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	03/15/2022

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

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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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. 32545 Based on interviews and review of the clinical record, it was determined that for one (R1) out of three residents reviewed for admission, the facility failed to ensure that R1 had a physician order for intravenous (IV) antibiotic for the resident's immediate care. Findings include: Cross refer to F760 R1's clinical record revealed: 1/28/22 at 10:08 AM - R1's hospital discharge summary documented that the Infectious Disease consultant's final recommendation was for six (6) weeks of IV (intravenous) Meropenem (antibiotic) for recurrent prosthetic joint infection due to multidrug-resistant E. coli. R1 had a PICC line already in place prior to hospital discharge. 1/28/22 at approximately 2 PM - R1 was admitted to the facility for IV antibiotic therapy and rehabilitation status post hospitalization . 1/28/22 - R1's physician orders lacked evidence that her IV antibiotic was ordered by the physician on her admission. 3/10/22 at 1:55 PM - During an interview, E5 (RN) confirmed that he only completed R1's skin assessment on her admission to the facility. E5 stated that he did not call the physician to review R1's admission orders. 3/15/22 at 3:45 PM - During an interview, E4 (ADON) stated that he thought E5 completed R1's admission orders. 3/15/22 at 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference. The facility failed to ensure R1 had a physician order for an IV antibiotic for her immediate care.

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 32545 Based on interview and review of the clinical record, it was determined that for one (R1) out of three residents reviewed for admission, the facility failed to develop and implement a baseline care plan within 48 hours of a resident's admission that included instructions for person-centered care. Findings include: R1's clinical record revealed: 1/28/22 at 2 PM - R1 was admitted to the facility for IV antibiotic therapy and rehabilitation status post hospitalization for total knee replacement. R1's baseline care plan lacked evidence of instructions needed to provide effective and person-centered care, which included IV antibiotic therapy for treatment of a multidrug resistant organism, use and care of PICC line and surgical wound care and monitoring. 3/15/22 at 12:29 PM - During an interview, E2 (DON) acknowledged that R1's care plan was missing person-centered care information. 3/15/22 at 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference. The facility failed to develop and implement a person-centered baseline care plan within 48 hours of R1's admission that addressed IV antibiotic therapy, PICC line and her surgical wound.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 32545 Based on observation, interviews and review of the clinical record, it was determined that for one (R7) out of three residents reviewed for tube feedings, the facility failed to ensure that nutritional services provided, as outlined by the comprehensive care plan, must meet professional standards of quality. Findings include: R7's clinical record revealed: 2/24/22 - A physician's order documented that R7's diet was NPO (nothing by mouth), tube feeding only. 2/24/22 (last revised) - R7 was care planned for NPO due to swallowing difficulty with approaches that included to administer tube feedings as ordered. 3/11/2022 at 12:37 PM - R7 was observed by the Surveyor sitting on the side of his bed with a meal tray in front of him and eating the lunch meal served. E2 (DON) was immediately notified and confirmed that R7 was NPO. E2 confirmed that R7 consumed 25% of the pureed macaroni and cheese and 75% of the pureed fruit cocktail. Review of R7's meal ticket on the tray revealed that he was served a regular puree diet with honey thickened liquids for lunch. 3/11/22 at 1:35 PM - During an interview, E9 (FSD) and the Surveyor reviewed the kitchen's white binder that holds all of the diet change slips. E9 confirmed that there were no change diet slips for R7. E9 explained that the facility's process for diet changes was the physician/dietician order a specific diet and nursing staff completes a change diet slip order on the facility form and sends the form to the kitchen. The FSD then updates the resident's diet per the change diet slip form. E9 stated that the kitchen never received a change diet form for R7 on 2/24/22 or later. E9 stated that until the diet was changed, R7 would continue to receive his current diet order, a puree diet with honey-thickened liquids for each meal. 3/15/22 at 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference. The facility failed to ensure that the nutritional services provided were according to R7's comprehensive care plan and met the professional standards of quality. R7 was served a lunch meal tray despite being care planned as NPO and receiving tube feedings.