STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	**03/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview and review of facility documents as indicated, it was determined that for one (R154) out of five sampled residents for abuse investigation, the facility failed to identify an allegation of abuse and consequently, failed to thoroughly investigate the alleged violation, and failed to prevent further potential abuse while the investigation was in progress. Findings include: The facility's policy titled Abuse Investigation and Reporting, with a revision date of 7/2017, stated: .Role of the Administrator: 1. If an incident or suspected incident of resident abuse .is reported, the Administrator will assign the investigation to an appropriate individual . 4. The Administrator will suspend immediately any employee who has been accused of resident abuse pending the outcome of the investigation. 5. The Administrator will ensure that any further potential abuse .is prevented. 6. The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident . Role of the Investigator . 1. The individual conducting the investigation will, as a minimum . e. Interview the resident (as medically appropriate) . h. Interview the resident's roommate . i. Interview other residents to whom the accused employee provided care or services . Reporting . 5. The Administrator, or his/her designee, will provide the appropriate agencies or individuals listed above with a written report of the findings of the investigation within five (5) working days of the occurrence of the incident. Review of 154's clinical record revealed the following: 7/12/2019 6:30 PM - R154 was admitted to the facility from an acute care hospital. 7/13/2019 7 AM to 3 PM Shift - A Resident/Family Grievance Concern Form, completed by E20 (RN) documented: .Grievance: Pt. (patient) states 2 staff members went to her room around 4 AM and tried to undress her. She states they roughed her up. Pt. very agitated, and stated she was afraid and scared (Pt. is a new admit, was reassured that she will be safe and calmed down). Pt. states she does not want to be taken care by those 2 staff members . Grievance Summary Statement: Resident voiced concerned about 2 staff being rough around 4 a.m . Conclusion: Unsubstantiated regarding 11-7 shift staff .Date the written decision was issued: 7/15/2019 . Date/time/name of the resident and/or resident representative notified of grievance: msg (message) left 7/15/19 at 10:07. This document was signed by E1 (NHA) and E7 (SS). There was lack of evidence that the facility identified the above as an allegation of abuse, they failed to thoroughly investigate the alleged violation, and failed to prevent potential for further abuse. 7/18/2019 - A witness statement by E7 (SS) was completed which documented after a care plan meeting, both R154 and her daughter requested to speak with E7. R154 discussed the concerns she reported on 7/13/2019 at 4 :00 AM. Per R154, 2 black female staff in regular clothes were rude to her and R154 yelled at them to stop. 7/18/2019 5:09 PM - The complaint made by R154 and her daughter to E7 after the care plan meeting was an allegation of abuse and it was reported to the State Agency. Despite the fact that a complaint was made on 7/18/2019, this was the second time that R154 made the allegation, with the first time being on 7/13/2019. The facility assumed incorrectly with the first complaint that the incident occurred prior to R154's admission to the facility on [DATE]. When the second complaint was received by the facility on 7/18/2019, the facility correctly identified the complaint as an allegation of abuse, however, they failed to investigate the allegation and failed to prevent further abuse. 7/26/2019 - A Follow Up was submitted to the State Agency, which documented, In conclusion, Resident no longer feels fearful. Interviewed staffs (sic) from that night. Resident reported concerns of staff stating staff from last night. She was in (Name of the hospital) that night. Staff also reported this concern to the supervisor. Staff were educated on approach during the 11-7 shift. Resident felt staff were loud when walking in her room. No further concerns voiced .allegation unsubstantiated . The facility failed to provide the findings within 5 working days. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 3/6/2020 at 2:25 PM.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined that for one (R154) out of three sampled residents for medication investigation, the facility failed to ensure at the time of admission that the facility obtained physician orders [REDACTED]. Findings include: Cross refer F755 Cross refer F760 The following was reviewed in R154's clinical record: 7/12/2019 6:30 PM - R154 was admitted to the facility from an acute care hospital. 7/12/2019 - The hospital's discharge list of medications documented the following medications: [REDACTED]. by mouth with dinner for 1 week then 200 mg. by mouth with dinner daily thereafter. - Apixaban (blood thinner) 5 mg by mouth twice a day. - [MEDICATION NAME] (for blood pressure) 75 mg by mouth every 12 hours. - [MEDICATION NAME] (to reduce acid in the stomach) 40 mg by mouth daily. - [MEDICATION NAME] Sodium (stool softener) 100 mg by mouth twice a day. - Fluconazole (antifungal) 100 mg by mouth one time a day. 7/13/2019 9:36 AM - A progress note by E20 (RN) documented that the admission medications were verified with E27 (NP). This was approximately 15 hours after R154 was admitted to the facility. 2/21/2020 3:00 PM - An interview with E2 (DON) confirmed that the facility failed to have evidence of physician orders [REDACTED]. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 3/6/2020 at 2:25 PM.
