STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085051	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Delaware Veterans Home	100 Delaware Veterans Blvd Milford, DE 19963

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that for one (R47) out of two residents reviewed for hospitalization, the facility lacked evidence that R47 was allowed to return timely to the facility. 11/26/24 - R47 was admitted to the facility. 12/6/24 - R47 was admitted to the hospital for altered mental status and for a psychiatric evaluation. The admission history and physical also reflected that R47 had recently been diagnosed with a urinary tract infection. 12/8/24 - A hospital progress note revealed Barriers: Patient is medically cleared for discharge. VA home is not taking patient on weekends . 12/9/24 - A discharge summary revealed that His mental status has improved, he has been pleasantly confused during the hospital stay, which appears to be his baseline. He is medically stable for discharge. 12/10/24 - A daily medical progress report revealed Barriers to discharge: medically cleared. Discharge disposition: placement issues. 12/12/24 - A daily progress report revealed Disposition hospital issue: Patient was already discharged by prior provider, but VA home refused to take him. They think he needs to go to inpatient psych or memory unit . If they think he needs to go to memory unit then he can go back to the same VA then they can start the process. Psych recommended no need for inpatient psych. 12/13/24 - R47's discharge instructions revealed Disposition hospital issue: Patient was already discharged by prior provider, but VA home refused to take him. They think he needs to go to inpatient psych or memory unit . If they think he needs to go to memory unit then he can go back to the same VA then they can start the process. Psych recommended no need for inpatient psych. 12/13/24 - R47 returned to the facility. 3/5/25 1:20 PM - In an interview, E2 stated that the facility wanted to send R47 to a specific behavioral health facility, but R47 was declined due to needing assistance with activities of daily living. E2 stated that the facility would not have refused R47 re-entry back to the facility but acknowledged that there concerns about the safety of the resident and staff due to his behaviors. E2 further stated that residents can return on the weekend although they prefer that they return during the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	week because leadership is also in the facility. E2 stated they would not refuse a resident to return. 3/6/25 12:33 PM - In an interview, E1 (NHA) and E2 stated they were not aware of any reason that R47 should not have returned to the facility on [DATE], which was a Monday. Both noted that they do not refuse weekend readmissions. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, it was determined that for five (R1, R11, R64 and R66) out of nineteen sampled residents, the facility failed to have input from all required interdisciplinary team (IDT) members at the residents' care plan meetings. Findings include: 1. 2/11/08 - R1 was admitted to the facility. 1/15/25 - A quarterly MDS was completed. 1/28/25 - A quarterly care plan meeting note lacked evidence of input from the physician. 10/16/24 - A quarterly MDS was completed. 10/29/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 7/17/24 - An annual MDS was completed. 7/30/24 - An annual care plan meeting note lacked evidence of input from the physician. 2. 6/11/24 - R11 was admitted to the facility. 6/17/24 - An admission MDS was completed. 7/9/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 9/11/24 - A quarterly MDS was completed. 9/24/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 12/11/24 - A quarterly MDS was completed. 12/26/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 3. 6/6/24 - R64 was admitted to the facility. 6/12/24 - An admission MDS was completed. 9/11/24 - A significant change MDS was completed. 9/24/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 12/11/24 - A quarterly MDS was completed. 12/26/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 4. 8/1/24 - R66 was admitted to the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/7/24 - An admissions MDS was completed. 11/16/24 - A significant change MDS was completed. 11/19/24 - A quarterly care plan meeting note lacked evidence of input from the physician. 2/5/25 - A significant change MDS was completed. 2/18/25 - A quarterly care plan meeting note lacked evidence of input from the physician. 3/5/25 1:20 PM - In an interview, E2 (DON) stated that while the charting system does not reflect that providers have direct input in the care plan meetings, all residents are seen and assessed by them on a consistent basis. E2 stated that he will ensure that the process is revised to include input from the provider specifically at the time of the care plan meeting. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 2. Review of R9's clinical record revealed: 1/16/24 - R9 was admitted to the facility. 12/18/24 6:43 PM - A nursing progress note documented that R9 had contacted 911 services due to having hallucinations. Due to the resident having a history of the behaviors, a note was left in the physician communication log and R9 had continued to be monitored. 