DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Springs Rehabilitation at Brandywine LLC **DATE SURVEY COMPLETED:** November 15, 2024

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from October 28, 2024, through November 15, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 153. The investigative sample totaled 91 residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**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 November 15, 2024: F557, F561, F565, F572, F577, F582, F584, F609, F610, F623, F626, F641, F644, F655, F656, F657, F658, F679, F684, F690, F697, F700, F802, F805, F806, F807, F809, F812, F842, F880, F881, F883 and F887.	Cross Refer to the Plan of Correction submitted 12/13/2024: F557, F561, F565, F572, F577, F582, F584, F609, F610, F623, F626, F641, F644, F655, F656, F657, F658, F679, F684, F690, F697, F700, F802, F805, F806, F807, F809, F812, F842, F880, F881, F883 and F887.	1/2/2025

Provider's Signature Marilyn P. Ames Title Administrator Date 12/13/24

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3201.3.0	**General Requirements**		
3201.3.7	**The nursing facility shall comply with 42 CFR 483.10, 483.13, 483.15, and/or 16 Delaware Code, §1121 regarding the rights of residents. Those rights shall be made available in writing to residents, guardians, representatives or next of kin.** **This requirement was not met as evidenced by:** Based on clinical record review and interview, it was determined that for seven (R70, R74, R75, R78, R80, R99, and R315) out of eight residents reviewed for resident rights, the facility failed to inform the residents both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities. Findings include: 9/11/23 – A revised State of Delaware resident rights notice was signed into law, and it became effective for facility compliance on June 27, 2024. The revised notice required that every facility in the State of Delaware have the resident/resident representative acknowledge and sign the document. 11/12/24 – A review of the electronic medical record (EMR) revealed that R70, R74, R75, R78, R80, R99 and R315 did not have a revised resident rights document in their record. 11/7/24 9:00 AM – During an interview, E14 (SW) stated that she began employment in the facility on July 18, 2024, and that she had been unaware of the revised State of Delaware Long Term Care resident rights document at that time. E14 stated that she has since learned of	STATE TAG 3201.3.7 A. R70, R74, R75, R78, R80, F99, F315 have been given copy of updated / current Resident Rights. B. Social Services Director will conduct a full house audit to assure that all current residents have been provided the updated Resident Rights. C. Root Cause determined to be lack of understanding that all residents needed to be provided with updated resident rights. Admissions Director, social services staff and Guest Services will be educated on providing updated resident rights. D. Nursing Home Administrator/designee will randomly audit weekly x4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	1/2/2025

Provider's Signature Amy Ann P. Amos Title Administrator Date 12/13/24

NAME OF FACILITY: Springs Rehabilitation at Brandywine LLC **DATE SURVEY COMPLETED:** November 15, 2024

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	the revised rights document, and now the facility has a process in place to get the document signed for every new admission to the facility, but the process to have current long-term residents sign the document is ongoing at this time. 11/13/24 3:00 PM – Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.		
16 Del. C., Ch. 11, SubCh. VII	**§1162 Nursing Staffing:** **(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **This requirement was not met as evidenced by:** Based on interview and review of facility records, it was determined that for four out of 39 days reviewed, the facility failed to provide staffing at a level of at least 3.28 hours of direct care per resident per day. Findings include: A staffing audit was conducted by the State of Delaware, Division of Long-Term Care Residents Protection during the November 15, 2024 annual and complaint survey. Review of the facility's documentation revealed the following days to be out of compliance: Sunday, 4/14/24 = 3.13 Saturday, 6/1/24 = 3.05 Sunday, 6/2/24 = 3.07	Nursing Staffing: A. No residents were negatively affected on the dates that the facility was below the state minimum requirements for staffing. B. Minimum staffing levels in effect. No residents are currently affected by the staffing levels of the facility. C. Root cause determined to be lack of thorough understanding on process of calculation of patient-per day. Staffing coordinator and nursing supervisors will be educated by NHA or designee on the minimum staffing requirements, and the processes for calculating PPD and ensuring the staffing requirements in the event of staffing call offs and census changes. D. Assistant director of nursing/designee will audit daily x3 weeks until a 100% compliance is achieved, then weekly x4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will	1/2/2025

Provider's Signature Mira Ann P. Amos Title Administrator Date 12/13/24

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	Saturday, 6/15/24 = 3.18 11/7/24 at 8:27 AM – During an interview, finding was confirmed with E1 (NHA). 11/13/24 at 1:30 PM – Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

Provider's Signature Mary Ann P. Amos Title Administrator Date 12/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS REHABILITATION AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

(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
E 000	Initial Comments An unannounced annual Emergency Preparedness survey was conducted at this facility by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection from October 28, 2024 through November 15, 2024. The facility census was 153 on the first day of the survey. The facility was in substantial compliance in accordance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from October 28, 2024 through November 15, 2024. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 153. The investigative sample totaled 91 residents. Abbreviations/definitions used in this report are as follows: Activities of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; BID- twice a day; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 00 to 15. 13-15: Cognitively intact 08-12: Moderately impaired 00-07: Severe impairment CDC- Center for Disease Control;	F 000		

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

Electronically Signed | 12/13/2024

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F 000	Continued From page 1 CMS- Centers for Medicare & Medicaid Services; CNA - Certified Nursing Assistant; C&S- culture & sensitivies; d/c - discharge; DELVAX- also known as Delaware Public Health Immunization Information System, a public portal hosted by the State of Delaware that immunizations are reported on; DON - Director of Nursing; DOR - Director of Rehab; dysuria- pain on urination; EBP - Enhanced Barrier Precautions; ESBL - extended -spectrum beta lactamses, an enzyme that makes some antibiotics ineffective to treat bacterial infections; Fecal disimpaction: a medical procedure that requires experiential training and is often performed by a physician or a specially trained nurse under the direction of a physician; FM - Family Member; Hydronephrosis; swelling of a kidney due to build up of urine; occurs when urine cannot drain out from the kidney to the bladder; ID- infectious disease; ID- intellectual disability; IM - intramuscularly; in situ- in place; IP- Infection Preventionist; LCD- last covered day; LPN - Licensed Practical Nurse; LTCM - ling-term care medicaid; MD - Medical Doctor; MDRO- multi-drug resistant organisms; MDS - Minimum Data Set/federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; Milligram (mg) - metric unit of weight, 1 mg	F 000		

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F 000	Continued From page 2 equals 0.0035 ounce; Milliliters (mL) - metric unit of liquid volume, 5 ml equals 1 teaspoon; NHA - Nursing Home Administrator; NP - Nurse Practitioner; NS - normal saline; NSS- normal saline solution; Obstructive uropathy- disorder of the urinary tract in which the flow of urine is blocked; Ombudsman - resident representative who investigates reported complaints and helps to achieve agreement between parties; PASSAR/Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions; PICC- peripherally inserted central catheter; PO - by mouth; PPE- personal protective equipment; QA - Quality Assurance; RC- related condition; RCC - Regional Clinical Coordinator; RN - Registered Nurse; RNAC: Registered Nurse Assessment Coordinator; Rt - right; SMI- significant mental illness; SNF - skilled nursing facility; SS - Social Services; UA- urinalysis; UM - Unit Manager; Urinary continence - ability to prevent accidental leakage of urine from bladder; UTI - urinary tract infection; Voiding Diary - a record of voiding (urinating) for 72 hours and/or 3 days.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2)	F 557		1/2/25

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F 557	Continued From page 3 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it has been determined that for five (R26, R29, R62, R81 and R82) randomly observed during the survey, the facility failed to ensure each resident were treated with respect and dignity. Findings include: 1. R82's clinical record revealed: 6/5/22 - R82 was admitted to the facility. 9/24/24 - A review of R82's MDS assessment revealed, [R82] was dependent for toileting, showering/bathing and personal hygiene. 10/2/24 (last revised) - R82's care plan interventions documented, "Resident has a suprapubic catheter position catheter bag and tubing below the level of the bladder and away from entrance doorway." 10/31/24 10:18 AM - Observed R82's suprapubic catheter bag and tubing was visible from the doorway. 10/31/23 10:33 AM - R82's catheter bag remained visible from the hallway. During an	F 557	(1) A. R82's foley bag was moved to the window side. Staff will be educated regarding plan of care B. Residents with Foley catheter will be reviewed to ensure residents preference for foley bag positioning is honored to promote respect/dignity. C. Root cause was determined to be due to staff's lack of understanding on the importance of following plan of care and maintaining dignity. Staff Development/Designee will educate staff regarding honoring resident plan of care for foley bags positioning and to promote respect/dignity D. Daily audit by Unit Manger/Designee of residents with foley catheter to ensure foley bags are placed as per plan of care and in a dignified manner x 5 days until 100% compliance is achieved and sustained. The following will be a weekly	

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F 557	Continued From page 4 interview, E25 (CNA) stated, "I'm [R82's] care provider this is my first time working with him, I guess I overlooked where the bag was." E25 left R82's room and was observed entering another resident's room." R82's catheter bag and tubing remained visible from the hallway. 10/31/24 10:38 AM - During an interview, E26 (LPN) stated, "[R82's] catheter bag should be placed on the side of the bed that the tubing is positioned." E26 also stated, "I'm not really sure what is in [R82's] care plan for his catheter." At 10:43 AM, E26 entered R82's room and stated to R82, "I need to place your catheter bag away from your door you can see it from the hallway, it's a dignity issue and it should not be seen from the hallway. E26 repositioned R82's catheter bag so it was not visible from the hallway. 11/13/24 11:05 AM - Findings were confirmed with E2 (DON). 11/15/24 at 2:35 PM - Finding was reviewed with E1 (NHA), E2 (DON), E4 (LPN/QA/IP), E55 (RCC) and E27 (ADON). 2. An observation by the Surveyor on 11/15/24 at 12:10 PM revealed E53 (CNA) sitting in an armchair with her legs hanging over the left armrest dangling and on her cellphone while positioned between two out of the four residents eating lunch at the table in the dining room. E53 was not facing nor assisting either resident at the time of the observation. The residents at the table were: R26, R29, R62 and R81. 11/15/24 at 12:15 PM - Finding was immediately reviewed with E54 (RN/UM).	F 557	audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. (2) A. No adverse effect related to the observation for R26, R29, R62 and R81. E53 was immediately educated regarding the observation B. Nursing staff will be educated by Staff Development/Designee regarding expectations when providing supervision to residents while in a resident care area and to treat residents with respect and dignity. The root cause was determined to be due to the staff's lack of understanding on their actions pertaining to maintaining residents' respect and dignity. Staff Development/Designee will educate nursing staff regarding expectations when providing supervision while in a resident care area and to promote resident respect and dignity. D. Daily audit of each unit dining areas by the Unit Manager/Designee by observation during mealtimes to ensure residents are treated with respect/dignity x 5 days until 100% compliance is achieved and sustained. The following will be a	

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F 557	Continued From page 5 11/15/24 at 2:35 PM - Finding was reviewed with E1 (NHA), E2 (DON), E4 (LPN/QA/IP), E55 (RCC) and E27 (ADON).	F 557	weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process and revision will be made to maintain and sustain compliance.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not	F 561		1/2/25

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F 561	Continued From page 6 interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of other facility documentation, it was determined that for three (R20, R78 and R80) out of four sampled residents reviewed for activities, the facility failed to allow cognitively intact residents the choice to go outside on their own or alone. Findings include: 1. Cross refer F679, example 1 8/21/20 - An activity care plan was developed for R20 to participate in current preferred leisure group of his choice including... community outings, outdoors during appropriate weather months. R20's interventions included providing a program of activities that was of interest and empowers R20 by encouraging/allowing choice, self expression and responsibility... R20's preferred activities are:... community outings, outdoors during appropriate weather months. 10/28/24 1:46 PM - During an interview, R20 stated, "With the new management, we are not allowed to go outside to get some fresh air. Before, we were allowed to go out - there's a courtyard that is enclosed but we can't go there whenever we want to go, unless (sic) staff would take us outside." 11/8/24 2:00 PM - During an interview, E16 (Activities Director) stated that residents are allowed to go out to the courtyard to enjoy breath of fresh air weather permitting with staff supervision for safety reasons.	F 561	(1)(2) A. R20 discharged from the facility. Activity Director will meet with R78 and R80. Activity preferences will be reviewed and they will be informed of the supervision procedure for outdoors. R78 and R80 have been provided with a copy of the current outdoor activities for the month. B. A review of care plans will be conducted to identify like residents and a copy of the current outdoor activities for the month will be provided. C. Root cause was determined to be due to staff□s lack of understanding of residents□ rights to choice outdoor activities on their own or alone. The IDT team will review the activity calendar and will adjust the frequency of outdoor activities based on the resident interviews conducted. Activities staff will be educated by Operations Consultant on resident rights to choice outdoor activities on their own or alone. Residents will be educated via Resident council on the process for outdoor supervision and access to lobby. D. NHA or designee will conduct weekly	

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F 561	Continued From page 7 2. Cross refer F679, example 2 6/21/22 - An activity care plan was developed for R80 to participate in current preferred leisure group of his choice including... community outings, outdoors during appropriate weather months. [R80's] interventions included providing a program of activities that was of interest and empowers [R80] by encouraging/allowing choice, self expression and responsibility... [R80's] preferred activities are:... community outings, outdoors during appropriate weather months. 10/28/24 1:30 PM - During an interview, R80 stated, "We are not allowed to go outside to get some fresh air without (sic) staff. Most of the time there is no staff to take us out in the courtyard." 11/8/24 2:05 PM - In a follow-up interview, E16 (Activities Director) stated that the residents have to be supervised by staff everytime they go out "even if it's just going out in the courtyard." 11/12/24 2:35 PM - Findings were discussed with E1 (NHA), E2 (DON) and E47 (Regional Nurse Consultant). 3. Cross refer F809, example 2 Review of R78's clinical record revealed: 1/18/22 - R78 was admitted to the facility. 9/4/24 - R78's annual MDS documented that R78 had a BIMS of 15. 9/2/24 - R78's Elopement assessment documented no risk for elopement; R78's quarterly fall assessment revealed no falls in the	F 561	audits x4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance (3) A.The facility cannot retroactively correct the issue related to R78. The mealtime sheet and truck delivery log was reviewed, by the regional dining consultant on 10/29/24 to ensure posted mealtimes met regulatory requirements. B. The dietary staff were educated, on 10/29/24, on the mealtime sheet and the requirements for the start time of each meal. Tray line start times were posted for the kitchen staff and the mealtime sheet was updated and distributed to the units. C. The root cause analysis determined that staff failed to follow the posted start times for each meal to ensure all units received meals in a timely manner. All dietary staff received additional education on 10/29/24 by food service director and regional consultant, on mealtimes and following the posted times to start the tray line for each meal. In addition, the dietary team member who delivers the food trucks to the units will document the time the truck is delivered to the unit and the nursing team will sign off on the time the truck was received. D. The food service director/designee will audit the culinary staff to ensure that trayline starts at the recommended times	