F 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that for one (R154) out of three sampled residents for medication investigation, the facility failed to ensure that the pharmaceutical services provided included the accurate dispensing and administration of medications. Findings include: Cross refer F635 Cross refer F760 The following was reviewed in R154's clinical record: 7/12/2019 6:30 PM - R154 was admitted to the facility from an acute care hospital. 7/12/2019 - The hospital's discharge list of medications documented the following medications: [REDACTED]. by mouth with dinner for 1 week then 200 mg. by mouth with dinner daily thereafter. - Apixaban (blood thinner) 5 mg by mouth twice a day. - [MEDICATION NAME] (for blood pressure) 75 mg by mouth every 12 hours. - [MEDICATION NAME] (to reduce acid in the stomach) 40 mg by mouth daily. - [MEDICATION NAME] Sodium (stool softener) 100 mg by mouth twice a day. - Fluconazole (antifungal) 100 mg by mouth one time a day timed at 9:00 AM. 7/13/2019 9:36 AM - A progress note by E20 (RN) documented that the admission medications were verified with E27 (NP). This was approximately 15 hours after R154 was admitted to the facility. 7/13/2019 through 7/14/2019 - admission orders [REDACTED]. - Apixaban 5 mg by mouth twice a day timed at 9:00 AM and 5:00 PM. - [MEDICATION NAME] 75 mg by mouth every 12 hours timed at 9:00 AM and 9:00 PM. - Fluconazole 100 mg by mouth one time a day timed at 9:00 AM. 7/13/2019 9:00 AM - A review of the eMAR lacked evidence that the scheduled 9:00 AM medications Apixaban, [MEDICATION NAME], and Fluconazole were administered. 7/13/2019 5:00 PM - A review of the eMAR lacked evidence

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

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 0755 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) that the scheduled 5:00 PM medication [MEDICATION NAME] 400 mg was administered. 7/13/2019 7:47 PM - A progress note documented Medication not available pending delivery from pharmacy, call placed to pharmacy. Per pharm rep (representative) medication will be delivered on next run. Call placed to MD to notify of medication delivery status. Return call pending. 7/13/2019 8:39 PM - A progress note documented Return call received from MD, new order, administer medication when it comes in, will notified (sic) 11-7 shift. There was lack of evidence when the facility received the medications. 7/14/2019 5:00 PM - A review of the eMAR lacked evidence that the scheduled 5:00 PM medication [MEDICATION NAME] 400 mg was administered. 7/15/2019 5:00 PM - A review of the eMAR revealed that R154 was administered her first dose of [MEDICATION NAME] 400 mg since admission, three days ago. 2/21/2020 3:00 PM - An interview with E2 (DON) confirmed that the previously documented medications were not administered to R154. The facility failed to ensure that the pharmaceutical services provided to R154 included the accurate dispensing and administration of medications. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 3/6/2020 at 2:25 PM.
F 0760 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined that the facility failed to ensure for one (R154) out of three sampled residents reviewed for medication review, that the resident was free from significant medication errors. Findings include: Cross refer F635 Cross refer F755 The following was reviewed in R154's clinical record: 7/12/2019 6:30 PM - R154 was admitted to the facility from an acute care hospital. 7/12/2019 - The hospital's discharge list of medications documented the following medications: [REDACTED]. by mouth with dinner for 1 week then 200 mg. by mouth with dinner daily thereafter. - Apixaban (blood thinner) 5 mg by mouth twice a day. - [MEDICATION NAME] (for blood pressure) 75 mg by mouth every 12 hours. - [MEDICATION NAME] (to reduce acid in the stomach) 40 mg by mouth daily. - [MEDICATION NAME] Sodium (stool softener) 100 mg by mouth twice a day. - Fluconazole (antifungal) 100 mg by mouth one time a day timed at 9:00 AM. 7/13/2019 9:36 AM - A progress note by E20 (RN), documented that the admission medications were verified with E27 (NP), approximately 15 hours after R154 was admitted to the facility. 7/13/2019 through 7/14/2019 - admission orders [REDACTED]. - Apixaban 5 mg by mouth twice a day timed at 9:00 AM and 5:00 PM. - [MEDICATION NAME] 75 mg by mouth every 12 hours timed at 9:00 AM and 9:00 PM. - Fluconazole 100 mg by mouth one time a day timed at 9:00 AM. 7/13/2019 9:00 AM - A review of the eMAR lacked evidence that the scheduled 9:00 AM medications Apixaban, [MEDICATION NAME], and Fluconazole were administered. 7/13/2019 5:00 PM - A review of the eMAR lacked evidence that the scheduled 5:00 PM medication [MEDICATION NAME] 400 mg was administered. 7/13/2019 7:47 PM - A progress note documented Medication not available pending delivery from pharmacy, call placed to pharmacy. Per pharm rep (representative) medication will be delivered on next run. Call placed to MD to notify of medication delivery status. Return call pending. 7/13/2019 8:39 PM - A progress note documented Return call received from MD, new order, administer medication when it comes in, will notified 11-7 shift. There was lack of evidence when the facility received the medications. 7/14/2019 5:00 PM - A review of the eMAR lacked evidence that the scheduled 5:00 PM medication [MEDICATION NAME] 400 mg was administered. 7/15/2019 5:00 PM - A review of the eMAR revealed that R154 was administered her first dose of [MEDICATION NAME] 400 mg since admission. 2/21/2020 3:00 PM - An interview with E2 (DON) confirmed that the previously documented medications were not administered to R154. The facility failed to be free of significant medication errors when R154 missed multiple doses of medications due to not obtaining the required medications timely. Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference on 3/6/2020 at 2:25 PM.