12/19/24 9:30 AM - A physician's order was written for a urinalysis with a culture and sensitivity to be collected on 12/20/24. 12/20/24 - A urine sample was collected and sent to the lab for analysis and culture. 12/20/24 - A provider note by E13 (NP) documented, . Was asked to see patient [R9] today due to complaints of intermittent hallucinations unit manager reports patient having intermittent visual hallucinations. Today's urinalysis results showed 2+protein and trace of leukocytes . Urinalysis review. Will await urine culture and sensitivity . 12/23/24 12:26 PM - The lab results revealed the urine culture was positive for a urinary tract infection with a positive growth of greater than 100,000 colony forming units of Serratia Marcescens (a type of bacteria). 12/23/24, 12/24/24 and 12/25/24 - The clinical record lacked evidence that R9's UTI was addressed. 12/26/24 1:28 PM - A progress note by E14 (RN) documented, Provider onsite and reviewed UA C&S results. New order for gentamicin 40mg/ml - administer 7 mls BID x 5 days for UTI. Probiotic to be ordered BID for 10 days. 12/26/24 1:35 PM - A physician's order was written for gentamicin sulfate (antibiotic) 40mg/mL, inject 3.5 mL in the muscle two times a day for urinary tract infection for 5 days. There was a delay of two days before the urine results were reviewed and R9 received antibiotics. 3/4/25 2:20 PM - An interview with E15 (RN) stated that if the unit manager is working, they will keep track of results for labs. Otherwise, the supervisor will be available to keep track of lab results. If a lab result is critical, the result can be called to the on-call provider if a provider is not present. 3/4/25 2:29 PM - An interview with E14 stated that lab results automatically populate in the resident's chart. E14 stated that positive results also get faxed to the facility where the fax is monitored each shift for any results. E14 stated, If there was a positive urinary culture result, we try to let the provider know immediately so the medication can be ordered for the resident since the provider does not order anything until the culture results are completed. 3. Review of R35's clinical record revealed: 8/17/22 - R35 was admitted to the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	4/30/24 - A physician's order for lisinopril 10 mg give one tablet by mouth one time a day for hypertension (high blood pressure). Hold for systolic blood pressure less than 100 and hold if heart rate is less than 60. 7/10/24 - The July MAR documented R35 had a blood pressure listed 120/77 and heart rate of 56 and a signature indicating lisinopril medication was administered. 7/1/24 - 7/23/24 - A pharmacist's medication regimen review documented that for R35, recommendation to the facility: [R35] is receiving lisinopril 10mg with parameters to hold is systolic blood pressure (SBP) is less than 100 or heart rate (HR) less than 60 and was the medication was given (per MAR). 9/20/24 - A physician's order for lisinopril 10 mg give 0.5 tablet by mouth one time a day for hypertension (high blood pressure). Hold for systolic blood pressure less than 100 and hold if heart rate is less than 60. 12/27/24 - The December MAR documented R35 had a blood pressure listed 114/75 and heart rate of 55 and a signature indicating lisinopril medication was administered. 1/1/25 - 1/13/25 - A pharmacist's medication regimen review documented that for R35, recommendation to the facility: [R35] is receiving lisinopril 10mg with parameters to hold is systolic blood pressure (SBP) is less than 100 or heart rate (HR) less than 60 and was the medication was given (per MAR). 3/6/25 10:30 AM - An interview with E18 (RN) confirmed that if a resident has vitals outside the parameters medication should be held and notification to the provider if an ongoing pattern. E18 confirmed that R35 received the lisinopril on 12/27/24 per the MAR. 4. Review of R41's clinical record revealed: 3/3/22 - R41 was admitted to the facility. 12/4/24 - A physician's order for cozaar 25 mg give 50 mg tablet by mouth one time a day for hypertension (high blood pressure). Hold for systolic blood pressure less than 120. 12/5/24- The December MAR documented R41 had a blood pressure of 119/68 and a signature indicating cozaar medication was administered. 12/9/24 - The December MAR documented R41 had a blood pressure of 110/70 and a signature indicating cozaar medication was administered. 12/14/24 - The December MAR documented R41 had a blood pressure of 112/76 and a signature indicating cozaar medication was administered. 12/15/24 - The December MAR documented R41 had a blood pressure of 116/83 and a signature indicating cozaar medication was administered. 12/1/24 - 12/19/24 - A pharmacist's medication regimen review documented that for R41, the pharmacist recommendation to the facility: [R41] is receiving cozaar with parameters to hold is systolic (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	blood pressure (SBP) is less than 120. On 12/5, 12/9, 12/14, and 12/15 SBP was less than 120 and the medication was given (per MAR). 3/6/25 10:30 AM - An interview with E18 (RN) confirmed that if a resident has vitals outside the parameters medication should be held and notification to the provider if an ongoing pattern. E18 confirmed that R41 received the lisinopril on the aforementioned dates per the MAR. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON). Based on record review and interview, it was determined that for four (R422, R9, R35 and R41) out of four residents reviewed for quality of care, the facility failed to ensure care/treatment in accordance with professional standards of practice. For R422 the facility failed to provide treatment for a urinary tract infection for four days causing a change in condition that required a transfer to the hospital. This delay in care resulted in harm to R422. For R9, the facility failed to provide treatment for a urinary tract infection for two days. For R35 and R41, the facility failed to follow a doctor's order. Findings include: Cross Refer F773 1. Review of R422's clinical record revealed: 5/23/24 - R422 was admitted to the facility with a history of a stroke affecting his right dominant side, Parkinson's disease and dementia. 6/13/24 - A nursing progress note documented that E16 (MD) was notified that R422 was getting confused, disoriented and drowsy. 6/13/24 - A physician's order was written by E16 for a urinalysis and urine culture. 6/14/24 - A nursing progress note documented the urine sample was collected and sent to the lab for analysis and culture. 6/16/24 - A review of the lab results revealed a urine culture with a positive growth of enterococcus casseliflavous greater than 100,000 CFU /ml, indicating R422 had a urinary tract infection. 6/16/24 - The clinical record lacked evidence that R422's positive urine culture was treated. 6/17/24 and 6/18/24 - The clinical record lacked evidence that the UTI was being addressed. 6/19/25 3:30 PM - A change in condition evaluation performed by E23 (RN) documented, resident noted with increasing lethargy, altered mental status .increased lethargy. 6/19/24 4:50 PM - A physician progress note documented a change in condition: altered level of copiousness, increased confusion, disorientation, altered mental status .with increased lethargy, send patient to the ER (emergency room) for further evaluation and possible admission. 6/19/24 6:32 PM - Hospital records documented R422 was admitted with altered mental status. A urinalysis was positive for a large number of leucocytes and many bacteria. Awaiting urine culture and sensitivity. R422 was immediately treated with IV antibiotics. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	7/13/24 10:18 AM - Hospital records documented that R422 was treated for encephalopathy likely in the setting of a UTI. Upon admission, all tests performed ruled out a stroke and the principal diagnosis was a UTI. 7/8/24 - R422 was discharged from the hospital and chose not to return to the facility. 3/5/25 10:50 AM - During an interview, E2 (DON) stated that lab results are faxed to the nurse supervisor's office. If a lab result is critical and requires immediate attention, the nurse supervisor or the nurse who is assigned to the resident will call the on-call provider, if the provider is not present. 3/6/25 9:25 AM - During an interview, E16 confirmed that she was unaware of the critical lab value for R422 E16 stated that her NP would have been on-call that weekend. In addition, E16 confirmed there were no progress notes and no antibiotic orders for R422. E16 also confirmed she ordered the urine analysis and culture, but did not follow up on the results. 3/6/25 9:48 AM - During an interview via telephone E13 (NP) confirmed that she was not notified of R422's positive urinary tract infection results.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interviews and record review, it was determined that for one (R4) out of three residents reviewed for accidents, the facility failed to implement the correct assistant device to transfer the resident to prevent accidents. Based on review of the facility's evidence to correct the non-compliance and the facility's substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 12/20/24. Findings include: Review of R4's clinical record revealed: 7/11/23 - R4 was admitted to the facility. 11/20/23 - A new diagnoses for R4 included, but was not limited to, peripheral autonomic neuropathy, lack of coordination, generalized muscle weakness and unsteadiness on the feet. 10/16/24 - A care plan documented that R4 was high risk for falls related to impaired gait/balance. 11/15/24 - A new order documented R4 was a total assist for transfer and to be transferred with two staff using a Hoyer lift. 12/4/24 - R4's annual MDS documented a BIMS score of 15, revealing an intact cognitive state. R4 was documented with impairments on both sides for upper and lower extremities and was dependent on staff for transferring. 12/14/24 12:35 AM - A facility progress note by E6 (RN) documented, Resident in shower room getting ready for a shower. When lowering resident into shower chair resident started to sit himself down, even after staff (CNA and RN) repeatedly told him not to sit yet. Resident started slipping out of sling and he was gradually lowered to the ground. once resident was sitting on the ground, we repositioned the sling and was able to hoyer lift him into the chair. Resident had no c/o pain during or after the entire process. Resident and RN report no injuries . 12/16/24 10:46 AM - A facility incident report revealed that R4 had a witnessed fall while being transferred using a sit-to-stand transfer and the resident was a Hoyer lift for transferring. R4 slipped out of the sling and was lowered to the floor by the staff where no harm occurred to the resident. 