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	085004	A. BUILDING _____ B. WING _____	C 11/15/2024

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SPRINGS REHABILITATION AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

(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 561	Continued From page 8 preceding three months and that resident was independent with activities of daily living and ambulation (moving about; walking). 11/1/24 11:00 AM - During an interview, R78 stated that she is not able to go into the facility lobby, outside the facility, or into an enclosed outside courtyard as she would like because the doors out of the facility residential areas are always locked. 11/1/24 11:00 AM - During an interview, R78 reported that because of the late lunch meal lunch tray deliveries on the B hallway where her room is located, that sometimes she must choose between eating lunch or participating in a 2:00 PM activity. A review of the October activities calendar revealed that there was a daily activity that started at 2:00 PM. 11/12/24 10:30 AM - During an interview E1 (NHA) stated that "[R78] is permitted to go outside of the facility, [R78] needs to ask someone, and then she needs to have staff with her when she is outside. Sometimes, there aren't staff members available to sit with residents outside in the courtyard. E1 stated that (R78) "could go into the lobby at any time upon request, so that the door to the lobby could be unlocked." -Review of the facility schedule for lunch tray deliveries revealed that lunch tray deliveries are supposed to end at 1:15 PM. -A review of the facility meal tray delivery logs revealed that on 10/6/24 the lunch meal trays were delivered to B hallway at 2:15 PM; on 10/27/24, the lunch trays were delivered to the B	F 561	for all meals. The Food service director will monitor the truck delivery logs for consistency. The audits will be completed daily, or once 100% compliance is achieved, for three consecutive days. The audits will continue to occur 3x a week for 3 consecutive weeks, or until 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 561	Continued From page 9 hallway at 2:26 PM. -10/28/24 2:13 PM - An observation revealed that the lunch meal cart delivered was delivered at 2:13 PM to the B hallway. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 561		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced	F 577		1/2/25

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F 577	Continued From page 10 by: Based on observation and interview, it was determined that the facility failed to have the survey results from the past three years available in a readily accessible area for residents, family members and legal representatives. Findings include: 10/31/24 11:10 AM - During a random observation in the facility lobby, the facility's survey results were not visible in the lobby. Upon surveyor request, E13 (receptionist) retrieved the survey results binder that was located behind the reception desk. During an interview on 11/1/24 at 8:30 AM, E13 stated that the survey results binder was always kept behind the reception desk. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 577	A. Community posting has been updated notifying residents, visitors, and employees of the location of Survey findings. Binder containing survey results have been relocated and are no longer behind the receptionist desk. No adverse effect related to deficiency. B. Residents will be educated via Resident council as to the location and accessibility of survey results. C. Root cause determined related to recent cosmetic changes to lobby and failure to readdress location of survey results. NHA/Designee will educate the IDT team to include business office manager, reception team, guest services staff, nurse management, and social services of the requirement for survey results from the past three years to be readily available. D. Activities Director or designee will conduct weekly audits x4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice	F 582		1/2/25

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F 582	Continued From page 11 CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident	F 582		

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F 582	Continued From page 12 representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R159) out of four residents reviewed for beneficiary notification, the facility failed to provide R159's responsible party with the required notification of the expiration of her Medicare of benefit. Findings included: R159's clinical records revealed: 9/20/23 - R159 was admitted to the facility with diagnoses including Parkinson's Disease, muscle weakness and dementia. 9/26/23 - R159's admission MDS documented a BIMS score of 3, indicating severe cognitive impairment. 10/4/23 3:34 PM - R159's Social Services notes documented, "Resident/Rp [Responsible Party] invited to participate in care plans scheduled this week. Copy of care plan, medications, and orders offered."	F 582	A. R159 has been discharged from the facility. No NOMNC was issued as resident had exhausted Medicare coverage. B. An audit of current Medicare Part A residents to validate exhaust dates will be completed C. Root cause determined to be staff not following best practices of reviewing exhaustion of benefits although NOMNC not required. Education of Social services staff, Business Office Manager, RNACs will be completed by Operations Consultant to review the requirements of issuing NOMNC. D. SSD or Designee will conduct weekly audit x4 until a 100% compliance is achieved, then monthly x 3 months with a	

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F 582	Continued From page 13 1/4/24 12:45 PM - R159's clinical records documented, "Resident [R159] to discharge to home to be picked up by daughter and HHA (Home Health Association) referral sent out and accepted by resident." 11/6/24 10:00 AM - During a telephone interview, F1 (R159's Responsible Party) stated, "My brother and I visit every evening and we speak to the nurses. No one told us anything that the Medicare payment was ending, and we would have to pay privately. I was taking my mother to an appointment on 1/4/24 and the admission person ran out and said that she had been trying to get hold of me. She said that my mother's Medicare ran out on 1/1/24 and she was going to be billed $482 per day. The bill came up to about $1,000 and we had to pay half of it. The facility paid the other half. My mother is on a fixed income, and she should not have had to pay any money. " 11/7/24 11:17 AM - A review of R159's clinical records lacked evidence that a Notice Of Medicare Non-Coverage (NOMNC) and the option to appeal the end of the skilled services were provided to her responsible party. During an interview, E1 (NHA) stated, "I was not here when that happened, so I don't know anything about it." The facility failed to provide R159's responsible party with the NOMNC, and the option to appeal the ending of the skilled Medicare benefits. This failure resulted in R159 paying out of pocket for care. 11/12/24 1:30 PM - Findings were confirmed with E1 and E2 (DON)	F 582	goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance	

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F 584	Continued From page 14	F 584		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to	F 584		1/2/25

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F 584	Continued From page 15 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for residents rooms observed in three out of five hallways and two shower rooms, the facility failed to ensure that the necessary housekeeping and maintenance services were performed to maintain a sanitary and comfortable interior with an adequate supply of clean linens that are in good condition. Findings include: 1. Surveyor observations from 10/28/24 and 10/29/24 revealed: B hallway: - Room B1: floor in the bedroom was dirty with stains. Along the baseboard under the window was a old heating system but in disrepair where it was coming apart and dirt can be seen inside of it. The shared bathroom had a over the toilet commode with rusted legs. The bathroom door had a vent that was rusted along the top. Two plastic wash bins were sitting directly on the floor uncovered. - Room B3: floor in bedroom was dirty with stains and dust, especially the corners. In addition, there were two nails exposed on top of the windowsill and the windowsill was in disrepair as it was missing a piece of the edge. - Room B5: floor in bedroom was dirty with stains and dust. - Room B7: floors in bedroom and bathroom were dirty with stains and dust. F hallway:	F 584	1. A. Resident rooms and bathrooms: B1, B3, B5, C11 and B7 room and bathroom floors were cleaned. B1 Toilet commode was removed and replaced. B1, C11 Bathroom door vents were cleaned and painted. B1 Plastic bins removed from room and discarded. B1, B3 the 2 exposed nails on the windowsill were removed. B1, B3 the windowsill was repaired. B1 the old heating system cover was replaced/ fixed. F14 bed rail removed for room. B5 floor mat was cleaned. B15 trashcan liners were placed in trashcan. E15 stained ceiling tiles were replaced and the room touched up with paint. C11 soap dispenser was added, and hand sanitizer was filled. C11 holes were spackled and painted in the room and bathroom. Shower Rooms: B hall shower room floor tile repaired, light fixtures were cleaned, floor tile grout was cleaned, and equipment was power washed and sanitized. E Hall shower room floor wash cleaned, light fixtures were cleaned, chair scale was cleaned, and resident belongings	

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F 584	Continued From page 16 - Room F14: right side quarter length bed rail was laying on top of the resident's dresser as the Surveyor was told by the resident that her bed rail was "knocked off... two weeks ago." On 11/7/24 from 3:42 PM to 4:10 PM - An environmental tour conducted with E17 (Regional Maintenance Director) and E18 (Environmental Services Director) revealed the following: B Hallway: - Room B1: bedroom and bathroom floors were dirty with stains and dust. The shared bathroom had an over the toilet commode with rusty legs and gray paint chipping off the legs. There were two plastic wash bins sitting directly on the floor uncovered. The bathroom door vent was rusted at the top. The old heating system (not in use anymore) along the baseboard under the window was in disrepair with dirt observed inside. - Room B3: bedroom was inaccessible during the environmental tour. Surveyor reviewed with E17 the following issues that were identified during screening on 10/29/24: two nails exposed on top of the windowsill and the windowsill was in disrepair as it was missing a piece of the edge. - Room B5: bedroom floor and fall mat were dirty with stains. - Room B7: shared bedroom and bathroom floors were dirty with stains. - Room B15: shared bathroom floor was dirty with stains and no trashcan liner was in place. E Hallway: - Room E15: bedroom and bathroom had discolored ceiling tiles and the wall against the bed had chipped paint and scratches. F Hallway:	F 584	were removed and wheelchair parts removed and placed in therapy storage. 2. Linen: E wing, D wing linen has been replenished. Received order and replenished entire building. B. Inspection Audit was completed for the door vents being in good shape. An Audit was completed for resident room detail cleaning. Inspection audit was completed for any loose or broken baseboard covers. Inspection audit was completed for toilet commodes in good working order. Inspection audit was completed for exposed nails. Inspection audit was completed for bed side rails. Inspection audit completed that trashcans have liners. Inspection audit for stained tiles was completed. Soap dispenser audit was completed. Hand sanitizer audit was completed. Tub room cleaning audits completed. Wall and paint audit inspection completed. C. Root cause was determined to be lack of staff understanding the necessary housekeeping and maintenance services required to maintain a sanitary and comfortable interior with an adequate supply of clean linen. Housekeeping staff will be educated by the Director of Environmental / designee on policy and procedures on how to keep a Safe and Homelike Environment. Director of maintenance or designee to in-service maintenance staff on policy and	

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F 584	Continued From page 17 - Room F14: right side quarter length bed rail was observed still laying on top of the resident's dresser. Observations of two community shower rooms revealed: - B Hallway shower room had broken floor tile, discolored grout in the shower, the shower chair had brown substance smeared on the left side and small brown clumps were scattered on the shower floor and the ceiling light cover had evidence of insect debris. - E Hallway shower rooom floor was dirty and the ceiling light cover had evidence of insect debris. There was black debris in tile grout in many locations of the room, and it was heavier in the resident shower space, the wheelchair scale was dirty with debris, and there were shoes and wheelchair parts scattered on the floor in the toilet area. During a combined interview while on the environmental tour, E18 stated that the shower rooms get cleaned everyday. When the Surveyor asked if the facility conducts housekeeping audits, E17 and E18 were unable to provide any evidence. E17 stated that he has not been in this building for approximately one year. E17 stated that the facility has had three (3) maintenance directors over the past year and the most recent one just resigned yesterday. When asked to see the monthly maintenance audits, E17 stated that he cannot find them. E17 stated that they use an electronic system to track their work orders called Records, which has been in use for one year. All findings were confirmed during the tour. 2. Surveyor observations on 10/28/24 at 2:45 PM and 10/29/24 at 3:23 PM revealed the following:	F 584	procedures on how to keep a Safe and Homelike Environment. Director of maintenance or designee to in-service maintenance staff on proper installation and safety of base board heater covers. D. Environmental Director / Designee will audit sanitary and comfortable interior with adequate supply of linen weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. (wash basin) A. R41's bathroom was checked, and each resident's basins were replaced, labeled and stored appropriately when not in use. B. Active residents' bathroom and bath basins will be checked, labeled and will be stored appropriately when not in use. C. The root cause was determined to be lack of process with labeling and storing bath basins when not in use. Staff Development/Designee will in-service nursing staff, and new hires to ensure bath basins are labeled and stored appropriately when not in use. D. Daily audit by Unit Manager/Designee	

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F 584	Continued From page 18 C hallway room 11: - The bathroom lacked a hand soap dispenser, and the hand sanitizing gel dispenser was empty; - Holes on the bathroom wall were present where the previous soap dispenser had been located; - The ventilation grate on the bathroom door had visible areas of rust; - The bathroom floor in bathroom appeared dirty; - The walls in the bedroom were in disrepair, with visible peeling paint. 10/30/24 8:15 AM - Observations of the E wing linen closet revealed a minimal supply of linens: - 2 fitted sheets; - 5 flat sheets; - No washcloths or towels. 10/30/24 8:20 AM - During an interview E23 (CNA) confirmed the lack of linens in the E wing linen closet. 10/30/24 2:00 PM - The observations for room C hallway room 11 were confirmed by E12 (Maintenance Director) during a tour of the C hallway room 11 bathroom and bedroom. 10/31/24 8:30 AM - Observations of the D wing linen closet revealed a minimal supply of linens: - 1 fitted sheet; - 1 bed pad; - 2 wash cloths; - No towels. 10/31/24 8:45 - During an interview, E26 (LPN) and E59 (CNA) confirmed the D wing linen closet observation and stated that in the facility, "there are never enough linens, any day or at any time, and it makes it difficult to do our jobs."	F 584	to ensure bath basins are labeled and stored appropriately when not in use 5 days or until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 584	Continued From page 19 10/31/24 10:09 AM - During an interview with another surveyor, E26 stated that because there were no wash cloths available to use, that E26 needed to use a towel to both wash and dry a resident while providing care to the resident. E26 stated that "one side is wet and one side is dry". 10/31/24 11:17 AM - During an interview, E18 (Environmental Services Director-Housekeeping) stated that there is no overnight laundry staffing shift in place in the facility, so dirty linens do not get laundered overnight, and that affects how quickly linen closets are restocked with clean linens the next morning. The morning laundry shift must come in and get started right away to do laundry from the night before, in order to resupply the linen closets with clean linens. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 584		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(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	F 609		1/2/25

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	085004	A. BUILDING _____ B. WING _____	C 11/15/2024

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F 609	Continued From page 20 the events that cause the allegation do not involve 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 record review, it was determined that for one (R14) out of seven residents reviewed for hospitalization, the facility failed to report the injury of unknown origin, which resulted in an emergent transfer to the hospital for treatment, to the State Agency. Findings include: Cross refer F610 R14's clinical record revealed: 9/4/24 6:30 AM - The facility's incident report documented that R14 was found in bed with a bleeding laceration to her left lower leg. R14 was transferred to the hospital. 9/5/24 10:00 PM - Approximately 39 hours later, the facility reported R14's incident from 9/4/24 at 6:30 AM to the State Agency.	F 609	A. R14's incident was reported on 9/5/24. The facility cannot retroactively correct the issue B. Injury of unknown origin that meets the abuse reporting criteria will be reviewed in the last 7 days to ensure incident is reported as per the reporting guideline. C. The root cause was determined to be due to an oversight from the facility staff to understand the abuse reporting timeframe. Staff Development/Designee will educate the management team (Admin/DON/ADON/IP/UM/Supervisors/SW) regarding timeframe for reporting of injury of unknown origin that meets the abuse reporting guideline.	

