STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085035	A. BUILDING _____ B. WING _____	C 07/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD SMYRNA, DE 19977

(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	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from July 22, 2019 through July 24, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 101. The survey sample totaled three residents. Abbreviations/Definitions used in this report are as follows: DON - Director of Nursing; DHCQ - Division of Health Care Quality; eMAR - (electronic Medication Administration Record) - a record of medication orders and dates and times administered; NHA - Nursing Home Administrator; QAA - Quality Assurance Administrator; RN - registered nurse; UM - Unit Manager.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve	F 609		8/23/19

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

Electronically Signed | 08/07/2019

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.

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F 609	Continued From page 1 abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documents it was determined that for one (R1) out of three residents sampled for allegations of staff to resident abuse, the facility failed to immediately report an allegation of verbal/emotional abuse to the state survey agency. Findings include: The facility policy titled "Protection from Abuse and Responding to Reportable Incidents" dated 8/8/18, indicated notification shall be issued by the Facility Director or designee "to all required entities...not later than two (2) hours after...receiving notification" of the incident. Review of facility documentation revealed the following: 6/25/19 - A memo prepared by E4 (RN, UM) revealed that at approximately 8:30 AM the same morning E4 received a phone call from a family member of R1. The family member reported an	F 609	A. Individual/Resident Impacted The facility failed to immediately report an allegation of verbal/emotional abuse to the state survey agency for one (R1) out of three residents sampled for allegations of staff to resident abuse. This is an isolated incident and not a facility practice. R1 was not negatively impacted as a result of the cited deficient practice. A thorough investigation of the allegation of verbal/emotional abuse involving R1 was conducted by Quality Assurance on 6/25/19; and, it was determined that the allegation could not be verified or substantiated. However, there was no evidence that the allegation of verbal/emotional abuse was reported to the state survey agency within two hours. The Protection from Abuse and Responding to Reportable Incidents Policy was updated to include clarification	

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F 609	Continued From page 2 observation made on 6/24/19 of E5 (RN) "in [R1's] face screaming." 6/28/19 3:44 PM - The above named incident was reported to DHCQ by E3 (QAA). 7/25/19 1:00 PM - During an interview, E1(NHA) and E3 (QAA) revealed that although there was a delay in reporting to the state survey agency, there was not a delay in internal investigation. The delay in reporting to the state agency was due to lack of sufficient evidence for substantiating the allegation. There was no evidence that the allegation of verbal/emotional abuse was reported to the state survey agency within two hours. Findings were reviewed and confirmed with E1 (NHA), E2 (DON), and E3 (QAA) on 7/25/19 at 1:00 PM.	F 609	of our time frame for reporting allegations of abuse to the state survey agency as of 8/6/19. (Attachment 1) B. Identification of other residents All residents in the facility have the potential to be affected by this deficient practice in which the facility failed to report an allegation of verbal/emotional abuse to the state survey agency. The Nursing Home Administrator on 08/07/19 completed refresher training (Attachment 3) for all Nursing Supervisors on immediate reporting of all alleged violations involving abuse, neglect, exploitation, and mistreatment, including injuries of unknown source and misappropriation of resident property, to the State Survey Agency. Appropriate corrective actions will be taken for Nursing Supervisors who fail to report the alleged violations as required by the facility's incident reporting policies and procedures. C. System Changes The root cause of this deficient practice is a failure to validate the requirements relative to reporting and responding to allegations of verbal/emotional abuse. All Nursing Supervisors have completed refresher training (Attachment 3) on 08/07/19 to report all allegations to the state survey agency no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the	

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F 609	Continued From page 3	F 609	allegation do not involve abuse and do not result in serious bodily injury. The Nursing Home Administrator, Director of Nursing, QA Administrator, and/or designees will be notified directly of all alleged violations involving abuse, neglect, exploitation, and mistreatment. They will ensure that the reporting requirements were met within the 2-hour time frame. In addition, all staff will be re-educated on the updated Protection from Abuse and Responding to Reportable Incidents Policy by the Trainer Administrator II no later than 8/23/19. D. Success Evaluation The Nursing Home Administrator and QA Administrator and/or designees will review, monitor, (Attachment 2) and discuss all incident reports and resident concerns within 72 hours upon receipt for 100% accuracy and timely reporting for 10 weeks and then monthly for 3 consecutive months. The results will be discussed at the monthly QAPI committee meetings and reported at the quarterly QAPI Steering Committee meetings. When the facility reaches 100% compliance for 3 consecutive months, then the facility will conclude that they have successfully addressed the deficient practice	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 610		8/23/19

