurrence NHA/designee educated Clinical management team on consistent preforming C.NA evaluations. Reminders in the payroll system will be set so C.NAs evaluations will be completed near or on hire Month.<br>Step 4: To monitor and maintain on-going compliance the NHA and/or designee will randomly check 2 employee files monthly for 6 months to ensure C.NA□s | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 730 | Continued From page 38<br>evidence of a yearly performance evaluation.<br><br>1/26/24 3:45 PM - During an interview, E1 (NHA) and E2 (DON) confirmed the findings.<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 730 | evaluations have been completed. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |
| F 755 SS=D | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and | F 755 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 39<br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined for one (R274) out of five sampled residents for pain the facility failed to provide routine pharmaceutical services for acquiring and receiving medication. Findings include:<br><br>Review of R274's clinical record revealed:<br><br>10/30/21 - R274 was admitted to the facility with a diagnoses of cervical disc degeneration, wedge compression fracture of thoracic vertebra, and chronic low back pain.<br><br>12/18/21 - An updated physician order was written for hydromorphone (narcotic pain medication) 2 mg give one tablet every eight hours as needed for severe pain.<br><br>12/30/21 6:33 PM - A shipment detail form confirmed delivery of hydromorphone (15 tablets) by pharmacy to the facility.<br><br>1/5/22 10:20 PM - A controlled substance log revealed that R274 received a dose of hydromorphone and the count resulted of zero of quantity.<br><br>1/6/22 9:45 AM - A progress note revealed that R274 was out of hydromorphone 2 mg. E9 (LPN) notified pharmacy that medication was not available and requested to remove medication from the back up. The progress note revealed that the hydromorphone in the back up was expired. The pharmacy was to deliver medication | F 755 | Step 1: R274 unable to correct resident is discharged and occurrence happened in 2021.<br>Step 2: All residents receiving pain medication have the potential to be affected. The DON/designee reviewed medication in Omnicell back up medication is not expired. Issues that were identified were addressed.<br>Step 3: RCA: Medication in Omnicell was expired.<br>To prevent the potential for reoccurrence DON/designee educated all nurses with steps to ensure residents receive medication. Complaint verbally made at time of issue with pharmacy and addressed immediately. Omnicare reviews Omnicell on a monthly bases and reviews expiration dates of medication.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly check Omnicell 1 time weekly for 3 months to ensure medication is current. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 755 | Continued From page 40<br>during the evening delivery.<br><br>1/6/22 6:35 PM - A shipment detail form confirmed delivery of hydromorphone (15 tablets) by pharmacy to the facility.<br><br>1/11/22 6:06 PM - A controlled substance log revealed that R274 received a dose of hydromorphone and the count resulted of zero of quantity.<br><br>1/13/22 11:04 AM - A shipment detail form confirmed delivery of hydromorphone (15 tablets) by pharmacy to the facility.<br><br>1/26/24 9:30 AM - An interview with E8 (Pharmacist) confirmed the pharmacy delivered the medications on 12/30/21, 1/6/22, and 1/13/22. E8 also confirmed the hydromorphone was expired in the back up pharmacy and was replaced on 1/19/22.<br><br>1/26/24 12:31 PM - An interview with E9 (LPN) confirmed R274 did not have hydromorphone available from 1/5/22 10:30 PM utill 1/6/22 6:30 PM.<br><br>2/1/24 3:05 PM - An interview with E2 (DON) confirmed the hydromorphone was unavailable from 1/11/22 through 1/13/22.<br><br>The facility failed to order and receive a medication to meet resident's needs.<br><br>2/1/24 3:40 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 755 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) | F 758 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 758 | Continued From page 41<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended | F 758 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 758 | Continued From page 42<br>beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined that for two (R54, R98) out of five residents (R2, R43, R54, R98, R106) reviewed for unnecessary medications, the facility failed to ensure that R54's PRN for Lorazepam Gel 1 mg for anxiety was limited to 14 days, and R98's PRN order for Alprazolam 1 mg for anxiety was limited to 14 days. Findings include:<br><br>1. 11/20/23 - R54 was admitted to the facility with diagnosis including muscle weakness, dementia, and major mood disorder.<br><br>12/22/23 - R54's physician's orders included, "lorazepam gel, apply to skin topically every twelve (12) hours as needed for agitation".<br><br>1/18/24 - A review of R54's physician's orders revealed that the PRN order for lorazepam gel was still active for a total of twenty-seven (27) days.<br><br>1/22/24 8:30 AM - During an interview E2 (DON), confirmed that R54's clinical record lacked the fourteen (14) days stop date for the use of the PRN antianxiety medication. | F 758 | Step 1: Stop dates obtained for resident R54 and R98s PRN Anxiety medication.