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F 609	Continued From page 21 11/12/24 8:28 AM - During a combined interview, findings were reviewed and discussed with E1 (NHA), E2 (DON) and E4 (LPN/QA/IC). 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 609	D. Daily audit by DON/Designee to ensure incidents of unknown origin that meet the criteria for abuse reporting guideline are reported timely x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	
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: §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 observation, record review, interview	F 610	A. R14 has no adverse effect related to	1/2/25

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F 610	Continued From page 22 and review of other documentation as indicated, it was determined that for one (R14) out of seven residents reviewed for hospitalizations, the facility failed to have evidence that R14's injuries of unknown origin were thoroughly investigated. Findings include: R14's clinical record revealed: 9/2/24 - A weekly skin evaluation was performed on day shift and there was no documented evidence of a bruise under R14's left side chin. 9/4/24 6:30 AM - The facility's incident report documented that a "CNA went to resident room to perform rounds and noted blood on sheet and on resident leg. Informed nurse. Resident unable to give description... Immediate Action Taken... Pain assessment and first aid. Resident sent to ED [emergency department]... Laceration... left lower leg... Resident has extremely fragile skin, non-compliance with DermaSavers, legs dangling on side of bed...". 9/4/24 7:53 AM - The hospital record documented, "... 8 in [inch] linear laceration on medial L [Left] calf with clean borders exposing underlying adipose [fat] tissue, multiple blood clots present... Patient is from a nursing home, and they noted this morning that she was in a pool of blood from a large gaping wound to her left lower extremity. Patient is a poor historian from severe dementia and cannot give any history to explain how the wound was made. The staff reports that they did not note any trauma or anything sharp in her bed. She was found in her bed, did not have any fall or any other signs of injury. She does have a very thin and frail skin and is prone to skin tears, but nothing this	F 610	the deficiency. B. Injury of unknown origin will be reviewed in the last 7 days to ensure that incidents were thoroughly investigated. C. The root cause was determined to be due to an oversight from the facility staff to assess resident skin and thoroughly investigate an incident before transfer from the facility. Staff Development/Designee will be educated regarding thorough investigation through skin assessments of residents with injury of unknown origin. D. Daily audit to ensure incidents of unknown origin are thoroughly investigated x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 610	Continued From page 23 significant...". In addition, the hospital Forensic Nurse Examiner documented that R14 had a bruise measuring 1 cm x 2 cm circular green and purple under her chin on the left side. 9/4/24 10:14 PM - A nurse's note documented that R14 was readmitted to the facility. There was no evidence of a skin assessment upon R14's return. 9/6/24 7:50 AM - Almost 33 hours after returning from the hospital, a skin/wound note was documented that R14 was seen for a skin assessment and had a "... Left side of mandible [chin]- bruise...". 9/11/24 - An additional note to the facility's 9/4/24 incident report documented, "Investigation completed. Resident has a history of fragile skin. Environmental check completed. Per investigation resident had legs laying over edge of bed when skin issue was noted. No sharp edges were noted but because of resident's (sic) fragile skin, age and diagnosis of osteoarthritis, nonrheumatic aortic stenosis, dementia, and ischemic heart disease it was concluded that resident (sic) fragile skin condition along with her diagnosis and contact with the side of bed caused skin alteration. Resident also self-propels in wheelchair. Measures implemented including padding bed frame and wheelchair frame... abuse and neglect ruled out." While the facility's investigation focused on R14's left lower leg laceration, the facility failed to identify and investigate the bruise under R14's chin which was noted on the 9/6/24 skin assessment.	F 610		

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F 610	Continued From page 24 Surveyor observation of the hospital and forensic nurse examiner record revealed pictures of R14's bruise under her chin and the left medial lower leg laceration. There was no documentation in R14's EHR that the chin bruise was identified by the facility nursing staff through skin checks until 9/6/24 and thoroughly investigated as the resident requires assistance for transferring with two staff assistance. Review of the facility's investigation lacked evidence of the following: - no statement obtained from R14's assigned CNA from 9/4/24 at 6:30 AM; and - no statements/interviews obtained from the previous shift, 9/3/24 on 3-11 PM. The facility failed to thoroughly investigate R14's injuries of unknown origin from 9/4/24 at 6:30 AM incident requiring emergent transfer to the hospital and treatment with sutures and steri-strips. 11/12/24 8:28 AM - During a combined interview, findings were reviewed and discussed with E1 (NHA), E2 (DON) and E4 (LPN/QA/IC). No further documentation was provided to the Surveyor. 11/13/24 1:30 PM - Findings were reviewed with E1, E2, E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.	F 610		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must-	F 623		1/2/25

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F 623	Continued From page 25 (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written	F 623		

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F 623	Continued From page 26 notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information	F 623		

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F 623	Continued From page 27 becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R102) out of six residents reviewed for transfer/discharges, the facility failed to notify the Ombudsman of R102's 4/27/24 transfer to the hospital. Findings include: Review of R102's clinical record revealed: 8/20/23 - R102 was admitted to the facility. 4/27/24 - R102 was transferred to [hospital]. 11/7/24 11:30 AM - Review of R102's electronic medical record (EMR) and April 2024 [facility] Ombudsman Transfer log lacked evidence that the Office of the State Long-Term Care Ombudsman was notified. 11/8/24 9:50 AM- During an interview, E1 (NHA) confirmed that R102 was sent to the hospital from the facility on 4/27/24. E1 also confirmed that R102's name did not appear on the April 2024 [facility] Ombudsman Transfer log nor did the facility have any documentation to prove that the Ombudsman's Office was notified of this transfer.	F 623	A. R 102 will be added to the April transfer log, and April log to be resubmitted. B. Facility audit last 60 days of transfers to validate all transfers are logged and sent to the Ombudsman as required. C. Root Cause is determined to lack of understanding the process of completing the monthly transfer log for submissions. Education will be provided to the Social Services staff, Business Office Manager and Admissions Director by the Operations Consultant. D. SSD or designee will log transfers weekly and audit weekly x4. weekly audit x4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be	

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F 623	Continued From page 28 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.	F 623	made to maintain and sustain compliance. NHA or designee will validate Ombudsman log submission monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance	
F 626 SS=E	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges.	F 626		1/2/25

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F 626	Continued From page 29 §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R125) out of six residents reviewed for transfer/discharge, the facility failed to implement a policy allowing R125 to return to the facility after his 10/31/23 hospitalization. The facility refused to allow R125 to return to the facility due to lack of a payor source and he remained unnecessarily hospitalized for an additional 91 days. The facility also failed to allow R125 to return to the facility while appealing this discharge. Findings include: Facility's Transfer and Discharge- Policy Explanation and Compliance Guidelines:... 2. Once admitted, the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions:... e. The resident has failed, after reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for his or her stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay...". Revised 9/2024	F 626	A. R125 has been readmitted to the facility B. A review of residents hospitalized over the past 30 days will be completed to verify that there are no current like residents C. Root Cause determined lack of understanding at the time that a 30-day letter of discharge would have been required. Reeducation will be completed with Social services staff, BOM, and Admissions Director by the Operations Consultant to ensure that there is understanding of issuance of 30 day notice. Education will be provided to the Admissions team by the Operations Consultant related to identifying like residents and assuring that the resident is able to admit to the facilities next available beds. D. Admissions Director or Designee will conduct weekly audits x 4 weekly audit x4 until a 100% compliance is achieved, then	

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F 626	Continued From page 30 Cross refer F644, example 2 7/26/23 - R125 was admitted to the facility with diagnoses, including but were not limited to, cardiomyopathy and anxiety disorder. 9/28/23 - R125 was presented a Notice of Medicare Non-Coverage (NOMNC), which stated "therapy issued LCD (last covered day) of 9/28/23" and included information about daily rates and the right to appeal. The NOMNC also documented that R125 refused to sign the NONMC. R125 stayed in the facility as private pay but refused to participate the Medicaid application process. The facility failed to issue a 30 day discharge notice to R125. 10/31/23 - R125 transferred to [hospital] for change in mental status. 11/22/23 12:35 PM- The [Hospital] Discharge Summary documented that [R125] was diagnosed at the hospital with "sepsis secondary to UTI (urinary tract infection) from chronic indwelling catheter... [R125] is medically stable for discharge to SNF (skilled nursing facility)...". 12/4/23 9:45 AM - C2 (hospital case manager) documented in [hospital] discharge planning notes, "... Pt (patient) is medically stable for d/c (discharge) when bed available...". 12/11/23 5:09 PM - C2 documented in [hospital] discharge planning notes, "... [hospital] management has requested this case be escalated to complex CM (case management) for	F 626	monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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(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 626	Continued From page 31 review in order to transfer pt to long term inpatient...". 12/27/23 11:22 AM - C3 (hospital case manager) documented in [hospital] discharge planning notes, "... Pt agreeable to providing financials for long term Medicaid. Pt reports being homeless and not having any family that he speaks to...". 1/2/24 11:23 AM - C4 (RN hospital case management) documented in [hospital] discharge planning notes, "... confirmed with [facility] liaison that the patient did come from their facility and that they do not want to take the patient back because he owes them money. CM (case management) asked liaison if they gave the patient a 30 day discharge notice. CM also asked if LTCM (long term care Medicaid) was obtained, would they consider taking the patient back. Per liaison, she will follow up with this CM as she will forward these questions to administration for clarity. CM to complete PAE (pre-admission evaluation- level of care form) and have the patient and provider sign off on it so that LTCM can be initiated." 1/3/24 9:28 AM - C5 (hospital case management) documented in hospital discharge planning note, "Emailed PAE, PASARR and clinicals to DHSS (Department of Health and Social Services) CIU." 1/8/24 12:49 PM - C4 (RN hospital case management) documented in the hospital discharge planning notes, "... the patient's DE (Delaware) Medicaid app (application) was initiated today. CM asked if they can accept the patient Medicaid pending." 1/22/24 24 2:30 PM - C4 (RN case management)	F 626		

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F 626	Continued From page 32 documented in the hospital discharge planning notes, "... CM confirmed with liaison at [facility] that the patient does not have any days left and they are unable to take him back since he owes them money." 1/29/24 12:26 PM - C4 documented in hospital discharge planning notes, "CM spoke to State Ombudsman [name][phone number] regarding this patient. Per Ombudsman, if the patient has been at the facility longer than 30 days and has not received a 30 day discharge notice, then the patient will have to return to [facility]." 1/30/24 2:50 PM - C4 documented in hospital discharge planning notes, "... Per [facility] liaison, her administration still is declining the patient...". 1/31/24 2:24 PM - C4 reported situation to DHCQ. 2/7/24 8:44 AM - C4 documented in hospital discharge planning notes, "CM received call from liaison of [facility] stating that they have to take the patient back once he is medically cleared to do so... patient has another UTI, on IV antibiotics with ID (infectious disease) following." 2/15/24 10:36 AM - C4 documented a late entry in the hospital discharge planning notes, "liaison of [facility] asked CM yesterday if this patient was on isolation for his ESBL (extended -spectrum beta-lactamases) UTI. CM stated patient is currently not being isolated. Per liaison, the facility isolates for this organism until the resident has completed treatment. Liaison stated [facility] does not have any isolation beds at this time but she will double check. "	F 626		

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F 626	Continued From page 33 3/4/24 12:02 PM - C4 documented in hospital discharge planning notes, "Patient for discharge. Confirmed with liaison of [facility] that they have a bed available. CM scheduled 1600 pick up time...". 10/30/24 2 :46 PM - During an interview, E58 (RDO) stated, "... [R125] was here on Med A rehab and burned through his 100 days. He was sent to the hospital... I don't remember why he was transferred to the hospital. He did not have a payor source so we did not want to take him [R125] back... [R125] had refused to participate in the Medicaid application process... he would not share his financial details... at the time, I and the facility did not know that you had to give a 30 day discharge to residents whether they are long term care or a rehab resident. We thought that only had to be done for long term care residents. I don't think other states have that policy. Again, we were not aware. When he was in the hospital, he was not even a paid bedhold at that time. Now he is Medicaid. We had a training session with C6 (DE Health Care Facilities Administrator), C7 (DE Ombudsman) and C8 (DE Ombudsman) regarding this." 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office. 1 out of 6 residents	F 626		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		1/2/25