3/4/25 9:53 AM - During an interview E6 stated that E7 (CNA) and her, were transferring R4 to a shower chair using the sit-to-stand transfer. E6 stated that R4 was already in a sling for a sit-to-stand transfer when she came to assist and did not stop to check if that was the correct mode of transfer for R4. When R4 was being lifted in the sit-to stand method, R4 was trying to sit and could not get his legs back up. E6 stated that they lowered him to the floor and assessed him and he had no injuries. 3/4/25 10:47 AM - During an interview E7 stated that they used a sit-to stand transfer of R4 to the shower chair. When R4 was lifted, he began to wiggle and then he was lowered to the floor. E7 stated R4 was supposed to be a Hoyer lift transfer and R4 did not have any injuries after the incident. 3/5/25 9:32 AM - During an interview E8 (DOT) stated R4 was changed from a sit-to-stand transfer to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a Hoyer lift because R4's participation would not allow him to do the sit-to-stand safely. E8 stated that R4 would not hold on and let go during the sit-to-stand causing him to be a safety risk. 3/6/25 9:05 AM - During an interview E9 (ADON) stated that after the incident re-education was completed that included: lift and transfer competencies, chain of command notification for resident refusals, how to access the transfer status of residents, how to access the Kardex for transfer status of residents, the appropriateness of providing more assistance. The facility audited the evaluations on the Hoyer lift for the residents. In addition, on-going audits are reviewed weekly. The facility created a subcommittee for falls where they are planning to implement additional appropriate signage such as stars for residents at risk. Based on the review of the facility's thorough investigation, documented response, completion of in-service training and audits, staff interviews and no further incidents related to injuries using a Hoyer lift, R4's accident was determined to be past non-compliance. The plan of correction was initiated on 12/14/24 and completed on 12/20/24. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. 2. Review of R9's clinical record revealed: 1/16/24 - R9 was admitted to the facility. 12/19/24 9:30 AM - A physician's order was written for a urinalysis with a culture and sensitivity to be collected on 12/20/24. 12/20/24 - A urine sample was collected and sent to the lab for analysis and culture. 12/23/24 12:26 PM - The lab results revealed the urine culture was positive for a urinary tract infection with a positive growth of greater than 100,000 colony forming units of Serratia Marcescens (a type of bacteria). 12/26/24 1:28 PM - A progress note by E14 (RN) documented, Provider onsite and reviewed UAC&S results. New order for gentamicin (antibiotic) 40mg/ml - administer 7 mls BID x 5 days for UTI. Probiotic to be ordered BID for 10 days. There was a delay of two days before the provider was notified and reviewed the urine results. 3/4/25 2:20 PM - An interview with E15 (RN) stated that if the unit manager is working, they will keep track of results for labs. Otherwise, the supervisor will be available to keep track of lab results. If a lab result is critical, the result can be called to the on-call provider if a provider is not present. 3/4/25 2:29 PM - An interview with E14 stated that lab results automatically populate in the resident's chart. E14 stated that positive results also get faxed to the facility where the fax is monitored each shift for any results. E14 stated, If there was a positive urinary culture result, we try to let the provider know immediately so the medication can be ordered for the resident since the provider does not order anything until the culture results are completed. 3/6/25 2:35 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2. Based on record review and interview, it was determined, for two (R442 and R9) out of three residents sampled for laboratory services, the facility failed to promptly notify the ordering medical practitioner of abnormal laboratory results. Findings include: Cross refer F684 1. Review of R422's clinical record revealed: 5/23/24 - R422 was admitted to the facility with diagnoses that included Parkinson's disease, history of a stroke affecting the right dominent side and dementia. 6/13/24 - A physician's order was written for a urinalysis with a culture and sensitivity. 6/16/24 - The results were faxed to the facility supervisor's office which revealed R422's urine (continued on next page)

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	culture had a positive growth of enterococcus casseliflavous (a type of bacteria) greater than 100,000 cfu/ml, indicating a urinary tract infection. 3/5/25 - A review of R422's clinical record revealed lacked evidence of the laboratory results and notification of provider. 3/5/25 10:34 AM - During an interview, E2 (DON) stated that all lab results are faxed to the nurse supervisor's office. If a lab result is positive the supervisor or the nurse assigned to the resident notifies the on-call provider if a provider is not present. 3/6/25 9:25 AM - During an interview, E16 (MD) confirmed that there was no evidence of provider notification, progress notes. E16 confirmed the lab results were positive and she was not notified.