STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. Building B. Wing	01/25/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Healthcare & Rehab Center	801 N. Broom Street Wilmington, DE 19806

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 44706 Based on interview and record review it was determined that for one (R3) out of three residents sampled for pressure ulcers the facility failed to complete an accurate MDS admission assessment. Findings include: Cross refer to F686 Review of R3's clinical record revealed: 10/2/20 - R3 was admitted to the facility. 10/2/20 - R3's skin assessment on admission documented one pressure ulcer to the thigh. R3's skin assessment failed to include a wound to the coccyx. 10/9/20 - The Admission MDS assessment documented that R3 had no pressure ulcers. 1/19/22 1:45 PM - During an interview, E6 (MDS Coordinator) confirmed that the admission MDS assessment was inaccurate and both the pressure ulcer to the thigh and to the coccyx were not identified. E6 stated that another nurse performed the skin evaluation, therefore she was unable to describe what the resident's skin looked like. Findings were reviewed during the exit conference via telephone on 1/25/22 at 1:45 PM with E1(NHA), E2 (DON) and E4 (Corporate RN).

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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40163 Based on record review, interview, and review of EMS (Emergency Medical Services) documentation, it was determined that for one (R1) out of three residents sampled for hospitalization , the facility failed to properly assess, monitor and provide respiratory interventions for a resident in respiratory distress. R1 was caused harm and further distress when he remained in respiratory distress without supplemental respiratory interventions (oxygen) until EMS implemented interventions upon arrival to the facility and was admitted to the hospital ICU in respiratory failure, intubated, and placed on a ventilator (a tube placed in the throat and put on a machine to breath). In addition, the facility failed to notify the practitioner of R1's refusal to have labs drawn (blood work). Findings include: Review of R1's clinical record revealed: 1a. [DATE] - R1 was admitted to the facility with a history of a brain tumor and stroke. [DATE] 10:53 PM - EMS (Emergency Medical Services) documentation included, Dispatcher received the call at 2253 (10:53 PM) for mentioned location (the facility where R1 resided). Caller advised they needed an ambulance for a patient with change in mental status, crackling lung sounds, elevated respirations, and he was not acting normal . [DATE] 10:57 PM - EMS documentation revealed that EMS was dispatched to the facility where R1 resided. [DATE] 11:00 PM - E5 (LPN) documented R1's vital signs were as follows: temperature 98.0 Fahrenheit; pulse 140 beats per minute; and oxygen saturation 92%. R1's clinical record lacked evidence that R1's blood pressure and respirations were obtained. (A normal range for an adult's pulse rate is ,d+[DATE] beats per minute. A normal range for respirations (breathing) is ,d+[DATE] breaths per minute at rest. A normal blood oxygen saturation is ,d+[DATE]%). [DATE] 11:04 PM - EMS' initial documentation of R1's vital signs were as follows: Blood pressure ,d+[DATE]; pulse 127 beats per minute; respirations labored at 58 breaths per minute; and oxygen saturation was 62% on room air (without supplemental oxygen). R1 had an abnormal heartbeat and was unresponsive. Although the facility documented R1's oxygen saturation as 92% on room air at 11:00 PM, that was significantly inconsistent four minutes later when EMS arrived at the facility and recorded an oxygen saturation of 62%. This was a 40% drop in oxygen saturation in four minutes. R1's was using accessory muscles, had bilateral decreased breath sounds and increased respiratory effort. [DATE] 11:08 PM - A nursing progress note documented, Resident noted during last rounds unconscious and abnormal breathing, heart rate 140, respiration 30, noted with SOB (shortness of breath)/distress. MD (doctor) notified; resident sent to ER (emergency room) for further evaluation. R1's clinical presentation was inconsistent with E5 (LPN)'s documentation that R1 had an oxygen saturation of 92%. Although the Practitioner was called, no order for oxygen use was requested for a resident in respiratory distress. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] (Untimed) - A narrative note composed by EMS documented, .found the patient lying in bed. No staff was present in the room at the time and no care was being rendered to the patient. Despite the patient presenting in severe respiratory distress, no O2 (oxygen) was being administered to the patient. Staff finally came into the room and advised that the patient was last known normal at 9:00 PM . [DATE] 11:51 PM - Hospital documentation included, .presenting to the emergency department today from his (R1's) nursing home via (by) medic (EMS) for respiratory distress. Patient was found at his nursing facility satting (pulse ox) in the 50's on room air (no oxygen) without any interventions being performed. He had shallow rapid breathing in the 60's per minute. They (EMS) initiated BVM (bag-valve-mask - mechanical