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 32545 Based on interview and review of the clinical record, it was determined that for one (R3) out of three residents reviewed for urinary catheter, the facility failed to ensure that a resident who was unable to carry out activities of daily living (ADL), received the necessary services to maintain good grooming and personal hygiene. Findings include: R3's clinical record revealed: 2/12/21 - R3 was care planned for extensive to total care with his ADLs. 2/22/21 - R3 was care planned for a shower as his preference for personalized care. R3 was scheduled for showers twice a week on Tuesday and Thursday during the 3 PM to 11 PM shift. From January 1, 2022 through February 25, 2022, review of the CNA documentation on R3's showers revealed: -For the month of January 2022, R3 was not showered out of eight (8) scheduled opportunities. Rather, R3 received only three partial bed baths and two complete bed baths during the eight scheduled shower times. The other three scheduled times were either NA (not applicable) or left blank. -From February 1-25, 2022, R3 was not showered out of eight (8) scheduled opportunities. Rather, R3 received one complete bed bath and three partial bed baths during the eight scheduled shower times. The other four (4) scheduled times were left blank. 2/25/22 at 11:30 PM - According to R3's clinical record, he was sent to the hospital for a fever and high blood sugar. 2/28/22 at 8:50 AM - An outside complaint was received by the State of Delaware's Division of Health Care Quality (DHCQ) triage regarding the filthy condition that R3 arrived in at the hospital on 2/25/22. During a follow-up interview on 3/22/22 at 10:53 AM with the hospital Nurse (H1), who was present when R3 arrived to the hospital, she stated that she was very familiar with R3 as he had been to the hospital many times. H1 stated that on 2/25/22, R3 arrived to the hospital in the worst condition that she has ever seen him. R3 smelled of rancid urine although he had a foley catheter. H1 stated that R3 appeared that he had not been cleaned in a long time. R3's fingernails were visibly dirty and his body was covered with a wax coating that occurs when someone has not been bathed. H1 stated that R3's foley catheter was filthy with body dirt on the catheter tubing and there was no evidence of any cleaning. 3/15/22 at 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference. The facility failed to ensure that R3, a dependent resident, received his scheduled showers as was his preference to maintain good grooming and personal hygiene.

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F 0690 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32545 Based on interview, review of the clinical record and other resources as indicated, it was determined that for one (R3) out of three residents reviewed for urinary catheter, the facility failed to ensure that a resident with an indwelling catheter received appropriate care and services to prevent urinary tract infection (UTI). R3 was hospitalized from 2/25/22 to 3/3/22 for severe sepsis, resulting in harm to R3. Findings include: The facility's policy entitled Catheter Care, Urinary, last revised September 2014, included, but was not limited to: General Guidelines to maintain a closed drainage system after insertion of urinary catheter; Input/Output by maintaining an accurate record of the resident's daily output; maintaining unobstructed urine flow; infection control by providing routine hygiene; changing catheter based on clinical indications such as infection, obstruction or when the closed system was compromised; complications by monitoring urine for unusual appearance and other signs and symptoms of UTI or urinary retention. Review of R3's clinical record revealed the following: R3 had diagnoses that included, but were not limited to, urinary retention, benign prostatic hyperplasia, a stage 4 pressure ulcer on his sacrum and use of an indwelling urinary catheter. 2/12/21 (last revision) - R3 was care planned for a foley catheter and was at risk for complications of usage. The interventions included: -dignity bag in place; -foley catheter bag to be changed monthly and PRN (as needed); and -foley catheter to straight drainage. Despite the interventions listed above, the facility failed to personalize R3's catheter care plan to address the following based on the standards of practice*: -monitoring of the foley catheter access site (i.e. urine leakage, skin irritation/routine hygiene); -monitoring urine output (i.e. color, odor, sediment, patency); -type of foley catheter being used (i.e. size, type, insertion date); -replacement of the foley catheter based on clinical indications: infection, obstruction; -device being used to secure the catheter to prevent movement, dislodgement, pain or trauma; (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	-maintenance of the urinary drainage bag (keep below bladder level, do not place on floor, emptying schedule); -maintain a closed drainage system. *Healthcare Infection Control Practices Advisory Committee (HICPAC) Guideline for Preventions of Catheter-Associated Urinary Tract Infections 2009, last update: June 6, 2019. https://www.cdc.gov/infectioncontrol/guidelines/cauti. Despite the facility's policy stating to change a resident's catheter based on clinical indications such as infection, obstruction or when the closed system was compromised, R3 did not have a physician's order to change his catheter. 