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F 641	Continued From page 34 Based on record review and interview, it was determined that for one (R158) out of the residents reviewed in the investigative sample, the facility failed to ensure the Minimum Data Set (MDS) was accurate. Findings include: 6/27/24 - R158 admitted to the facility. 6/27/24 - E3 (MD) ordered R158's nightly bipap with settings in the EMR. 11/10/24 2:17 PM - Review of R158's admission MDS revealed that in Section O - Special Treatments, Procedures and Programs, the facility failed to document R158's bipap usage. 11/12/24 10:59 AM - During an interview, E57 (RNAC) stated, "yeah, we did not code for [R158]'s bipap." 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.	F 641	A. Modified resident R158□s 6/27/24 5d/Discharge to reflect resident being on Bi-Pap. B. An audit of MDSs completed in the last two weeks will be reviewed to ensure that section O residents with BiPap will be conducted to ensure that MDS assessments were completed accurately for those residents C. Root Cause determined lack of understanding of assessments pertaining to B-Pap device. RNACs will be in-serviced by Regional MDS Consultant on assuring the Accuracy of Assessments pertaining to Bi-Pap device to assure proper coding on the MDS. D. RNAC/Designee will audit MDS assessments to assure coding accuracy for Bi-PaPs. Audits will be completed weekly x4 then monthly x3 then quarterly or until 100% compliance is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review	F 644		1/2/25

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F 644	Continued From page 35 (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R141 and R125) out of two sampled residents reviewed for PASARR, the facility failed to notify the appropriate state-designated authority when the residents' new diagnosis of mental disorder were identified. Findings include: 1. Review of R141's clinical record revealed the following: 7/11/24 - A PASARR Level I Screen Outcome revealed "No Level II Required". 7/12/24 - R141 was admitted to the facility. 10/24/24 1:00 PM - An encounter note by E52 (NP) documented, "Chief Complaint: Depression... Patient verbalized that he is feeling okay now and goes in and out of feeling depressed secondary to being here in the facility."	F 644	A. The PASRR has been updated and submitted for R141 and R125. B. An audit of current residents in-house with psychotropic medication changes and/or psychiatric consults in the past 30 days will be conducted to confirm that the PASRR is updated as indicated. C. Root Cause determined lack of understanding of the need to update the change in condition as it was not noted upon hospital return. IDT team of Admissions Director, Social Services staff, Nursing managers and Business office Manager will be reeducated by the Operations Consultant regarding coordination of the PASRR. D. SSD or designee will conduct random audits weekly x4 until a 100% compliance	

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F 644	Continued From page 36 10/28/24 - R141 had a physician's order for citalopram (Lexapro) 20 mg (milligram) 1 tablet by mouth daily for depression. 10/28/24 - A nurse progress note by E54 (RN/UM) documented, "... resident [R141] was started on new medication Lexapro 20 mg daily...". 11/6/24 - A facility Psychiatric Evaluation revealed that R141 was diagnosed with adjustment disorder with depressed mood. 11/7/24 12:29 PM - There was a lack of evidence the state PASARR authority was made aware. 11/7/24 3:50 PM - In an interview, E1 (NHA) confirmed that the state PASARR authority was not contacted for R141 when he was diagnosed with depression and was prescribed with an antidepressant medication on 10/28/24. E1 also stated that the facility submitted a referral to the state PASARR authority "... only today when it was brought to our attention by the surveyor." 2. Cross refer F626 Review of R125's clinical record revealed: 7/13/23 - The [hospital] obtained R125's PASARR, which stated no Level II required. 7/25/23 - R125 admitted to the facility. 8/3/23 - E51 (NP) ordered in R125's EMR," Risperdal 0.5 mg PO (by mouth) BID (two times a day) for delusional disorder."	F 644	is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 644	Continued From page 37 At this time when R125 was diagnosed with a new psychiatric disorder and intiated on an atypical anti-psychotic medication (risperdal), the facility failed to refer R125 for a PASARR Level II screening as required. 10/31/23 - R125's quarterly Minimum Data Set (MDS) documented in Section I- Active Diagnoses YES to psychotic disorder. 10/31/23 - R125 admitted to the hospital. 1/10/24 - The [hospital] obtained a new PASARR, which stated no Level II required- No SMI (significant mental illness)/ ID (intellectual disability)/ RC (related conditions). On this PASARR application, the hospital incorrectly stated that R125 was on risperdal for major depression disorder when in fact R125 was on risperdal for delusional disorder, a reportable psychiatric disorder on the PASARR application. 3/4/24 - R125 was re-admitted to the facility with an order for Risperdal 1 mg twice a day for delusional disorder. 3/10/24 - R125's admission MDS documented in Section I Psychotic disorder- YES. The facility failed to recognize the need to correct R125's PASARR application to reflect R125's diagnosis of delusional disorder that required a prescription for Risperdal, an atypical anti-psychotic medication. 11/11/24 1:35 PM - During an interview, E1 (NHA) acknowledged the need for R125 to have a PASARR level II evaluation and stated that Social Services had already put the application.	F 644		

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F 644	Continued From page 38 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.	F 644		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		1/2/25

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F 655	Continued From page 39 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R157) out of 42 residents reviewed in the investigative sample, it was determined that the facility failed to ensure that the baseline care plan was provided to the resident/resident representative. Findings include: Cross refer F697 Review of R157's clinical record revealed: 7/27/24 - R157 was admitted to the facility with multiple diagnoses, including dementia. 7/28/24 - A baseline care plan was generated and was signed by E27 (Previous DON, now ADON) on 8/2/24. 7/31/24 - R157's MDS documented that R157 had a BIMS score of 6, which indicated that R157 had severe cognitive impairment, and that it was very important to R157 to have her family involved in discussions about her care. 11/6/24 - A review of R157's baseline care plan	F 655	A. R157 had been discharged. The facility cannot retroactively correct the issue B. New admissions from the last 7 days will be reviewed to ensure the baseline care plan was provided to the resident/representative based on the requirement. C. The root cause was determined to be due to lack of understanding by the IDT team related to providing baseline care plan to the resident/ representative. Staff Development/Designee will in-service IDT team members on providing baseline care plan to the resident/ representative based on the requirement. Daily in morning meeting, baseline care plan will be reviewed to ensure appropriate documentation is in place to	

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F 655	Continued From page 40 revealed that a Resident/ Resident Representative signature was not present on the baseline care plan. 11/7/24 9:00 AM - During an interview E14 (SW) confirmed that baseline signature page was not signed by R157's resident representative. E14 could not confirm that the baseline care plan had been reviewed with R157's representative since the signature page was blank. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 655	assure that baseline care plans were provided to the resident/ representative based on the requirement. D. Daily audit by NHA/Designee to ensure proof of documentation that baseline care plan were provided to resident/representative for new admissions based on the requirement x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and	F 656		1/2/25

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F 656	Continued From page 41 (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R41) out of five residents reviewed for medications and three (R14, R67 and R76) out of seven residents reviewed for side rails, the facility failed to develop and implement individualized care plans with respect to a seizure disorder and bed rail usage that included measurable objectives and	F 656	(1) A. R41's care plan for Seizure diagnosis was initiated on 11/12/24 B. Active residents receiving anti-convulsant medication will be reviewed to ensure care plan is in place.	

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F 656	Continued From page 42 timeframes. Findings include: 1. R41's clinical record revealed: 11/22/20 - R41 had a active physician's order for Levetiracem 500 mg tablet two times a day for a diagnosis of seizure disorder. 8/9/24 - The significant change MDS assessment documented that seizure disorder was an active diagnosis. Review of R41's comprehensive care plan lacked evidence of an individualized seizure disorder care plan. 11/12/24 at 10:34 AM - During a combined interview, finding was confirmed with E2 (DON) and E4 (LPN/QA/IC). 2. Cross refer F700, example 2 R14's clinical record revealed: 11/7/24 at 4:50 AM - Surveyor observed R14 receiving incontinence care in her bed with left sided quarter length (22 inches) bed rail positioned up, stationary and padded with gray styrofoam. Review of R14's comprehensive care plan revealed the absence of a person-centered care plan for the left side quarter length bed rail. 11/7/24 at 1:50 PM - During a combined interview with E2 (DON) and E47 (RCC), the Surveyor requested R14's bed rail care plan. The facility lacked evidence that a bed rail care plan was developed and implemented for R14.	F 656	C. The root cause was determined to be due to an oversight during chart review. Staff Development/Designee will educate licensed nurses to ensure residents receiving anticonvulsant medications have a care plan in place. ADON/Designee will review with Unit Manager/Designee during chart review to ensure residents receiving anticonvulsant medications have a care plan in place. D. Daily audit by DON/Designee to ensure residents receiving anticonvulsant medications has care plan in place x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. (2)(3)(4) A. R14 was assessed for need of bedrail/grab bar and care planned as indicated. R67 was assessed for need of bedrail/grab bar and care planned as indicated. R76 was assessed for need of bedrail/grab bar and care planned as indicated.	

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SPRINGS REHABILITATION AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

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F 656	Continued From page 43 3. Cross refer F700, example 4 R67's clinical record revealed: 10/31/24 at 9:52 AM - Surveyor observed R67 in bed with the bilateral grab bars (12 inches in length) positioned up and stationary, with the right side padded with gray styrofoam. 11/7/24 at 1:50 PM - During a combined interview with E2 (DON) and E47 (RCC), the Surveyor requested R67's person-centered care plan for bilateral bed rails/grab bars. The facility lacked evidence that a bed rail care plan was developed and implemented for R67. 4. Cross refer F700, example 6 Review of R76's clinical record revealed: 2/22/23 - R76 was admitted to the facility. 10/28/24 11:30 AM - During an observation a left sided quarter bed rail was in place in place on R76's bed. 11/7/24 - A review of R76's care plan revealed the lack of a care plan focus for the bed rail on R76's bed. 11/12/24 1:32 PM - During an interview, E3 (LPN) confirmed the lack of a care plan focus area for R76's bed rail. 11/13/24 at 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 656	B. Active residents with bedrail/grab bar will be reviewed to ensure the need and patient centered care plan is in place. C. The root cause was determined to be lack of understanding on the importance of bedrail/grab bar use and ensuring person centered care plan in place Staff Development/Designee will in-service licensed nurse/RNAC and new hires regarding bedrail/grab bar use and importance of a person-centered care plan. D. Daily audit by DON/Designee to ensure new admission/readmissions residents if bedrail/grab bar use is indicated and has a person-centered care plan in place x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 of new admissions/readmissions until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R67) out of three residents reviewed for activities, two (R6, and R16) out of seven residents reviewed for bed rails, and three (R18, R55 and R76) out of three residents reviewed for enhanced barrier precautions, the facility failed to review and revise each residents' comprehensive care plan.	F 657	(1) Activities A.R67 Activities Care Plan was updated to reflect her cognition and preferred activities of choice including the involvement of her family. B. The Activities Director/Designee will	1/2/25

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F 657	Continued From page 45 Findings include: 1. R67's clinical record revealed: 12/19/23 - R67 was admitted to the facility with a diagnosis of dementia. 12/21/23 - R67's activity care plan with an intervention that included, but was not limited to, "... preferred activities are: card/board games, exercise/sports, religious services, reading, trivia, outdoors (in appropriate weather months), gardening/floral arrangements, music, manicure, special themed events." 6/18/24 at 12:27 PM - An activity note documented that R67 "... refused invitations this past quarter to arts & (and) crafts, Coral Springs Cafe, bingo, religious services, exercise, word games, reading, music, women's group, and manicure...". 9/10/24 at 7:27 AM - An activity note documented that R67 "... refused invitations this past quarter to arts & crafts, Cafe, bingo, exercise, manicure, outdoors, (in appropriate weather months), religious services, STARS [group program for high risk fall residents] and board games...". The facility failed to review and revise R67's activity care plan since admission to ensure that it is individualized and person-centered based on resident's previous lifestyle (occupation, family, hobbies). Although the care plan stated that R67 enjoys Indian music, it does not address how and when this activity was to be provided. R67's care plan does not address the resident's physical and mental capabilities to participate in the general activities as she has dementia with a BIMS of 6.	F 657	conduct full house audit to assure Activities care plans have been revised as needed to reflect changes in condition or preference C. Root cause determined to be lack of knowledge on the importance of ensuring person-centered plan of care for activities and potential limitations related to cognition. Activities team will be reeducated by the Operations Consultant on the importance of ensuring person-centered plan of care related to cognition. D. Activities Director or Designee will complete weekly audit x4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. (2) Side Rails A. R6 care plan r/t bedrail/grab bar use was reviewed and revised. R16 care plan r/t bedrail/grab bar use was reviewed and revised. B. Active residents with bedrail/grab bar will be reviewed to ensure that they have a person-centered care plan C. The root cause was determined to be	

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F 657	Continued From page 46 The admission MDS stated that it was very important that R67 had family involvement in her care, but the care plan does not reflect participation and input by R67's family. 11/12/24 at 9:52 AM - During an interview, E16 (AD) acknowledged that R67's activity care plan was not reviewed and revised to ensure that it was person-centered. 2. Cross refer F700, example 1 R6's clinical record revealed: 10/29/24 at 7:11 AM - Surveyor observed bilateral quarter length (22 inches) bed rails positioned up while R6 was in bed sleeping. 11/7/24 at 1:50 PM - During a combined interview with E2 (DON) and E47 (RCC), the Surveyor requested R6's person-centered care plan for bilateral bed rails. In response, the facility provided a care plan for potential for falls with injury with an intervention, last revised on 6/7/23, for a "right side rail" only for turning/transfers. The intervention also addressed to "Ensure side rails are maintained with no gaps between rail and mattress and are secured properly. Assess need and safe use of rail quarterly and as needed for change in resident condition." The facility failed to review and revise R6's comprehensive care plan to reflect the current use of bilateral quarter length bed rails and ensure the bed rail care plan was person-centered with measureable outcomes and goals. 3. Cross refer F700, example 3	F 657	lack of understanding of the importance of reviewing and revising person centered care plans related to bedrail/grab bar. Staff Development/Designee will in-service licensed nurse regarding the reviewing and revisioning care plans for residents with bedrails/grab bars to ensure that it is person-centered. D. Daily audit by DON/Designee to ensure new admission/readmission residents who have bedrails/grab bars has a person-centered care plan in place x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. (3) A. R18's care plan was revised to reflect EBP. R55's care plan was revised to reflect EBP. R76's care plan was revised to reflect EBP. B. Current residents with PEG tube and dialysis catheters/ports will be reviewed to ensure EBP care plans are in place.	