breathing) and brought him in for evaluation.R1 was intubated (a breathing tube placed) and placed on a ventilator (a machine that breaths for you). R1 was diagnosed with respiratory failure due to COVID-19 and was admitted to the hospital in the intensive care unit. [DATE] 9:55 AM- During an interview E2 (DON) stated that he was at the facility the night of ([DATE]) when R1 was sent out via 911. R1's nursing progress note from [DATE] at 11:08 PM was discussed and E2 confirmed that the note lacked evidence of any staff interventions prior to EMS getting onsite. E2 stated that staff sat R1 up and stopped his tube feeding, but did not mention that oxygen was provided. E2 stated that there was a set of vital signs with a pulse ox of 92% in R1's clinical record on [DATE] at 11:00 PM, but it was not included in the nurses progress note regarding what occurred prior to R1 being sent out to the hospital. E2 confirmed that R1 was not administered oxygen when EMS arrived and stated that EMS did not provide oxygen to R1 prior to leaving the building and was not being provided BVM (mechanical ventilation) prior to leaving the building. [DATE] 5:,d+[DATE]:20 PM- During an interview, SS1 (EMS) stated that he was at the facility [DATE] to respond to a 911 call for R1. SS1 explained that his observation and assessment of R1 revealed that R1 was in severe respiratory distress with respirations in the 50's and oxygen saturations in the 60's. SS1 stated that R1 was not being administered oxygen and was alone when EMS entered R1's room. SS1 stated they did not get a good report from facility staff regarding R1's baseline status. [DATE] 11:35 AM - During an interview, E8 (LPN) stated that if a resident had increased labored respirations of 30 per minute, an increased pulse of 140 beats per minute and the resident was in distress, it was unlikely that a pulse ox of 92% would be normal and/or correct with those signs and symptoms. E8 stated that if a resident presented with unusual or abnormal vital signs, she would get another nurse, the DON (Director of Nursing) or the ADON (Assistant Director of Nursing) to come in and evaluate the resident and confirm her assessment. E8 stated that if she had a resident with respiratory distress, she would stay with the resident and get someone like a CNA to get another nurse. I would then put oxygen on the resident, elevate the head of the bed and check the resident's code status (whether the resident wants CPR or not). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] 12:26 PM - During an interview, E5 (LPN) (the nurse that was assigned to the resident the evening of [DATE]) stated that she went into R1's room on last rounds and it sounded like R1 was snoring loudly. R1 looked unconscious and had no response to sternal rub (a way of checking for a person's response). E5 stated that she elevated R1's head. R1's pulse ox was 92% and his respirations were elevated. E9 (agency CNA) was in the room. E5 stated that R1 had increased respirations and heart rate. E5 stated that she thought a pulse ox of 92% was normal for some people. E5 added that there was a CNA and E2 (DON) outside of the door. E5 stated that she was not in R1's room because she was the one who called 911, was getting the paperwork ready, and added there were a lot of people in there (R1's room when she left). E5 stated that R1 was never left alone, which is not consistent with documentation by the EMS crew. E5 confirmed that EMS applied oxygen to R1 while they were in the building. E5 stated that EMS and R1 were gone quickly. [DATE] 12:45 PM - During an interview, E9 (agency CNA) stated that the nurse E5 (LPN) wanted her to help in R1's room and she was in the room when EMS got there, but then left. E9 stated that prior to EMS arrival, while she was in R1's room, the nurse tried to get R1's blood pressure, but the blood pressure cuff did not work because it was too small for R1. E9 stated that E7 (LPN) went out of R1's room and got a hand pulse ox and checked him, but did not know what R1's pulse ox was at that time. E9 stated that she did not see oxygen started on R1 before EMS arrived, all she saw was R1's tube feeding. E9 stated that she remembers the nurse said that R1's pulse ox was low and that was why they called 911. E9 stated that it looked like R1 really wasn't breathing and was just lying there. There were two nurses working on the unit when this happened to R1 and it was E5 (LPN) and E7 (LPN) and E2 (DON) was outside of the door. [DATE] 2:00 PM - During an interview, E2 (DON) stated that the facility does not have standing orders for oxygen. E2 also stated that he did not know which Practitioner (Doctor or Nurse Practitioner) was notified of R1's change in status. [DATE] 4:50 PM - During an interview, SS2 (MD) reported that on [DATE] it was an on call service Practitioner that would have responded on that date and shift. SS2 stated that it is was unlikely that a resident would present with increased respirations of 30 per minute and a pulse of 140 and maintain a pulse ox of 92%. [DATE] 12:08 PM - An email composed by E2 (DON) included, I saw the resident from his doorway and did not see evidence of him in respiratory distress. Staff stated he was less responsive than usual. I asked for VS (vital signs) and was told (R1) Pulse Ox was 92% on R/A (room air). I directed staff to sit him upright, hold his TF (tube feeding) and call 911. I then went to the first floor to open the door and hold the elevator for EMS. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] 1:,d+[DATE]:55 PM - During an interview, E7 (LPN) stated that E5 (LPN) called her to R1's room related to R1's decline. E7 said that R1 usually fights you when you are trying to give him his meds (medications), tube feeding and care. E7 stated there was a CNA in R1's room and E5 was calling 911. E7 stated that she went to her cart to get her vital sign equipment and took R1's vital signs; they were normal when she was in R1's room. E7 added that the resident was at his normal and not in any distress other than his change in mental status, then added that R1 was not in any respiratory distress. E7 stated that she thought R1's pulse ox was 97 or 98%. The surveyor inquired if the resident (R1) was not in distress then why was 911 called? E7 stated that it was because of R1's change in mental status. The surveyor read her E5 (LPN)'s progress note (dated [DATE] at 11:08 PM) in R1's chart and asked her about the difference in her assessment and E5's assessment. E5 stated, I don't know. R1 was fine other than his change in mental status when she was in the room. The surveyor then asked E7 whether E2 (DON) went in to assess R1 and she stated No, he (E2) was outside the door and then went down to open door for EMS and was never in the room and did not assess the resident. E7 stated that R1 was not panting or anything. When asked about the EMS vitals E7 stated she did not know what they were when EMS obtained them on arrival. E7 stated that EMS said Don't you apply oxygen to a patient that is in respiratory distress? Based on interviews of facility staff and EMS, it is unclear whether the facility assessments of R1 were adequate and correct due to discrepancies in the interviews and documentation. The facility lacked evidence of appropriate respiratory assessments, adequate monitoring, and necessary interventions, including the application of oxygen when R1 was found in respiratory distress. 1b. Review of R1's clinical record revealed: [DATE] - R1 was admitted to the facility with a history of a brain tumor and stroke. [DATE] - R1 had a physician's order for labs to be collected. On [DATE] the lab result slip documented that R1 refused for labs to be drawn. [DATE] - R1 had a physicians order for labs to be collected. The record lacked evidence that the resident refused lab work and what (if any) interventions were conducted, including notifying the ordering doctor. [DATE] 10:15 AM - During an interview, E4 (Corporate Clinical Nurse) confirmed that R1 was ordered to have labs drawn on [DATE] and that the results report received the following day documented that the resident had refused. E4 confirmed there was no evidence that the Practitioner was notified. E4 also confirmed that there was an additional order for labs on [DATE] and it was documented in R1's record as completed and then discontinued on the same day. E4 thought it was because R1 refused, but confirmed there was not a progress note to support R1's refusal. E4 confirmed that a lab result report from the [DATE] order was unable to be located. The facility lacked evidence that on the aforementioned dates, the Practitioner was notified of the refusal of ordered labs. Findings were reviewed at the exit conference on [DATE], beginning a 1:45 PM, via phone with E1 (NHA), E2 (DON) and E4 (Corporate Clinical Nurse).

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 44706 Based on interview, record review and other documentation it was determined that for one (R3) out of three residents sampled for pressure ulcers, the facility failed to identify, assess and treat a pressure ulcer that was present on admission causing R3's coccyx pressure ulcer to significantly worsen which resulted in a delay in treatment causing harm to R3. Findings include: Review of the Agency for Healthcare Research and Quality, National Guideline Clearinghouse, included the clinical practice guidelines by the National Pressure Ulcer Advisory Panel dated 2014, which stated, . Pressure Ulcer Assessment .1. Assess the pressure ulcer initially and reassess it at least weekly .3. Assess and document physical characteristics . 7/17 (revision date) - Review of facility policy; Prevention of pressure ulcers/injuries revealed the following: - Assess the resident on admission (within eight hours) for existing pressure ulcer/injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. - Conduct a comprehensive skin assessment upon admission including: any evidence of existing or developing pressure ulcers or injuries; inspect the skin on a daily basis when performing or assisting with personal care or ADL's. - Inspect pressure points (buttocks, hips, elbows, heels). 9/25/20 - Review of hospital records described that R3 had a stage 3 full thickness pressure ulcer to the coccyx that measured length 0.3 cm x width 0.3 cm, and did not document depth. It was verified by two hospital practitioners as a stage 3 pressure ulcer. In addition, R3 also had a left upper thigh stage 3 pressure ulcer measuring length 1.5 cm x width 2.6 cm that was full thickness, had necrotic tissue, slough and red tissue. The following was reviewed in R3's clinical record: 10/2/20 - R3 admitted to the facility from the hospital. 