10/4/21 at 12:33 AM - A health status note documented by nursing stated that R3's urinary foley catheter was replaced in the hospital and the foley was draining clear urine. This is the last documented note in R3's clinical record indicating that his urinary catheter was changed. While facility nurses were documenting that foley catheter care was being provided every shift from 2/1/22 to 2/25/22, R3's eTAR lacked evidence of monitoring his urinary output for 73 out of 75 opportunities. From 2/10/22 to 2/25/22, review of R3's health status notes documented by nursing staff included a CBC lab result on 2/10/22: a declogging of R3's peg tube on 2/13/22 at the ED (Emergency Department) which only took one hour; a psychiatrist consult with a new medication order on 2/22/22; and behavior monitoring for new medication on 2/24/22. R3's health status notes lacked evidence of monitoring his foley catheter and the characteristics of his urine output. 2/25/22 at 11:27 PM - A nurse's note documented that R3 had a 'HI' blood sugar reading. Possible sepsis. Resident received routine blood sugar coverage. Resident noted with fever of 102. Nursing supervisor made aware. On call clinician . made aware. 911 called in. Resident is currently en-route to . hospital for further evaluation. RP . made aware. The facility's documentation in R3's clinical record lacked evidence of a nursing assessment, including updated vital signs and blood sugar, prior to R3 being sent to the hospital. There was no documented evidence of any issues with respect to R3's foley catheter and/or urine output. 2/26/22 - The hospital record revealed that R3's catheter was replaced in the ED with a 3-way foley in order to provide continuous bladder irrigation (CBI). At 7 AM, the hospital documented that R3's urine color description as having clots, cloudy, mucous, red, and sediment. (continued on next page)

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F 0690 Level of Harm - Actual harm Residents Affected - Few	2/28/22 at 8:50 AM - An outside complaint was received by the State of Delaware's Division of Health Care Quality (DHCQ) triage regarding the filthy condition that R3 arrived in at the hospital on 2/25/22. During a follow-up interview on 3/22/22 at 10:53 AM with the hospital Nurse (H1), who was present when R3 arrived to the hospital, she stated that she was very familiar with R3 as he had been to the hospital many times. H1 stated that on 2/25/22, R3 arrived to the hospital in the worst condition that she has ever seen him. H1 stated that R3 smelled of rancid urine although he had a foley catheter. H1 stated that R3 appeared that he had not been cleaned in a long time. R3's fingernails were visibly dirty and his body was covered with a wax coating that occurs when someone has not been bathed. H1 stated that R3's foley catheter was filthy with body dirt on the catheter tubing and there was no evidence of any cleaning. H1 stated that the foley catheter was the same type that the hospital used and it looked old. In addition, H1 stated that when hospital staff were cleaning R3, he still had the hospital's catheter securing device, called a Statlock (strap-free foley securement device with a special 360 degree swivel clamp to hold urinary catheters in place) which was found unsecured and loose in a crease between his groin and belly fold. H1 stated that R3's foley catheter was not secured upon his arrival to the hospital. 3/3/22 - The hospital record documented . sent from Regency for fever, lethargy/less responsive, blood sugar above 600 and foley output noted to have sediment . Work-up in ED noted to have vitals consistent with temperature 38.4 (Celsius equals to 101.1 degrees Fahrenheit), heart rate of 147 (normal 55 to 100), respiratory rate 42 (normal 12-20), elevated WBC count of 17.5 (white blood cell, normal 5.0-10.0 thousand) meeting sepsis criteria, also noted to have blood glucose in 600's (normal 74-99), aki (acute kidney injury) with creatinine 5.3 (normal 0.7-1.2), (elevated) lactic acid 3.6 (normal 0.5-1.0). Noted that foley he came in with cannot be flushed, which is replaced with evidence of [NAME] pus draining, given a dose of . antibiotics, IVF (intravenous fluids) . 3/4/22 - A facility Physician's readmission note documented that R3 was admitted to the hospital secondary to fever and elevated blood sugar. In the emergency room patient noted to have an elevated WBC of 17.5 and an elevated creatinine of 5.3 and elevated lactic acid level and his Foley catheter could not be flushed and noted to have pus draining and patient was given IV antibiotics and initiated with IV fluids. Patient diagnosed with severe sepsis and blood cultures grew out Klebsiella pneumonia . In regards to acute kidney injury due to underlying sepsis and patient initiated with IV fluids . 3/15/22 at 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference. The facility failed to ensure that R3, a resident with an indwelling catheter, received appropriate care and services to prevent an infection that resulted in R3 being hospitalized for severe sepsis.