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F 657	Continued From page 47 R16's clinical record revealed: 10/29/24 at 9:15 AM - Surveyor observed R16 in bed eating breakfast with bilateral quarter length side rails positioned up and stationary. 11/7/24 at 1:50 PM - During a combined interview with E2 (DON) and E47 (RCC), the Surveyor requested R6's individualized care plan for bilateral bed rails. In response, the facility provided a care plan for potential for injury related to falls with an intervention, last revised on 8/27/23, for bilateral rails as enabler to assist with turning and/or transfers. The intervention also addressed to "Ensure side rails are maintained with no gaps between rail and mattress and are secured properly. Assess need and safe use of rail quarterly and as needed for change in resident condition." The facility failed to review and revise R16's comprehensive care plan to reflect that the bed rail care plan was person-centered with measurable outcomes and goals. 4. Review of R18's clinical record revealed: 11/18/09 - R18 was admitted to the facility. 9/27/24 - R18's quarterly MDS documented that R18 had multiple current diagnoses including dysphagia (difficulty swallowing), right sided paralysis following a stroke and that R18 had a feeding tube. 11/7/24 - A review of R18's care plan lacked the infection control focus for EBP.	F 657	C. The root cause was determined to be due to lack of understanding to include EBP care plan for residents with PEG and dialysis catheters/ports. D. Daily audit by DON/Designee to ensure new admissions/readmissions and residents with conditions requiring EBP has corresponding plan of care in place x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 657	Continued From page 48 5. Review of R55's clinical record revealed: 12/13/17 - R55 was admitted to the facility. R55 had multiple current diagnoses including dysphagia (difficulty swallowing) and left sided paralysis following a stroke. and that R55 had a feeding tube in place. 9/30/24 - R55's quarterly MDS documented that R55 had multiple current diagnoses, including dysphagia (difficulty swallowing) and left sided paralysis following a stroke. R55 had a feeding tube in place. 11/7/24 - A review of R55's care plan revealed the lack the infection control precaution focus for EBP. 6. Review of R76's clinical record revealed: 2/22/23 - R76 was admitted to the facility. 9/27/24 - R76's quarterly Minimum Data documented that R76 had multiple diagnoses, including end stage kidney disease and required dialysis (cleansing of the blood by artificial means when kidneys have failed). Review of R76's care plan revealed that R76 had a dialysis port (an opening implanted into the skin) for dialysis. 11/7/24 - A review of R76's care plan lacked the infection control precaution focus area of EBP. 11/12/24 8:15AM - During an interview, E54 (RN) confirmed that the care plans for R18, R55 and R76 failed to include the care plan focus area of	F 657		

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F 657	Continued From page 49 EBP. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 657		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for five (R15, R102, R260, R310, R457) out of seven residents reviewed for assessments, the facility failed to meet the professional standards of practice by having an LPN complete assessments in violation of the State of Delaware Nursing Scope of practice. For R260, the facility failed to have an RN complete the post fall assessment. For R15, R102, R310 and R457, the facility failed to have an RN complete the Admission assessments as required by the Delaware Nursing Scope of Practice. Findings include: Delaware State Board of Nursing -RN, LPN and NA/UAP Duties 2024 "... Admission Assessments* - RN...* = Once a care plan is established, the LPN may do assessments... Admission History Review - RN...". The facility policy on falls, last updated 4/2024, indicated, "When a resident experiences a fall,	F 658	(1) A. The facility cannot retroactively correct the issue r/t R260 B. Active residents with falls in the 7 days will be reviewed to ensure the initial post fall assessment is completed by an RN. C. The root cause was determined to be due to an oversight with documenting post fall assessment by an RN. Staff Development/Designee will re-educate licensed nurses to ensure RN completes the initial post fall assessment when an incident occurs. Daily in morning meetings, medical records will be reviewed for residents with falls will be reviewed to ensure an RN completed the initial post fall assessment.	1/2/25

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F 658	Continued From page 50 the facility will: a. assess the resident. b. complete a post fall assessment." The policy lacked evidence that the initial post fall assessment be completed by a Registered Nurse. 1. Review of R260's clinical record revealed: 11/19/23 1:45 PM - E24 (LPN) documented on a fall incident report, "Called to assess [R260] post fall. Resident found laying on the floor in room...RN notified. MD contacted and no new orders at this time." The incident report contained VS, pain assessment, and neurological checks completed by E24 (LPN) as part of the initial post fall assessment. 11/4/24 1:00 PM - During an interview, E2 (DON) and E4 (QA) confirmed that "the RN should be doing the [initial post fall] assessment." 11/4/24 1:22 PM - During an interview, E24 (LPN) confirmed completion of R260's initial post fall assessment on 11/19/23. E24 stated that "any nurse" can completed the initial post fall assessment. 2. Review of R15's clinical record revealed: 9/20/23 - R15 was admitted to the facility. 9/22/24 to 9/26/24 - R15 admitted to the hospital. 9/27/24 - R15 re-admitted to the facility after hospital stay. 9/27/24 - E55 (LPN) completed the following facility required Admission Assessments: A. Resident Basics/Vitals/Medical History, B.	F 658	D. Daily audit by ADON/Designee to ensure RN completes the initial post fall assessment x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. (2) A. The facility cannot retroactively correct the issue for R15, R102, R310 and R457. B. Residents admitted/readmitted in the last 7 days will be reviewed to ensure that admission assessments are completed by an RN. C. The root cause was determined to be due to lack of understanding of the scope of practice for LPNs. Staff Development/Designee will educate licensed nurses regarding assuring that admission assessments are completed by an RN. The facility process will be reviewed and revised related to the role of an RN in the admission assessments. D. Daily audit by ADON/Designee to	

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F 658	Continued From page 51 Sensory/Facility Orientation/Elopement Risk, C. Pain, D/E. Musculoskeletal/Fall/Lift/Side Rail or Grab/ Skin Integrity/Braden Scale, F. Oral/Nutrition, G. Respiratory/Smoking, H. Bowel & Bladder, and I. IV/Other. An LPN, not an RN as required by the State of Delaware regulation for the Board of Nursing Scope of Practice, completed the initial assessments. 3. Review of R102's clinical record revealed: 8/20/23 - R102 was admitted to the facility. 9/20/24 to 9/22/24 - R102 admitted to the hospital. 9/22/24 - R102 re-admitted to the facility after hospital stay. 9/22/24 - E60 (LPN) completed the following facility required Admission Assessments: A. Resident Basics/Vitals/Medical History, B. Sensory/Facility Orientation/Elopement Risk, C. Pain, D/E. Musculoskeletal/Fall/Lift/Side Rail or Grab/ Skin Integrity/Braden Scale, F. Oral/Nutrition, G. Respiratory/Smoking, H. Bowel & Bladder, and I. IV/Other. An LPN, not an RN as required by the State of Delaware regulation for the Board of Nursing Scope of Practice, completed the initial assessments. 4. Review of R310's clinical record revealed: 10/18/24 - R310 was admitted to the facility.	F 658	ensure RN completes admission assessments x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 658	Continued From page 52 10/19/24 - E61 (LPN) completed the following facility required Admission Assessments: B. Sensory/Facility Orientation/Elopement Risk, C. Pain, F. Oral/Nutrition, G. Respiratory/Smoking, H. Bowel & Bladder, and I. IV/Other. 10/21/24 - E27 (RN/ADON) completed the following facility required Admission Assessment, A. Resident Basics/Vitals/Medical History. Of note, Section D/E. Musculoskeletal/Fall/Lift/Side Rail or Grab/Skin Integrity/Braden Scale of the facility required Admission Assessments was not completed for R310's admission. An LPN, not an RN as required by the State of Delaware regulation for the Board of Nursing Scope of Practice, completed the initial assessments. 5. Review of R457's clinical record revealed: 10/12/24 - R457 was admitted to the facility. 10/16/24 - E62 (LPN/UM) completed the following facility required Admission Assessments: A. Resident Basics/Vitals/Medical History, B. Sensory/Facility Orientation/Elopement Risk, C. Pain, D/E. Musculoskeletal/Fall/Lift/Side Rail or Grab/ Skin Integrity/Braden Scale, F. Oral/Nutrition, G. Respiratory/Smoking, H. Bowel & Bladder, and I. IV/Other. An LPN, not an RN as required by the State of Delaware regulation for the Board of Nursing Scope of Practice, completed the initial assessments.	F 658		

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F 658	Continued From page 53 10/31/24 - During an interview, E2 (DON) stated that the facility required the following admission assessments when a resident was admitted: A. Resident Basics/Vitals/Medical History, B. Sensory/Facility Orientation/Elopement Risk, C. Pain, D/E. Musculoskeletal/Fall/Lift/Side Rail or Grab/ Skin Integrity/Braden Scale, F. Oral/Nutrition, G. Respiratory/Smoking, H. Bowel & Bladder, and I. IV/Other. E2 provided the surveyor with blank copies of each of these admission assessments. 11/4/24 3:33 PM - During an interview, E62 (LPN/UM) confirmed that she completed the facility required admission assessments for R457. E62 stated that she was not aware that admission assessments were outside of her (LPN) scope of practice. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.	F 658		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced	F 679		1/2/25

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F 679	Continued From page 54 by: Based on observation, interview, record review and review of other facility documentation, it was determined that for two (R20 and R80) out of four sampled residents reviewed for activities, the facility failed to provide outdoor activities during appropriate weather based on their comprehensive assessments and care plans. Findings include: 1. Cross refer F561, example 1 Review of R20's clinical records revealed: 8/12/20 - R20 was admitted to the facility with diagnoses which included acquired absence (amputation) of the left leg above the knee. 8/21/20 - An activity care plan was developed for R20 to participate in current preferred leisure group of his choice including... community outings, outdoors during appropriate weather months. R20's interventions included providing a program of activities that is of interest and empowers R20 by encouraging/allowing choice, self expression and responsibility...R20's preferred activities are:... community outings, outdoors during appropriate weather months. 5/1/24 - R20's annual MDS revealed that R20 was cognitively intact, indicated going outside to get fresh air when the weather is good as very important and self propelled with a manual wheelchair. 5/19/24 - A facility Recreation Evaluation for R20 documented that it was very important for R20 to go outside to get fresh air when the weather is good. R20 was independent with participation in	F 679	1 R20 2 R80 A. R20 is no longer in the facility. Act Dir will meet with R80. Activity preferences will be reviewed and resident informed of the supervision procedure for outdoors. R80 have been provided with a copy of the current outdoor activities for the month. B. A review of care plans will be conducted to identify like residents and a copy of the current outdoor activities for the month will be provided. C. Root cause was determined to be due to staff□s lack of understanding of residents□ rights to choice outdoor activities on their own or alone. The IDT team will review the activity calendar and adjust the frequency of outdoor activities based on the resident interviews conducted. Activities staff will be educated by the Operations Consultant on resident rights to choice outdoor activities on their own or alone. Residents will be educated via Resident council on the process for outdoor supervision and access to lobby. D. NHA or designee will conduct weekly audits x4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In	

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F 679	Continued From page 55 activities. 10/28/24 1:46 PM - During interview, R20 stated, "With the new management, we are not allowed to go outside to get some fresh air. Before, we were allowed to go out - there's a courtyard that is enclosed but we can't go there whenever we want to go, unless a staff would take us outside." 11/4/24 - A review of R20's Daily Activities Log revealed the following: - July 2024 - R20 was involved in outdoor activity in 4 out of 31 opportunities; - August 2024 - R20 was involved in outdoor activity in 4 out of 31 opportunities; - September 2024 - R20 was involved in outdoor activity in 1 out of 30 opportunities and; - October 2024 - R20 was not involved in outdoor activity in 31 opportunities. 11/8/24 2:00 PM - During an interview, E16 (Activities Director) stated that residents are allowed to go out to the courtyard to enjoy breath of fresh air weather permitting with staff supervision for safety reasons. 2. Cross refer F561, example 2 Review of R80's clinical records revealed: 6/16/22 - R80 was admitted to the facility with diagnoses which included muscle weakness and lack of coordination. 6/21/22 - An activity care plan was developed for R80 to participate in current preferred leisure group of his choice including... community outings, outdoors during appropriate weather months. [R80's] interventions included providing a	F 679	an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance	

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F 679	Continued From page 56 program of activities that is of interest and empowers [R80] by encouraging/allowing choice, self expression and responsibility...[R80's] preferred activities are:... community outings, outdoors during appropriate weather months. 7/24/24 - R80's annual MDS revealed that R80 was cognitively intact, indicated going outside to get fresh air when the weather was as very important and R80 self propelled with a manual wheelchair or ambulates with a rolling walker. 7/25/24 - A facility Recreation Evaluation documented that R80, required a roller walker for mobility and ambulation and was moderately dependent with participation in activities. [R80] will have opportunities to participate in a variety of desired leisure groups such as... community outings, outdoors in an appropriate weather months... [R80] will be encouraged to attend preferred leisure activities... it was very important for [R80] to go outside to get fresh air when the weather is good. 10/28/24 1:30 PM - During interview, R80 stated, "We are not allowed to go outside to get some fresh air without (sic) staff. Most of the time there is no staff to take us out in the courtyard." 11/4/ 24 - A review of R80's Daily Activities Log revealed the following: - July 2024 - R80 was involved in outdoor activity in 4 out of 31 opportunities; - August 2024 - R80 was involved in outdoor activity in 4 out of 31 opportunities; - September 2024 - R80 was involved in outdoor activity in 2 out of 30 opportunities and - October 2024 - R80 was not involved in outdoor activity in the 31 opportunities.	F 679		

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F 679	Continued From page 57 11/8/24 2:05 PM - In a follow-up interview, E16 (Activities Director) stated that the residents have to be supervised by staff everytime they go out "even if it's just going out in the courtyard." 11/7/24 1:55 PM - Finding was confirmed by E47 (Regional Clinical Consultant). 11/12/24 2:35 PM - Finding was discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant).	F 679		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R159) out of seven residents reviewed for hospitalizations, the facility failed to ensure that R159 received care/treatment in accordance with professional standards of practice. The facility failed to monitor bowel movements resulting in a hospitalization requiring fecal disimpaction. Findings include: Review of R159's clinical records revealed: 9/20/23 - R159 was admitted to the facility with	F 684	A. R159 has been discharged. Facility not able to correct the deficiency. B. Active residents with no BM x 3 days will be reviewed to ensure bowel protocol is initiated per physician order. C. The root cause was determined to be lack of oversight in reviewing frequency of bowel movements and to ensure bowel protocol is activated when necessary and documented appropriately.	1/2/25