10/2/20 - An interagency discharge summary documented to follow up with the wound care center in one to two weeks. 10/2/20 - The initial admission skin assessment documented a stage 3 pressure ulcer to the left thigh measuring length, 9 cm x width, 9 cm x depth 0.25 cm. The facility failed to identify the stage 3 pressure ulcer to the coccyx. 10/2/20 - A Physician's order was written to cleanse the left thigh with normal saline and apply treatment gel to the wound bed and cover with a dressing every three days and as needed. 10/2/20 - Hospital discharge instructions for care of the coccyx area documented to apply barrier cream every day. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	10/3/20 through 10/29/20 - Review of CNA documentation indicated that the intervention for turning and repositioning every two hours was not completed for 12 shifts out of 81 shifts. 10/5/20 - R3's history and physical documented a UTI that was treated with antibiotics and a past medical history of spina bifida with lower extremity weakness and R3 relied on staff for ADL's (activities of daily living). 10/9/20 - An admission MDS assessment documented that R3 was at risk for pressure ulcers and no pressure ulcers were identified. The MDS documented under ADL's that R3 was an extensive assist and required a two person physical assist for the following: bed mobility, transfers, walking, dressing, toileting and personal hygiene. R3 had a BIMS score of 15. 10/9/20 through 10/29/20 - Review of clinical records lacked evidence of a weekly skin assessment. 10/21/20 - R3's care plan for being at risk of skin breakdown included the following interventions: Pressure relief cushion to chair while out of bed, presssure relief to mattress to bed, provide prompt peri care for incontinence episodes, provide turning and repositioning every two hours, and skin observation every two hours. 10/21/20 through 10/29/20 - Review of CNA documentation indicated that the intervention to check the skin every two hours was not completed for four out of 25 shifts. 10/28/20 9:34 PM - A nursing progress note documented, Completed wound care to stage 3 (pressure ulcer) gluteal, sacral area; encouraged resident to change position more frequent and the rationale for offloading that area; will continue to monitor. 10/29/20 - A wound assessment documented a pressure ulcer to R3's coccyx as measuring length 9 cm x width 8 cm x depth 2.5 cm wound bed necrotic, bloody drainange, periwound with eschar tissue.Supervisor and Physician were notified and a new order was obtained. 10/30/20 - A wound assessment by another facility nurse documented a pressure ulcer to R3's coccyx as measuring length 15 cm x width 12 cm x depth 6 cm. The order was changed to a more aggressive treatment. Although R3 had a newly identified pressure ulcer of the coccyx by the facility, there was lack of evidence of the stage of the wound. The characteristics of the wound to include necrosis and eschar would be consistent with an unstageable pressure ulcer. 11/3/20 - A physician discharge summary documented that R3 was sent to the emergency room for abdominal pain. 11/4/20 - R3 was admitted to the hospital with a diagnosis of a urinary tract infection. The skin assessment performed in the emergency room documented a large pressure ulcer overlying the coccyx. 11/7/20 - A hospital operative report documented a preoperative diagnosis of unstageable sacral pressure ulcer and a post operative diagnosis of a stage 4 sacral pressure, the report documented, .On admission, he (R3) was found to have an extensive unstageable sacral decubitus (pressure) ulcer with large amount of fecal spillage into the wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	1/19/22 1:45 PM - During an interview, E6 (MDS Coordinator) confirmed that the initial admission skin assessment was inaccurate, the pressure ulcer to the coccyx area was not identified and was therefore not captured in R3's admission MDS assessment. E6 also confirmed there were no further weekly skin assessments performed since admission until 10/29/20 when the pressure ulcer was first identified by the facility and documented in R3's EMR. 1/21/22 1:05 PM - During an Interview E2 (DON) stated that it was unclear whether R3 was admitted with the pressure ulcer or if it was facility acquired. 1/24/22 12:45 PM (approximate) - During an interview, E1 (NHA) and E2 (DON) confirmed that the pressure ulcer to the coccyx was present on admission on 10/2/20 and was not treated until 10/29/20, nearly a month later. The facility failed to: - identify the coccyx pressure ulcer on admission. - ensure consistent implemention of preventative measures to include turning and repositioning every two hours, weekly skin checks, skin checks and observations every two hours, and the application of barrier cream. - identify skin changes before the coccyx pressure ulcer was initially observed on 10/29/20 with characteristics of an unstageable pressure ulcer. Findings were reviewed during the exit conference via telephone on 1/25/22 at 1:45 PM with E1(NHA), E2 (DON) and E4 (Corporate RN).