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F 610	Continued From page 4 §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation it was determined that the facility failed to prevent further potential abuse while an investigation was in progress for one (R1) out of three residents reviewed for allegations of staff to resident abuse. Findings include: Review of facility documentaion revealed: 6/25/19 8:30 AM - A memo prepared by E4 (RN, UM) revealed that E4 received a phone call from a family member of R1. The family member reported an observation made on 6/24/19 of E5 (RN) "in [R1's] face screaming." 6/25/19 10:08 AM - E4 (RN, UM) documented a progress note about the above mentioned phone call. 6/25/19 6:09 PM - 6/26/19 1:00 AM - The facility's eMAR indicates that E5 (RN) administered PM and evening medications and monitoring to R1.	F 610	A. Individual/Resident Impacted The facility failed to prevent further potential abuse while an investigation was in progress for one (R1) out of three residents reviewed for allegations of staff to resident abuse. R1 was not negatively impacted as a result of the cited deficient practice. A thorough investigation of the allegation of verbal/emotional abuse involving R1 was conducted by Quality Assurance on 6/25/19; and, it was determined that the allegation could not be verified or substantiated. However, there was no evidence that R1 was protected from further potential abuse while the facility conducted an internal investigation. The Protection from Abuse and Responding to Reportable Incidents Policy was updated on 8/6/19 to include proper procedures on preventing further potential abuse which includes the process of reassigning any staff accused	

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F 610	Continued From page 5 6/25/19 11:00 PM - An Employee Interview Statement was completed by E5 (RN) . 6/28/19 3:44 PM - E3 (QAA) reported the incident to DHCQ and indicated that "the accused" was "immediately reassigned...pending further investigation." At the same time, it is reported that "findings were found to be inconclusive." 7/25/19 at 1:00 PM - E1 (NHA) revealed that it is difficult for the facility to reassign staff during each investigation of alleged abuse. There was no evidence that R1 was protected from further potential abuse while the facility conducted an internal investigation. Findings were reviewed and confirmed with E1 (NHA), E2 (DON), and E3 (QAA) on 7/25/19 at 1:00 PM.	F 610	of abuse, neglect, exploitation, or mistreatment until investigation is concluded. B. Identification of other residents All residents in the facility have the potential to be affected by this deficient practice in which the facility failed to prevent further potential abuse while an investigation was in progress. The facility has completed on 08/07/19 refresher training (Attachment 3) by the Nursing Home Administrator for all Nursing Supervisors on proper procedures to prevent further potential abuse during the investigation process. Appropriate corrective actions will be taken for Nursing Supervisors who fail to follow the proper processes as required by the facility's incident reporting policies and procedures. C. System Changes The root cause of this deficient practice was the facility 's failure to follow our established procedure to prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation was in progress. All Nursing Supervisors have completed on 08/07/19 refresher training (Attachment 3) on the proper procedures of reassigning staff who are involved in allegations of abuse, neglect, exploitation, or mistreatment upon notification of the allegations. The Nursing Home Administrator, Director of Nursing, QA Administrator, and/or designees will be notified immediately of staff	

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F 610	Continued From page 6	F 610	reassignments out of patient care for staff who have been accused of abuse. In addition, all staff will be re-educated on the updated Protection from Abuse and Responding to Reportable Incidents Policy by the Trainer Administrator II no later than 8/23/19. D. Success Evaluation The Nursing Home Administrator and QA Administrator and/or designees will review, monitor, (Attachment 2) and discuss all incident reports and resident concerns within 72 hours of receipt to ensure resident safety and 100% compliance of staff reassignment as necessary for 10 weeks and then monthly for 3 consecutive months. The results will be discussed at the monthly QAPI committee meetings and reported at the quarterly QAPI Steering Committee meetings. When the facility reaches 100% compliance for 3 consecutive months, then the facility will conclude that they have successfully addressed the deficient practice.	

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

DHSS - DHCQ
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Hospital F/t Chronically Ill (dhci) **DATE SURVEY COMPLETED: July 24, 2019**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201 3201.1.0 3201.1.2	**The State Report incorporates by reference and also cites the findings specified in the Federal Report.** An unannounced complaint survey was conducted at this facility from July 22, 2019 through July 24, 2019. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 101. The survey sample totaled three residents. **Regulations for Skilled and Intermediate Care Facilities** **Scope** **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.** This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed July 24, 2019: F609, and F610.	3201.1.2 Cross Refer to the CMS 2567-L survey completed July 24, 2019: F609, and F610.	08/23/19

H1-0000973
LNHA

Provider's Signature _____ Title Nursing Home Administrator Date 08/06/2019

08/02/19