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F 684	Continued From page 58 diagnoses including Parkinson's Disease, muscle weakness and dementia. 9/20/24 - R159's admission care plans included, "[R159] has potential for constipation r/t [related to] decreased motility." The interventions included, "Monitor and document bowel sounds and abdominal distention if no BM [bowel movements] after 3 days or resident refuses bowel interventions. Monitor BMs and document in CNA records." 9/20/23 - R159's physician's orders included, "Docusate Sodium Oral Liquid [stool softener] - give 100 ml by mouth 2 times a day for constipation and Bowel protocol per facility policy: Give 30 ml of milk of magnesia on 3-11 if no bowel movement, 11-7 give Fleets Enema if no results from 11-7, nurse will inform physician for further orders and communicate to 7-3 nurse per facility's protocol." 9/26/23 - R159's admission MDS documented a BIMS score of 3, indicating severe cognitive impairment. Review of R159's Activities of Daily Living (ADLs) flowsheets revealed: 11/2/23 - R159's clinical records documented a large bowel movement. 11/6/23 - R159's clinical records documented a small bowel movement. 11/11/23 - R159's clinical records documented a large bowel movement. The facility failed to initiate the bowel protocol for	F 684	Staff Development/Designee will educate nursing staff to ensure bowel protocol is followed and documented as indicated for residents with no bowel movements greater than 3 days Daily in morning meeting, residents with no bowel movements greater than 3 days will be reviewed to assure that bowel protocol was followed D. Daily audit by Unit Manager/Designee of residents with no bowel movements greater than 3 days to assure that bowel protocol was followed as indicated x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 684	Continued From page 59 5 days (14 shifts.) 11/16/23 - R159's clinical records documented a large bowel movement. 11/21/23 - R159's clinical records documented a small bowel movement. The facility failed to initiate the bowel protocol for 5 days (16 shifts.) 11/24/23 10:03 AM - R159's clinical records documented, "...Was notified that resident [R159] was not at baseline (normal status for R159). Neck hyper flexed (extended) and unable to relax. Normally resident would be able to stand, pivot and verbalize any concerns... not able to follow commands... spoke with NP and sent out for further evaluation." 11/28/23 4:11 PM - R159's hospital records documented, "... Large stool burden in the rectum with stool ball... measuring up to 7.5 cm [2.95 inches]... hospitalized for hypoactive (decreased bowel sounds), delirium with abdominal pain, both were improved after fecal disimpaction. [R159] was also treated MiraLax (medication for constipation), senna, glycerin [rectal] suppositories X (times) 2 with improvement in constipation... her mental status improved back to her baseline with treatment of her constipation." 11/6/24 10:00 AM - A review of R159's clinical records lacked evidence of documentation of a bowel movement from 11/16/23 through 11/24/23 for a total of 26 shifts. During an interview E21 (RN) stated, "We run a daily report and anyone who has not had a bowel movement is put on the bowel protocol. The bowel protocol should have	F 684		

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F 684	Continued From page 60 been started 3 days after she [R159] didn't have a BM." A review of R159's clinical records lacked evidence that prune juice, milk of magnesia or fleets enema were given per order or that the physician was notified of the lack of bowel movements. 11/8/24 2:30 PM - During an interview, the surveyor asked E22 and E23 (CNAs) what size of bowel movement would be considered a small one. E22 stated, "Like a small smear on the brief." E23 stated, "Small bowel movement does not count. That's not enough to say the resident has had an actual bowel movement." 11/12/24 12:15 PM - During an interview, E4 (LPN/QA/IP) stated, "The bowel protocol should have been started." The facility failure to monitor and initiate the bowel protocol for 13 shifts, caused R159 have abdominal pain and to be hospitalized from 11/24/23 through 11/28/23. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		1/2/25

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F 690	Continued From page 61 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R92) out of three residents reviewed for bladder continence, the facility failed to ensure that R92 received services and assistance to maintain bladder continence to the extent possible. Findings included: 4/20/24 - A facility document titled, "Incontinence", "Policy Explanation and	F 690	A. R92 bowel and bladder incontinence was reassessed. Toileting program will be initiated as indicated. B. Residents who were incontinent of bowel and bladder in the last 14 days will be reviewed to ensure there is evidence of a person-centered plan of care to promote bladder continence.	

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F 690	Continued From page 62 Compliance Guidelines", documented, "The facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain... Residents who are incontinent of bladder or bowel will receive appropriate treatment... and to restore continence to the extent possible." R92's clinical records revealed: 7/24/24 - R92 was admitted to the facility with diagnoses including muscle weakness and urinary tract infection. 7/24/24 - R92's nursing admission assessment documented, "Continent of bladder and bowel." 7/24/24 - R92's care plan documented, "[R92] is incontinent of bowel and bladder." The interventions included, "Assist to toilet as requested, apply barrier cream with each incontinent episode." 7/24/24 through 7/26/24 - R92's three-day voiding diary revealed no episodes of bladder incontinence. 7/29/24 - R92's admission BIMS documented a score of 15, indicating a cognitively intact status. 10/21/24 - R92's quarterly MDS documented, "Occasionally incontinent of bladder." R92's clinical records lacked evidence of interventions to restore bladder continence. 11/8/24 12:00 PM - During an interview, E22	F 690	C. The root cause was determined to be due to lack of consistent oversight in reviewing bowel and bladder incontinence. Staff Development/Designee will re-educate Licensed nursing staff to ensure bowel and bladder incontinence is reviewed quarterly and as needed to ensure there is evidence of a person-centered plan of care to promote bladder continence. D. Weekly audit by ADON/Designee to ensure new admissions/readmission residents with bowel and bladder incontinence have evidence of a person-centered plan of care to promote bladder continence to the extent possible as indicated x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 690	Continued From page 63 (CNA) stated, "I don't know if he [R92] can use the toilet. I was never told to put him on the toilet. I just change the pads when I take care of him." 11/8/24 1:30 PM - During an interview, R92 stated, "I came here to get better, but I don't think that is going to happen. I want to take myself to use the toilet, but I am afraid to do it by myself in case I fall." 11/8/24 2:00 PM - During an interview, E57 (RNAC) stated, "We do a 3-day voiding diary on admission and make a toileting plan based on the results [if the resident is incontinent.]" The surveyor asked what would happen if the resident was continent on admission and then became incontinent. E57 stated, "We would do a voiding diary and then make a toileting plan." 11/8/24 3:00 PM - A review of R92's bladder records from 10/11/24 through 11/8/24 revealed 12 episodes of incontinence out of 75 opportunities for continence. The ADLs flowsheets, Kardex and care plans lacked evidence of person-centered plan of care for to promote R92's bladder continence. The facility failed to provide services and assistance to maintain R92's bladder continence to the extent possible. 11/12/24 1:30 PM - Findings were confirmed with E1 (NHA) and E2 (DON)	F 690		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is	F 697		1/2/25

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F 697	Continued From page 64 provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interviews, record review and review of other documents as indicated, it was determined that for one (R157) out of six residents reviewed for hospitalization, the facility failed to provide the necessary treatment consistent with professional standards of practice, to provide pain assessments and pain medication prior to the daily wound care for R157's extensive left lower leg wounds. The result of that incomplete pain assessment and medication administration resulted in harm. R157 experienced pain when her wound care was completed. Findings include: Cross refer to F655 Review of R157's clinical record revealed: 7/27/24 - The hospital records and discharge summary revealed that R157 was admitted to the facility for wound care and physical therapy directly from a seventeen-day hospital stay. The hospitalization included an admission to the intensive care unit for the treatment of septic shock (potentially deadly condition with whole-body infection) from an infection in R157's left lower leg. R157 had surgery on her left leg on 7/17/24 to debride (remove dead tissue so that healthy tissue can grow) her left leg. The surgery resulted in R157 having three separate and large wounds to her left leg. Two wounds were located on the upper left thigh, front and back and one wound was located on the lower left leg, from her knee and extending to her heel. The three	F 697	A. R157 had been discharged. B. Active residents with wounds will be reviewed to ensure residents are assessed prior to wound care and that appropriate pain management is in place C. The root cause was determined to be due to inconsistent discharge instruction related to use of pain medication for residents with wounds. Staff Development/Designee will educate licensed nurses to ensure discharge instructions are clarified upon admission for residents with wounds related to pain medication prior to dressing changes. D. Daily audit by DON/Designee to ensure specific instructions related to pain management for residents with wounds are clarified upon admission with the facility provider x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to	

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F 697	Continued From page 65 wounds were extensive both in length and width and the wounds took up most of the skin space on R157's left leg. The hospital records that were sent to the facility with R157's admission documents included 7/24/24 color photographs of the three wounds on R157's left leg. A review of hospital records for the pain medications that R157 received during her hospital stay revealed the following: "Tylenol 650 mg by mouth every six hours, Oxycodone (expected pain) 10 mg by mouth twice daily as needed, Oxycodone 5 mg by mouth every four hours as needed." The 7/27/24 hospital discharge summary highlighted R157's medication changes to continue Oxycodone 10 mg by mouth thirty minutes before dressing changes. 7/27/24 - R157 was admitted to the facility with multiple diagnoses, including cellulitis (skin infection with swelling), of left lower leg, open wounds to the left lower leg, infection of the skin, a fractured spine, arthritis and dementia. 7/27/24 - A physician's order was written by E3 (Medical Director) for R157 to receive Tylenol 650 mg by mouth every six hours as needed for pain. 7/28/24 - Medication orders were written by E51 (Nurse Practitioner) for the following medications: - Oxycodone 10 mg by mouth every twelve hours as needed for pain dressing change. - Gabapentin 100 mg by mouth three times a day for nerve pain. - Celebrex 200 mg by mouth twice a day for pain.	F 697	maintain and sustain compliance.	

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(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 697	Continued From page 66 It is significant to note that according to the hospital discharge documents, Gabapentin and Celebrex were medications that R157 was taking at home before she was hospitalized on 7/10/24 and had left leg surgery on 7/17/24. 7/28/24 - An encounter note, written by E3 revealed that R157's wound photographs were reviewed with F2 (R157's daughter) when E3 examined R157. E3 documented that R157 had "extensive wounds encompassing the entire leg and that she does have pain with dressing changes." 7/31/24 - R157's Minimum Data Set (MDS, standardized assessment forms used in nursing homes) documented the following: - BIMS score of 6, which indicated that R157 had severe cognitive impairment. - R157 had received scheduled and as needed pain medications during the last five days. - R157 was unable to participate in the pain assessment interview at the time of the comprehensive assessment; the sections for the presence and the frequency of pain were not answered by R157 herself, but were completed with a staff assessment. - It was very important to R157 to have her family involved in discussions about her care. A review of R157's wound care orders revealed: 7/27/24 - 8/8/24 - Cleanse the wounds with Vashe wound solution (hypochlorous acid with antimicrobial properties), pat dry, apply intrasite and with oil emulsion (both promote moist wound for healing), cover with Vashe soaked gauze, ABD (absorbent gauze pads) and wrap with kerlix	F 697		

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F 697	Continued From page 67 (bandage rolls) and ace wrap (compression bandage to reduce swelling) for all wounds to left hip and lower left leg every day. 8/8/24 - 8/14/24 -Cleanse the wounds with Dakin's (bleach, acid and baking soda mixed in water to promote with antibacterial effects), pat dry, apply hydrogel AG (gel with antimicrobial properties), cover with oil emulsion dressing, ABD pad, wrap with Kling (stretch bandages) every day shift for all wounds to lower left extremity. Notify MD of worsening or signs of infection. 8/6/24 1:44 PM - A progress note was written by E6 (LPN, wound care) that the LLE (lower left extremity) calf wound from knee to back of ankle appeared to be infected due to redness around the wound, green drainage on the wound dressings, and increased drainage from the wounds. 8/7/24 11:37 AM - An encounter note written by E52 (NP) revealed "Patient is being seen today for concerns of pain in her left leg. Patient has an extensive left lower leg cellulitis with multiple wounds. The daughter is very involved in her care and is requesting the patient to be medicated with oxycodone half hour before her dressing changes. This has not always consistently been done. The patient is alert and oriented she is very pleasant she is a poor historian she is seen today lying in bed in no acute distress she does not appear to be in any pain at the present time she denies fever chills chest pain shortness of breath nausea vomiting. The daughter is concerned she is not getting her oxycodone prior to her dressing changes. Given the extent of the patient's wounds this is not an unreasonable request. I will write an order for the oxycodone to be given half hour	F 697		

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F 697	Continued From page 68 before dressing changes." A review of the electronic medical record revealed that the order was never written. A review of R157's "as needed" pain medication that R157 was given revealed: - Acetaminophen 650 mg by mouth was given twice in July at 7/30/24 at 9:01 PM and 8/4/24 at 9:55 AM. - Oxycodone 10 mg was given four times: 7/28/24 at 12:34 PM, 7/29/24 at 11:14 AM, 8/8/24 at 5:05 PM for pain 8/10 and 8/12/24 at 12:42 AM for pain 8/10. 8/12/24 - A progress note written by E52 (NP) revealed that E52 was called to R157's bedside because F2 was going to take R157 home and F2 wanted to speak with a medical provider. E52 arrived and found R157 with a change in mental status, increased confusion, pale skin, and she was moving all over the bed. E52 explained that from a clinical point of view, R157 would not be safe to be discharged to home because there was a concern that the left leg had a significant infection, that the wound was very complex, as it started from the groin and extended down to the foot. E52 explained that a discharge to home would be against the medical advice of the facility. F2 stated that she would then call 911 herself and that she did not want the nursing staff or the nurse practitioner to be involved. 8/12/24 10:26 AM - A nurses note documented that the medication orders, face sheet and the last provider note was sent to the hospital with the resident. A review of the hospital admission records	F 697		