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 32545 Based on interviews and review of the clinical record, it was determined that for one (R1) out of three residents reviewed for admission, the facility failed to ensure that R1 was free of any significant medication errors, specifically intravenous (IV) antibiotic therapy. Findings include: Cross refer to F635 R1's clinical record revealed: 1/28/22 at 10:08 AM - R1's hospital discharge summary documented that the H2's (Infectious Disease physician) final recommendation was for six (6) weeks of IV (intravenous) Meropenem (antibiotic) for recurrent prosthetic joint infection due to multidrug-resistant E. coli. R1 had a PICC line already in place prior to her hospital discharge. 1/28/22 at approximately 2 PM - R1 was admitted to the facility for IV antibiotic therapy and rehabilitation. The physician's orders lacked evidence that R1's IV antibiotic was ordered upon her admission on 1/28/22. There was also no evidence that nursing followed up or questioned R1's missing IV antibiotic throughout the weekend. Rather, nursing continued to document that they were flushing R1's PICC line prior to and post IV medication on the eMAR as per a physician's order. 1/31/22 at 12:32 PM - On Monday, a health status note by E4 (ADON) documented that a Follow up call place to (name of hospital) related to clarification of resident's ABT (antibiotic). Hospital SW (Social Worker) made aware that resident's discharge medication list did not include any ABT even though she was admitted for IV ABT infusion. This writer spoke with H2 (Infectious Disease physician) and received new order for Meropenem (IV antibiotic) every 8 hours with a cut off date of 3/6/22 . 1/31/22 at 11:04 PM - An administrative note by nursing documented that R1's IV antibiotic was not available and awaiting for pharmacy delivery. Review of R1's eMAR from admission on 1/28/22 through her discharge on 2/1/22 at 2 PM revealed that she received one dose of the IV antibiotic on 2/1/22 at 6 AM. R1 was transferred to the hospital for an unrelated reason on 2/1/22. 3/10/22 at 1:55 PM - During an interview, E5 (RN) confirmed that he did not complete R1's admission orders. 3/15/22 at 3:45 PM - During an interview, E4 (ADON) stated that he thought E5 (RN) completed R1's admission orders. 3/15/22 at 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference. The facility failed to ensure that R1 received IV antibiotic therapy to treat her multidrug-resistant infection upon her admission. It was not until five (5) days after she was admitted to the facility that R1 received her first and only dose of the IV antibiotic.

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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. 32545 Based on interview and review of the clinical record, it was determined for one (R3) out of three residents reviewed for foley catheter, the facility failed to ensure laboratory services were obtained per the physician's order. Findings include: R3's clinical record revealed: 2/7/22 - The physician ordered a CBC (complete blood count) lab to be done every week to monitor R3's hemoglobin (Hgb). 2/14/22 - R3's CBC lab was not completed. There was no evidence in R3's clinical record that the facility followed-up on the physician-ordered lab. 2/23/22 at 3:58 PM - R3's CBC lab was drawn, however the lab was not able to process the blood specimen and notified the facility that a redraw was necessary. There was no evidence in R3's clinical record that the facility followed-up on the physician-ordered lab. 3/15/22 at 12:29 PM - During an interview, E2 (DON) stated that the 2/14/22 was drawn by the Phlebotomist but was never processed and confirmed that the 2/23/22 lab was not redrawn. 3/15/22 at 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference. The facility failed to ensure R3's physician-ordered laboratory services were obtained.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32545 Based on interview and review of the clinical record, it was determined that for two (R1 and R3) out of three residents reviewed for admission, the facility failed to ensure that each resident's medical record was complete and accurately documented. Findings include: 1. R1's clinical record revealed that she was admitted to the facility on [DATE]. However, R1's clinial record lacked evidence that a nursing admission assessment was completed. 3/15/22 at approximately 12:20 PM - During an interview, E2 (DON) provided this writer with a list of assessments/evaluations that were to be completed on admission to the facility, which included but not limited to, an admission assessment. 2. R3's clinical record revealed: R3 had an active physician's order (started on 7/7/21) for Nepro tube feeding to be administered at a rate of 77 ml per hour and to start it at 6 PM. R3 also had an active physician's order (started on 12/8/21) for continuous Nepro tube feeding to be administered at a rate of 45 ml per hour until completed. From January 1, 2022 through February 25, 2022, the nursing staff on the 3 PM to 11 PM shift were signing off both active Nepro tube feeding orders despite having a difference in the tube feeding administration rates on R3's eMARs. 3/15/22 at 11:48 AM - During an interview, E2 (DON) acknowledged that the evening shift nursing staff were signing off on both active tube feeding orders on the January and February 2022 eMARs. 3/15/22 at 4:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference. The facility failed to ensure that R1 and R3's medical records were complete and accurately documented.