<br>Step 2: All residents□ anxiety medication have the potential to be affected. The DON/designee reviewed all residents for prn anxiety medication stop dates. Issues that were identified were addressed.<br>Step 3: RCA: Clinical staff did not obtain 14 day stop date for use for prn anxiety medication.<br>To prevent the potential for reoccurrence DON/designee educated all nurses/ providers related PRN stop dates for anxiety medication.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly check 2 residents 1 time weekly for 3 months to ensure resident prn anxiety medication has a 14 day stop date. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 758 | Continued From page 43<br>2. 12/22/23 - R98 was admitted to the facility with diagnoses including anxiety disorder and depression.<br><br>12/26/23 - R98's physician's orders included, "alprazolam, give one (1) milligram tablet by mouth every twenty-four hours as needed for anxiety".<br><br>1/18/24 11:30 AM - A review of R98's physician's orders revealed that the PRN order for alprazolam one (1) milligram tablet was still active for a total of twenty-three (23) days.<br><br>1/22/24 8:30 AM - During an interview E2 (DON), confirmed that R98's physician's orders lacked the fourteen (14) days stop date for the use of the PRN antianxiety medication.<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 758 | | |
| F 761 SS=E | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized | F 761 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 761 | Continued From page 44<br>personnel to have access to the keys.<br><br>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, it was determined that the facility failed to ensure that the start dates were documented when over the counter medications (bottles) were opened in four out of four medication carts reviewed during medication administration.<br><br>1/22/24 8:25 AM - During the medication administration observations, this surveyor observed multiple opened bottles of over-the-counter medications in the medication drawers. The bottles lacked the dates when they were opened. During an interview, E56 (LPN) stated, "I did not know we had to put start dates on the medications".<br><br>1/23/24 11:30 AM - During a phone interview E53 (pharmacist) stated, "I reviewed the medications carts this month, and gave the report to the administration to take care of." A review of E53's report revealed documentation of medications without start dates on all four medication carts.<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 761 | Step 1: OTC bottles dated with open dates.<br>Step 2: The DON/designee reviewed all medication carts to ensure OTC bottles are dated. Issues that were identified were addressed.<br>Step 3: RCA: Clinical staff not aware of regulation of dating medication when open.<br>To prevent the potential for reoccurrence DON/designee educated all nurses Dating medication when opened.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly check 1 medication cart 1 time a week for 3 months to ensure medication is dated when opened. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 SS=E | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.<br><br>§483.70(i) Medical records.<br>§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-<br>(i) Complete;<br>(ii) Accurately documented;<br>(iii) Readily accessible; and<br>(iv) Systematically organized<br><br>§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-<br>(i) To the individual, or their resident representative where permitted by applicable law;<br>(ii) Required by Law;<br>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;<br>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted | F 842 | | 3/1/24 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 46<br>by and in compliance with 45 CFR 164.512.<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, it was determined that for eight (R25, R29, R31, R50, R56, R99, R123 and R276) out of thirty (30) residents clinical records reviewed, the facility failed to ensure that each residents' record was complete, accurately documented and readily accessible. Findings include:<br><br>1. R25's clinical record revealed:<br><br>8/21/23 at 11:20 AM - E4 (Physician) documented | F 842 | Step 1: R25, R29, R31, R50, R56, and R99 notes uploaded from Physicians EMR to centers records, R123, and R276 have been discharged unable to correct.<br>Step 2: All current residents have the potential to be affected. The DON/designee reviewed all residents□ medical record to ensure resident has been seen by a physician per regulations. Issues that were identified were addressed. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 47<br>in a note, "Patient seen and examined. Progress note to follow."<br><br>As of 1/29/24, R25's clinical record lacked documented evidence of E4's 8/21/23 Physician completed progress note.<br><br>1/29/21 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record.<br><br>2. R29's clinical record revealed:<br><br>12/8/23 at 11:14 AM - E4 (Physician) documented in a note, "Patient seen and examined. Progress note to follow."<br><br>As of 1/29/24, R29's clinical record lacked documented evidence of E4's 12/8/23 Physician progress note.