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F 697	Continued From page 69 documented that R157 was hospitalized 8/12/24 thru 8/20/24 for treatment of a wound infection. 11/13/24 1:40 PM - During an interview, F2 stated that "because of my mother's dementia she cannot tell someone when she is having pain. I am her caregiver, and I can tell when she is in pain by looking at her eye movements and her subtle body changes." She was in pain when she had dressing changes when I was present. According to the College of Psychiatric and Neurologic Pharmacists, Mental Health Clinician Identification, Assessment, and Management of pain in patients with advanced dementia, 2016: Pain in a dementia patient is a prevalent symptom that can be underrecognized because of the ability of the patient to self-report. Health care providers must anticipate this and screen for and treat potential pain. This includes obtaining a self-report, searching for potential causes for pain, observing patient behavior, gaining proxy reporting of pain, and attempting an appropriate analgesic trial. Although R157 was a a severly cognitively impaired resident, the facility documents lacked evidence that the facility used any alternative pain assessment tools, with the exception of one tool, the "Pain Evaluation for Cognitively Impair and Intact" assessment tool that was used on 8/11/24. R157's harm was evidenced by the following: - R157 was a vulnerable facility resident with significant cognitive impairment and who may not have been able to adequately express her pain verbally or physically. R157 was medicated for	F 697		

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F 697	Continued From page 70 pain on an as needed basis on six shifts out of the fifty-two shifts that she was in the facility. - R157's wound care orders were changed on 8/8/24 to Dakin's, a bleach solution. R157 received "as needed" pain medication only two times after that change, and apparently not prior to dressing changes on those days. - R157 was a vulnerable eighty-eight facility year old resident because of her medically fragile state and her physical frailness. It was important to R157 that her daughter (F2) participate in her care while she was at the facility. F2 expressed concern to the facility about her mother's pain, specifically that her mother was not getting pain medication thirty minutes before her dressing changes. The facility made no further changes to R157's pain medications, or to document reasons why there were no changes made. - R157's wound deteriorated during her facility admission. R157 did not appear to be responding to the prescribed antibiotics that were started on 8/6/24. R157's pain medications continued to go unchanged as R157's wound infection progressed. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent	F 698		1/2/25

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F 698	Continued From page 71 with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility clinical record and dialysis record, it was determined that for one (R102) out of two residents reviewed for dialysis, the facility failed to have ongoing collaboration with R102's dialysis center with respect to her dialysis labs (monthly and weekly) from June 2024 through November 2024. Findings include: The facility's policy and procedure entitled Care Planning Special Needs - Dialysis, last revised 1/24, stated, "... 2. The care plan will reflect the coordination between the facility and the dialysis provider and will identify nursing home and dialysis responsibilities... 5. If no written report is received upon return from dialysis, nursing staff will call the dialysis provider to receive a report...". R102's clinical record revealed: 8/30/23 - R102 was admitted to the facility and care planned for dialysis. One of the interventions in the dialysis care plan was to monitor labs and report to doctor as needed. The positions that were responsible for this intervention was the RN and LPN. Review of the R102's EHR and the Dialysis Communication Logs revealed no evidence that R102's weekly and monthly labs were obtained and reviewed by the facility. The Dialysis Communication Logs stated at the bottom of form "**Dialysis please send a copy of labs monthly**." There was no evidence that the facility nursing	F 698	A. R102 is no longer in the facility. B. Active residents on Dialysis will be reviewed to assure that any laboratory workup done at the dialysis center the results are obtained. C. Root cause was determined to be due to lack of consistent oversight to ensure laboratory results are obtained from the dialysis center. Staff Development/Designee will educate licensed nurses, medical records and unit secretary to ensure dialysis residents laboratory results are obtained on a regular basis. D. Weekly audit by Unit Manager/Designee to ensure laboratory results are obtained from dialysis center on a regular basis; Audits will be weekly x 4 until 100% compliance is achieved and sustained. The following will be a monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 698	Continued From page 72 staff followed-up with dialysis to obtain R109's lab results. 11/15/24 at 1:15 PM - During an interview with R102's dialysis center, D1 (Nurse) confirmed that the only labs results that were requested from the facility was last May 2024 when the resident was on an antibiotic and the labs had to be sent to the Infectious Disease Doctor. 11/15/24 at 2:35 PM - Finding was reviewed with E1 (NHA), E2 (DON), E4 (LPN/QA/IC), E55 (RCC) and E27 (ADON).	F 698		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.	F 700		1/2/25

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F 700	Continued From page 73 This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for seven (R6, R14, R16, R60, R67, R76 and R119) out of seven residents reviewed for bed rails, the facility failed to have a system in place to ensure that each resident was assessed, risks/benefits reviewed, alternatives attempted, informed consent obtained prior to the installation of bed rails. Findings include: According to the Centers for Medicare and Medicaid Services State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, issued 8/8/24, under F700 Bed Rails, "Definitions... 'Bed rails' are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of the bed. Examples of bed rails include, but are not limited to: - Side rails, bed side rails, and safety rails; and - Grab bars and assist bars...". The facility's policy and procedures, dated 09/2024, entitled "Bed rails" stated the following: "Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails/Enabler bars. If bed rails/enabler bars are used, the facility ensures correct installation, use and maintenance of the rails. Guidelines 1. As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's	F 700	A. R6, R14, R60, R67, R76, R119 identified as having bedrails/enabler bars were assessed, risks/benefits reviewed, alternatives attempted and informed consent obtained if use was validated. B. Residents who currently have side rails/grab bars will be assessed, risks/benefits reviewed, alternatives attempted and informed consent obtained if use was validated. C. The root cause was determined to be due to lack of thorough understanding related to appropriate steps and evaluation prior to side rail/grab bar use. Staff development/Designee will educate Licensed nursing staff and maintenance team regarding importance of evaluation and steps to complete prior to side rail/grab bar initiation. Maintenance Director/Designee will educate the maintenance department on steps to complete prior to side rail/grab bar installation. Daily, new admission residents will be assessed, risks/benefits reviewed, alternatives attempted and informed consent obtained prior to initiation of side rails/grab bar. D. Daily audit by DON/Designee to ensure	

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F 700	Continued From page 74 needs, and whether or not the use of bed rails/enabler bars meets those needs: a. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms b. Cognition c. Mobility (in and out of bed) d. Risk of falling 2. The resident assessment must also assess the resident's risk from using bed rails. Examples of the potential risks with the use of bed rails include: a. Accident hazards (e.g. falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails) b. Barrier to residents from safely getting out of bed. 3. If it is determined to be a restraint, the facility will follow their procedures related to physical restraints. 4. The facility will attempt to use appropriate alternatives prior to installing or using bed rails. Alternatives include, but are not limited to: a. Lowering the bed b. Concave/perimeter mattresses c. Enabler/grab bars 5. Alternatives that are attempted should be appropriate for the resident, safe and address the medical conditions, symptoms or behavioral patterns for which a bed rail was considered...". 1. Cross refer to F657, example 2 R6's clinical record revealed: 11/7/17 - R6 was admitted to the facility. 10/29/24 7:11 AM - Surveyor observed bilateral quarter length (22 inches) bed rails positioned up while R6 was in bed sleeping. The bed rails	F 700	appropriate evaluation is completed prior to side rail/grab bar initiation x 5 day or until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. Daily audit by Maintenance Director/Designee to ensure appropriate bed/mattress evaluation is completed prior to initiation of siderail/grab bar x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x4 then monthly x 3 months with a goal of 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 700	Continued From page 75 cannot be lowered as they are stationary. Review of R6's clinical record lacked evidence of the following: - the specific date the bed rails were installed; - the medical need for the bed rails; - the attempt to use appropriate alternatives prior to installing the bed rails; - an assessment of R6 for risk of entrapment from bed rails prior to installation; - review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation; and - review the bed dimensions are appropriate for the resident's size and weight. 11/4/24 10:19 AM - The facility's form entitled Side Rail/Grab Bar Evaluation documented that R6 only had a left bed rail despite the Surveyor's observation of bilateral bed rails on 10/29/24. 11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates the residents and determines if bed rails should be ordered. E66 stated that Rehab does not specify the size of the bed rails when it is communicated to maintenance that the resident was ordered a bed rail. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. During this interview, Surveyors requested all therapy bed rail documentation for R6 and the email that was sent to the IDT team and maintenance. 11/12/24 1:30 PM - During a combined interview with E1 (NHA), E2 (DON), E4 (LPN/QA/IC) and E47 (RCC), Surveyors reviewed the information and assessments required prior to installing bed rails. Surveyors extended another opportunity to	F 700		

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F 700	Continued From page 76 review facility evidence that would meet the Federal requirement up to the exit conference. The facility failed to provide evidence of the components specified in the Federal requirement prior to installing bilateral quarter length bed rails on R6's bed. In addition, the facility did not provide Surveyors with the email(s) referenced in E66's interview. 2. Cross refer F656, example 2 R14's clinical record revealed: 5/31/19 - R14 was admitted to the facility with a diagnosis of dementia. 7/30/24 - The quarterly MDS assessment documented that R14 had a BIMS of 3, which reflects a severe cognitive impairment. 10/28/24 1:01 PM - The facility's form Side Rail/Grab Bar Evaluation by E54 (RN, UM) documented, that R14 was educated on the risks associated with side rail/grab bar use despite having a severe cognitive impairment. 11/7/24 4:50 AM - Surveyor observed R14 receiving incontinence care in her bed with left sided quarter length bed rail positioned up. The bed rail cannot be lowered as it was stationary. Review of R14's clinical record lacked evidence of the following: - the specific date the bed rails were installed; - the medical need for the bed rails; - the attempt to use appropriate alternatives prior to installing the bed rails; - an assessment of R14 for risk of entrapment	F 700		

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F 700	Continued From page 77 from bed rails prior to installation; - review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation; and - review the bed dimensions are appropriate for the resident's size and weight. 11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates the residents and determines if bed rails should be ordered. E66 stated that Rehab does not specify the size of the bed rails when it is communicated to maintenance that the resident was ordered a bed rail. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. During this interview, Surveyors requested all therapy bed rail documentation for R14 and the email that was sent to the IDT team and maintenance. No further information was received from the facility. 3. R16's clinical record revealed: 9/3/20 - R16 was admitted to the facility. 8/13/24 - The quarterly MDS assessment documented that R16 was cognitively intact, had a diagnosis of a stroke with right sided hemiplegia and had a functional limitation in range of motion on the right arm and leg. 10/29/24 9:15 AM - Surveyor observed R16 in bed eating breakfast with bilateral quarter side rails positioned up. The bilateral quarter length (22 inches) side rails are stationary and unable to be lowered.	F 700		

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F 700	Continued From page 78 Review of R16's clinical record lacked evidence of the following: - the specific date the bed rails were installed; - the medical need for the bed rails; - the attempt to use appropriate alternatives prior to installing the bed rails; - an assessment of R16 for risk of entrapment from bed rails prior to installation; - review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation; and - review the bed dimensions are appropriate for the resident's size and weight. 11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates the residents and determines if bed rails should be ordered. E66 stated that Rehab does not specify the size of the bed rails when it is communicated to maintenance that the resident was ordered a bed rail. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. During this interview, Surveyors requested all therapy bed rail documentation for R16 and the email that was sent to the IDT team and maintenance. No further information was received from the facility. 4. Cross refer to F656, example 3 R67's clinical record revealed: 12/19/23 - R67 was admitted to the facility with a diagnosis of dementia. 10/31/24 9:52 AM - Surveyor observed R67 in bed with the bilateral grab bars (12 inches in	F 700		

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	085004	A. BUILDING _____ B. WING _____	C 11/15/2024

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F 700	Continued From page 79 length) positioned up and stationary. 9/2/24 10:55 AM - The facility's form entitled Side Rail/Grab Bar Evaluation completed by E54 (RN, UM) documented that R67 had bilateral half side rails despite the Surveyor's observation on 10/31/24 of bilateral grab bars. The form had grab bars as an option, but only half side rails were checked by E54. Review of R67's clinical record lacked evidence of the following: - the specific date the bed rails were installed; - the medical need for the bed rails; - the attempt to use appropriate alternatives prior to installing the bed rails; - an assessment of R67 for risk of entrapment from bed rails prior to installation; - review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation; and - review that the bed dimensions are appropriate for the resident's size and weight. 11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates the residents and determines if bed rails should be ordered. E66 stated that Rehab does not specify the size of the bed rails when it is communicated to maintenance that the resident was ordered a bed rail. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. During this interview, Surveyors requested all therapy bed rail documentation for R67 and the email that was sent to the IDT team and maintenance. No further information was received from the facility.	F 700		

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F 700	Continued From page 80 5. Review of R60's clinical record revealed: 3/31/17 - R60 was admitted to the facility. 8/1/24 - R60's MDS documented that R60 had a BIMS of 10, indicating moderate cognitive impairment, and had diagnoses of high blood pressure and arthritis. 10/28/24 9:05 AM - An observation revealed a quarter length (22 inches) side rail on the right side of R60's bed. Review of R60's clinical record lacked evidence of the following: -the date that the bed rail was installed; -the attempt to use appropriate alternatives prior to installing the bed rail; -an assessment of R60 for the risk of entrapment from the bed rail prior to installation; -the presence of the informed consent for the use of a bed rail -review that the bed dimensions are appropriate for the resident's size and weight. 10/18/24 1:02 PM - The facility's form Side Rail/Grab Bar Evaluation by E21 (RN, UM) documented that R60 was educated on the risks associated with side rail/grab bar use, despite having moderate cognitive impairment. 11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates residents and determines if bed rails should be ordered. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. E66 stated that Rehab does	F 700		

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F 700	Continued From page 81 not specify the size of the bed rail when it is communicated to maintenance that the resident was ordered a bed rail. During this interview, a request was made for R66 to send the surveyor all therapy bed rail documentation for R60, and the email that was sent to the IDT team and maintenance in reference to R60's bed rail. No further information was received from the facility. 6. Cross refer F656 example 4. Review of R76's clinical record revealed: 2/23/23 - R76 was admitted to the facility. 10/8/24 - R76's MDS documented that R60 had a BIMS of 11, indicating moderate cognitive impairment, and that R76 had diagnoses of renal disease and coronary artery disease. 10/28/24 9:45 AM - An observation revealed a quarter length (22 inches) side rail on the left side of R76's bed. Review of R76's clinical record lacked evidence of the following: -the date that the bed rail was installed; -the medical need for the bed rail; -the attempt to use appropriate alternatives prior to installing the bed rail; -an assessment of R76 for the risk of entrapment from the bed rail prior to installation; -the presence of the informed consent for the use of a bed rail -review that the bed dimensions are appropriate for the resident's size and weight.	F 700		