<br><br>1/29/21 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record.<br><br>3. R31's clinical record revealed:<br><br>11/3/23 at 9:53 AM - E4 (Physician) documented in a note, "Patient seen and examined. Progress note to follow."<br><br>Despite this note in R31's clinical record, review by the Surveyor on 1/29/24 revealed that R31's clinical record lacked documented evidence of R31's initial comprehensive note dated 11/3/23.<br><br>1/29/21 at 12:01 PM - During an interview with E4 | F 842 | Step 3: RCA: Physician documentation not present in centers medical records. To prevent the potential for reoccurrence NHA/designee educated physician and extenders on the need to ensure their documentation is in centers record. Physician/extender notes checked during clinical meeting.<br>Step 4: To monitor and maintain on-going compliance the DON and/or designee will randomly check 2 residents 1 time weekly for 3 months to ensure physician/extenders notes are in medical record. Where necessary, corrections will be made, and the responsible party re-educated. The results will be presented to the facility QAPI committee for continued review and revision. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 48<br>(Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record.<br><br>4. R50's clinical record revealed:<br><br>1a. On the following dates/times, E4 (Physician) documented in R50's clinical notes, "Patient seen and examined. Progress note to follow."<br>- 4/18/23 at 10:42 AM;<br>- 7/24/23 at 1:34 PM.<br><br>As of 1/29/24, R50's clinical record lacked documented evidence of both E4's 4/18/23 and 7/24/23 Physician progress notes.<br><br>1b. 8/3/23 - R50's physician orders by E4 (Physician) documented to discontinue INR (lab) check twice a week; and start INR check once a week.<br><br>Review of R50's progress notes revealed that E5 (NP) documented to continue INR checks twice a week in three progress notes: 8/9/23, 9/22/23 and 11/27/23; and E4 (Physician) documented to continue INR checks twice a week in the 12/22/23 progress note.<br><br>1/29/21 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record.<br><br>5. R56's clinical record revealed:<br><br>On the following dates/time, E4 (Physician) documented in the clinical notes, "Patient seen and examined. Progress note to follow."<br>- 10/19/23 at 10:49 AM; | F 842 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 49<br>- 12/2/23 at 11:30 AM.<br><br>As of 1/29/24, R56's clinical record lacked documented evidence of both E4's 10/19/23 and 12/2/23 Physician's progress notes.<br><br>1/29/21 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record.<br><br>6. R99's clinical record revealed:<br><br>6/5/23 at 2:03 PM - E4 (Physician) documented in a note, "Patient seen and examined. Progress note to follow."<br><br>As of 1/29/24, R99's clinical record lacked documented evidence of E4's 6/5/23 Physician progress note.<br><br>1/29/21 at 12:01 PM - During an interview with E4 (Physician), E5 (NP) and E1 (NHA), findings were reviewed regarding the incomplete and inaccurate clinical record.<br>7. Review of R276 clincal record revealed:<br><br>6/2/23 - R276 was admitted to the facility.<br><br>6/2/23 9:31 PM - An evalutation for continence and retraining schedule was completed for R276 indicating the need for a bowel and bladder diary to be completed.<br><br>8/29/23 3:36 PM - An evaluation for continence and retraining schedule was initiated for R276 with no outcome or score noted.<br><br>1/29/24 11:35 AM - An interview with E10 (RN) | F 842 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 50<br>confirmed the evaluation was incomplete and inaccurate.<br><br>8. R123's clinical record revealed:<br><br>10/31/23 - R123 was admitted to the facility with diagnoses including, but not limited to, stroke and diabetes.<br><br>11/1/23 - E4 (MD) ordered "Rivaroxaban (anti-coagulation medicine) 2.5 mg (milligrams)- give 1 tablet by mouth two times a day for DVT (deep vein thrombosis) and Plavix (platelet aggregate inhibitor) oral tablet 75 mg- give 1 tablet by mouth one time a day for ischemic stroke."<br><br>11/19/23 5:00 AM - Incident report documented that R123 was found "sitting on the floor with both feet resting on the bed and back against the wall and that he was getting stuff from his wheelchair. Resident was assessed for injury, none noted ... Neuro check initiated ...".<br><br>Due to a low blood sugar and the inability to effectively correct the blood sugar, R123 was transferred to the hospital at approximately 7:36 AM on 11/19/23.<br><br>11/19/23 7:36 AM - R123's Change in Condition evaluation stated that R123 was not on coumadin. In response to the statement, "Resident/patient is on other anticoagulant (direct thrombin inhibitor or platelet inhibitor)", the staff responded "No".<br><br>At the time, R123 was on both rivaroxaban and clopidogrel, a platelet aggregate inhibitor medicine. | F 842 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 085039 | A. BUILDING _____ B. WING _____ | C 02/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| NEW CASTLE HEALTH AND REHABILITATION CENTER | 32 BUENA VISTA DRIVE NEW CASTLE, DE 19720 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 51<br><br>1/29/24 2:37 PM - Findings were reviewed E1 (NHA) and E2 (DON). | F 842 | | |