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F 700	Continued From page 82 11/7/24 at 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates residents and determines if bed rails should be ordered. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. E66 stated that Rehab does not specify the size of the bed rail when it is communicated to maintenance that the resident was ordered a bed rail. During this interview, a request was made for R66 to send the surveyor all therapy bed rail documentation for R76, and the email that was sent to the IDT team and maintenance in reference to R76's bed rail. No further information was received from the facility. 7. Review of R119's clinical record revealed: 1/18/24 - R119 was admitted to the facility. 10/2/24 - R119's MDS documented that R119 had a BIMS of 10, indicating moderate cognitive impairment, and that R119 had a diagnosis of dementia. 10/28/24 10:13 AM - An observation revealed a quarter length (22 inches) side rail on the right side of R119's bed. Review of R119's clinical record lacked evidence of the following: -the date that the bed rail was installed; -the attempt to use appropriate alternatives prior to installing the bed rail; -an assessment of R119 for the risk of entrapment from the bed rail prior to installation; -the presence of the informed consent for the use of a bed rail	F 700		

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F 700	Continued From page 83 -review that the bed dimensions are appropriate for the resident's size and weight. 11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates residents and determines if bed rails should be ordered. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. E66 stated that Rehab does not specify the size of the bed rail when it is communicated to maintenance that the resident was ordered a bed rail. During this interview, a request was made for R66 to send the surveyor all therapy bed rail documentation for R119 and the email that was sent to the IDT team and maintenance in reference to R119's bed rail. No further information was received from the facility. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 700		
F 802 SS=F	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff.	F 802		1/2/25

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F 802	Continued From page 84 The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility records, it was determined that the facility failed to ensure that a qualified person in charge was present during hours of Kitchen operation. Additionally, the facility failed to ensure that breakfast trays were provided to residents within 45 minutes of the facility's scheduled time for meals. Findings include: 1. 10/28/24 11:20 AM - In an interview, E33 (Regional Dietary Consultant) stated she was not sure if a food service member was present during hours of kitchen operation whenever E8 (Dietary Supervisor) takes off from work schedule. 11/1/24 8:45 AM - A review of the facility's dietary time cards from September 2024 through October 2024 revealed no members in the facility's food service department possessed valid Food Protection Manager certificates from an Accredited Food Safety Program on the following dates: - 9/7/24; - 9/8/24; - 9/21/24; - 9/22/24; - 10/5/24; - 10/10/24; - 10/24/24; and	F 802	1 A.1. The schedule was reviewed and revised to ensure a qualified person was scheduled during all hours of operation on 11/14/24. B1. All culinary staff, who do not have an active servsafe certification, have been enrolled in the servsafe manager course. The regional dining consultant will proctor servsafe exam once course completion has been verified. C.1. The root cause analysis determined that staff failed to follow the recommended guidelines for hiring qualified culinary staff. All dietary staff received additional education on 11/25/24 by food service director and regional consultant, on mealtimes and following the posted times to start the tray line for each meal. In addition, the dietary team member who delivers the food trucks to the units will document the time the truck is delivered to the unit and the nursing team will sign off on the time the truck was received. D.1. The food service director/designee	

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F 802	Continued From page 85 - 10/27/24. 11/1/24 10:21 AM - Findings were confirmed by E33 and E8. 11/12/24 2:35 PM - Findings were discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant). 2. 10/28/24 10:14 AM - An observation during breakfast on the B unit revealed that the meal delivery truck arrived after 10:00 AM. 10/29/24 10:24 AM - An observation during breakfast on the B unit revealed that the meal delivery truck arrived after 10:00 AM. 10/31/24 9:25 AM - In an interview, E63 (CNA) confirmed that the resident in the B unit were not getting their breakfast meals on time. E63 further stated, "They are getting brunch and sometimes they get their breakfast meals very close to lunch time." 11/1/24 10:10 AM - Review of the facility's scheduled meal times for the residents in the B Unit, it was documented that the dinner meal was served beginning at 6:15 PM and the breakfast meal the following day was served beginning at 8:40 AM. 11/1/24 10:15 PM - Review of the facility Meal Truck Delivery Log for the B Unit from September 2024 through October 2024 revealed the following: - on 9/4/24, dinner was delivered at 5:40 PM. The following day, 9/5/24, breakfast was delivered at 10:09 AM; - on 9/14/24, no documentation of dinner delivery	F 802	will audit the culinary staff to ensure that they have an active servsafe certification and the trayline starts at the recommended times for all meals. The Food service director will monitor the truck delivery logs for consistency. The audits will be completed daily, or once 100% compliance is achieved, for three consecutive days. The audits will continue to occur 3x a week for 3 consecutive weeks, or until 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. 2 A.2. The facility cannot retroactively correct the issue related to R78. The mealtime sheet and truck delivery log was reviewed, by the regional dining consultant on 10/29/24 to ensure posted mealtimes met regulatory requirements. B.2. The dietary staff were educated, on 10/29/24, on the mealtime sheet and the requirements for the start time of each meal. Tray line start times were posted for the kitchen staff and the mealtime sheet was updated and distributed to the units. C.2. The root cause analysis determined that staff failed to follow the posted start times for each meal to ensure all units received meals in a timely manner. All dietary staff received additional	

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F 802	Continued From page 86 time. The following day, 9/15/24, breakfast was delivered at 10:36 AM; - on 10/17/24, dinner was delivered at 5:52 PM. The following day, 10/18/24, breakfast was delivered at 10:09 AM; - on 10/18/24, dinner was delivered at 5:50 PM. The following day, 10/19/24, breakfast was delivered at 10:14 AM; - on 10/19/24, dinner was delivered at 6:27 PM. The following day, 10/20/24, breakfast was delivered at 10:48 AM; - on 10/27/24, dinner was delivered at 5:14 PM. The following day, 10/28/24, breakfast was delivered at 10:15 AM and; - on 10/28/24, dinner was delivered at 6:07 PM. The following day, 10/29/24, breakfast was delivered at 10:29 AM. 11/1/24 11:21 AM - In an interview, E8 (Dietary Supervisor) confirmed that there were delays in the meal delivery times and that, "... The kitchen staff need to be more efficient with time management starting at the tray line." 11/12/24 2:35 PM - Findings were discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant). 2. 11/4/24 9:00 AM - During an interview, R78 stated that the lunch and dinner meals on Sunday 11/3/24 were both late in delivery and did not have reasonable portions or selection of foods. 11/4/24 3:15 PM - An email request was made to E1 (NHA) to provide the kitchen staff time cards for 11/2/24 and 11/3/24. 11/4/24 - A review of the facility dietary time cards for 11/3/24 revealed that no member in the	F 802	education on 10/29/24 by food service director and regional consultant, on mealtimes and following the posted times to start the tray line for each meal. In addition, the dietary team member who delivers the food trucks to the units will document the time the truck is delivered to the unit and the nursing team will sign off on the time the truck was received. D.2. The food service director/designee will audit the culinary staff to ensure that trayline starts at the recommended times for all meals. The Food service director will monitor the truck delivery logs for consistency. The audits will be completed daily, or once 100% compliance is achieved, for three consecutive days. The audits will continue to occur 3x a week for 3 consecutive weeks, or until 100% achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 802	Continued From page 87 facility's food service department possessed a valid Food Protection Manager certificate from an Accredited Food Safety Program on 11/3/24 during dinner preparation and service, between the hours 3:52 PM - 6:14 PM. 11/13/24 - During an interview, E1 (NHA) confirmed that E70 (kitchen cook), who was the cook in the kitchen during dinner preparation, did not possess a valid Food Protection Manager certificate from an Accredited Food Safety Program. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.	F 802		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R141) out of 13 residents reviewed for food, the facility failed to ensure that R141's food was prepared and appropriate to meet R141's needs and according to his care plan. Findings include: Review of R141's clinical record revealed the following: 7/12/24 - R141 was admitted to the facility.	F 805	A. Resident R141 diet texture was corrected, and updated to Regular texture, in the tray tracking system on 11/7/24. B. All diet orders were verified for accuracy in the tray tracking program and the PCC system, by the Food service director and regional consultant, on 11/7/24 to ensure all diet orders were entered into the system correctly, and the	1/2/25

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F 805	Continued From page 88 7/15/24 - R141 had a care plan developed for nutrition/hydration risk related to poor food intake by mouth and for potential for weight changes. R141's interventions included but not limited to monitor and to report to the physician "... refusing to eat, appears concerned during meals and to provide and serve diet as ordered...". 9/23/24 - R141 had a physician's order for regular diet regular texture, regular (thin) consistency diet for comfort feeding. 10/28/24 1:30 PM - An observation of R141's lunch tray revealed a plate with ground fried chicken with country gravy, buttered mashed potatoes, seasoned spinach, buttered dinner roll and diced pears. R141's meal ticket documented mechanical soft (texture). 10/28/24 1:31 PM - During an interview, R141 stated that he had been telling the nursing staff that he wanted to eat regular texture food, yet he continued to receive "chopped and grounded baby food" on his food tray. 10/28/24 1:35 PM - In an interview, E56 (LPN) stated that she was not aware if R141 was allowed to eat regular texture food. E56 confirmed that R141 had a mechanical soft texture meal served on [R141's] lunch tray. The facility failed to ensure that R141 received the prescribed and appropriate regular texture food during meals. 11/07/24 1:55 PM - Finding was confirmed by E47 (Regional Clinical Consultant).	F 805	residents received the prescribed diet type and texture. The food service director and assistant food service director were educated, by regional consultant, on transmission of diet orders. C. The root cause was determined to be that staff failed to follow the policy and procedure for transmission of diet orders, by the residents receiving the incorrect textured food items. The Food service director and assistant food service director received additional training on 11/7/24 by regional dining consultant, on verifying diet orders and following the policy and procedure of Transmission of diet orders. D. The food service director will audit the tray tracking program, and PCC, to ensure that all diet orders have been entered into the system correctly and the resident□s meal ticket is reflective of the correct diet and texture. The audits will be completed daily, or once 100% compliance is achieved, for three consecutive days. The audits will continue to occur 3x a week for 3 consecutive weeks, or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is sustained the deficient practice will be considered resolved. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee for further evaluation, recommendations, and sustainability plan.	

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F 805	Continued From page 89 11/12/24 2:35 PM - Finding was discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant).	F 805		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for two (R141 and R78) out of 13 residents reviewed for food, the facility failed to accommodate a food preference. Findings include: 1. 10/28/24 1:15 PM - During an interview, R141 stated that a facility staff (not identified) came to see him that morning and showed him the day's lunch menu. R141 also stated that he told the staff that he did not want the primary menu which was fried chicken with gravy, mashed potatoes, seasoned spinach and dinner roll. R141 stated that he told the staff that for his lunch, he wanted to order the alternative tuna sandwich instead. 10/28/24 1:30 PM - An observation of R141's lunch tray revealed a plate with ground fried chicken with country gravy, buttered mashed potatoes, seasoned spinach, buttered dinner roll	F 806	A. 1. The facilities always available menu was updated on 11/16/24 to include breakfast items. 2. The food service director collected preferences for R141 and R78 and input them into the tray tracking program. B. 1. The updated always available menu will be included in the packets provided to the residents on a daily basis, the food service director and dietary staff were educated on 11/15/24 regarding the updated always available menu 2. The food service director provided the activities director with a weekly menu on Friday 11/22/24 to be distributed to the residents on Monday 11/25/24. The Food service director, or designee, will collect the resident□s menu choice selections by	1/2/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. BUILDING _____ B. WING _____	C 11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGS REHABILITATION AT BRANDYWINE	505 GREENBANK ROAD WILMINGTON, DE 19808

(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 806	Continued From page 90 and diced pears. 10/28/24 1:35 PM - In an interview, E56 (LPN) stated that she was not aware that R141 had spoken to a facility staff earlier and had requested for the alternative tuna sandwich instead of the primary lunch menu. E56 confirmed that R141 had the following on his lunch tray: ground fried chicken with country gravy, buttered mashed potatoes, seasoned spinach, buttered dinner roll and diced pears. E56 further stated that she called the kitchen to request for R141's tuna sandwich. 11/1/24 10:21 AM - In an interview E8 (Dietary Supervisor) stated, "... Sometimes alternative menus or other food requests are not done because they don't get to us or they (nursing/activity staff) don't drop the paper into the bin hung outside by the kitchen door." 11/1/24 11:15 AM - In an interview, E37 (Activities Staff) stated that every morning Activities staff give out packets to the residents with information including the day's breakfast, lunch and dinner menus. E37 further stated, "If they don't like what's on the menu, they can refer to the Always Available Menu page with a list of alternative sandwiches, soups and salads. Sometimes we make the changes for them if they don't want what's on the list. We take the paper to the kitchen and drop it on the bin outside the kitchen by the door." 11/1/24 2:56 PM - During an interview, E31 (RD) stated that it's the Food Service Director's or Dietary Supervisor's responsibility to ask residents of their meal preference, or ask for alternative food in case residents don't want the	F 806	Wednesday and the selections will be added to the resident□s meal ticket. C. 1. The root cause was determined to be due to the lack of consistent process related to residents□ menu choice selections. The food service director, assistant food service director, activities director and staff were provided with additional education by the regional dining consultant, on 11/22/24 regarding the new process for resident□s menu selections. 2. The food service director, assistant director, and the registered dietitian failed to follow recommended guidelines of collecting residents preferences within 72 hours of admission, additional education provided by the regional dining consultant on 11/22/24. D. The food service director, or designee, will conduct audits to ensure the residents preferences have been collected. The audits will be completed daily, or once 100% compliance is achieved, for three consecutive days. The audits will continue to occur 3x a week for 3 consecutive weeks, or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is sustained the deficient practice will be considered resolved. Results of all audits will be presented to the Quality Assurance and Performance Improvement Committee for further evaluation, recommendations, and sustainability plan.	