DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Capitol

DATE SURVEY COMPLETED: December 12, 2024

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates 12/09/24 - 12/12/24. Census:109		
3201	Sample: 29		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **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:**	Please Cross reference electronic POC in epic system F558, F600 F609, F610, F689, F812, and F919	02/12/2025

Provider's Signature [signature] Title Administrator Date 01/02/2025

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	Cross refer tags are F558, F600, F609, F610, F689, F812 and F919.	Please cross reference electronic POC in Epic system f558, F600, F609, F610, F689, F812 and F919	02/12/2025

Provider's Signature Debby Oakley Title Administrator Date 01/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	C 12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION CAPITOL	1225 WALKER ROAD DOVER, DE 19904

(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 A Recertification Emergency Preparedness survey was conducted by Healthcare Management Solution on behalf of the State of Delaware, Department of Health and social Services, Division of Health Care Quality on 12/09/24-12/12/24. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates 12/09/24-12/12/24 Census:109 Sample: 29	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure one of 29 residents (Resident (R) 39 reviewed had their call light accessible for use creating the potential for needs not to be met.	F 558	1. R39□s call bell was immediately positioned so that the resident could reach the call bell. R 39 was not negatively impacted by the deficient practice. 2. All residents have the potential to be	1/24/25

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

Electronically Signed | 01/02/2025

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F 558	Continued From page 1 Findings include: Review of the "Admission Record" located under the "Profile" tab in the electronic medical record (EMR) revealed R39 was initially admitted on 11/06/19 with diagnoses that included adjustment disorder with depressed mood, congestive heart disease, chronic kidney disease stage three, and gout. Review of the annual "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 10/29/24 revealed R39 had a "Brief Interview for Mental Status (BIMS)" score of 12 out of 15 which indicated R39 was moderately cognitively impaired. On 12/09/24 at 12:44 PM, R39 was in bed and the call light was underneath his bed. On 12/09/24 at 1:09 PM, R39 was observed in bed and the call light was underneath the bed. During an interview at the time of the observation. R39 said he did not know where the call light was. During an observation on 12/11/24 at 8:35 AM, R39 was in bed and the call light was underneath his bed. During an interview on 12/11/24 at 9:41 AM, Licensed Practical Nurse (LPN1) was asked was R39's call light. LPN1 located the call light under the bed and confirmed that R39 was able to use the call light if it was in reach of his right hand. LPN1 stated, "He can't use his call light if it's under the bed, the staff know better than this." During an interview on 12/11/24 at 10:39 AM, Certified Nurse Aide (CNA3) stated, "Yes, I took	F 558	affected by this deficient practice. Future Residents will be protected from this deficient practice by taking the corrective action outlined in #3. 3. A house-wide sweep was conducted and no other findings were identified. A root cause analysis was conducted and it was determined that the facility did not have a process in place to assure that all residents have their call bells within reach at all times when care is not being provided. The facility purchased clips for each call bell so that the call bell is secured to the bed at all times. Additionally, call bell placement was added to the weekly rounding schedule for all department heads as a means for checking for placement. The Staff Educator will inservice all direct care staff on proper call bell placement. 4. The DON or designee to perform audits of random rooms for proper call bell placement the audits will be conducted daily until 100% compliance x3consecutive audits. Then audits will be completed weekly x 3 consecutive audits. Then audits will be completed monthly until x3 Once 100% compliance is achieved the deficient practice will be considered resolved. The results of the audits will be presented and discussed at the facility's quarterly QA meeting.	

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F 558	Continued From page 2 care of [R39] this morning. I didn't realize the call light was under the bed." Interview on 12/11/24 at 4:30 PM, R39 demonstrated how he was able to push the call bell with his right hand and stated, "I can push it, just my left hand doesn't work." Interview on 12/12/24 at 9:16 AM, the Director of Nurses (DON) confirmed that the CNAs were to ensure that each resident had their call light accessible to them during and after cares. Interview on 12/12/24 at 4:00 PM, the Nurse Consultant (NC2) stated, "We don't have a policy on call lights."	F 558		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure two (Residents	F 600	1.R 52 was not negatively impacted by this deficient practice. All staff will monitor	1/24/25

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F 600	Continued From page 3 (R) R71 and R37) of six residents reviewed for abuse, were free from resident-to resident abuse for two separate incidents. This had the potential to affect resident safety at the facility. Findings include: Review of the facility's abuse policy titled, "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime," revised January 12, 2023, indicated," ... It is the policy of Cadia Healthcare to protect residents and prevent occurrences of abuse ...." 1. Review of R52's electronic medical record (EMR) revealed a "Face Sheet" located under the "Profile" tab indicated the resident was admitted to the facility on 08/08/22 with diagnosis of depression, dementia, anxiety disorder and Alzheimer's. Review of the quarterly "Minimum Data Set" (MDS) located under the "MDS" tab with an Assessment Reference Date (ARD) of 11/09/24 indicated a "Brief Interview for Mental Status (BIMS)" score of 0 out of 15 indicating the resident was severely cognitively impaired. The assessment indicated the resident exhibits physical and verbal behavior toward others. Review of the "Care plan" located in the EMR under the "Care Plan" tab indicated R52 had a tendency to be verbally and physically aggressive to others. Review of the "Progress Note" located in the EMR under the "Progress Note" tab revealed that on 11/25/23, R71 was ambulating in the hallway	F 600	and report all resident-to-resident incidents. Staff were unable to safely identify potential triggers of resident to reduce potential resident to resident abuse. 2. A route cause analysis was conducted and revealed that the facility failed to identify potential behaviors that may provoke increased verbal or physical aggression. The residents will be protected from this deficient practice by taking the corrective action outline in number three. No residents were negatively impacted by this deficient practice. 3. A full house education to be completed on monitoring and intervene for behaviors that might provoke increased verbal and or physical aggression. 4. The DON or designee will conduct audits of resident behaviors and documentation of interventions daily x 3, weekly x 3 then monthly x 3 until 100% compliance is achieved. At this time the deficient practice will be considered resolved. All audits and findings will be presented and reviewed at the facility's quarterly QA meeting. F600 part B 1.R 63 was not negatively impacted by this deficient practice. All staff will monitor and report all resident-to-resident incidents. Staff were unable to safely identify potential triggers of resident to reduce potential resident to resident abuse. 2. A route cause analysis was conducted and revealed that the facility failed to identify potential behaviors that may	

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F 600	Continued From page 4 and began urinating in the floor. R52 walked up to R71 and struck him in the back. The residents were immediately separated. Review of R71's "Face Sheet" located in the EMR under the "Profile" tab in the EMR indicated the resident was admitted to the facility on 03/13/21 with diagnosis of alcohol abuse, schizophrenia, anxiety, and depression. Review of the quarterly "MDS" located in the EMR under the "MDS" tab with an ARD of 09/05/24, indicated the resident had a "BIMS" score of four out of 15 indicating the resident was severely cognitively impaired. Review of R71 "Care Plan" located in the EMR under the "Care Plan" tab indicated the resident with a behavior of being verbally aggressive. Review of a facility incident reported 11/25/23 revealed R71 was ambulating in the hall outside of his room and started to urinate on the floor. The nurse attempted to redirect the resident to his room without success. R52 was ambulating in the hall and yelled at R71. R52 walked up to R 71 striking him in the back. During an interview on 12/12/24 at 10:01 AM, Registered Nurse 2 (RN) stated that both residents can get agitated, but both can be redirected easily. Interview on 12/12/24 at 12:59 PM, the Director of Nursing (DON) stated the incident was resident to resident abuse. 2. R63 was admitted to the facility on 10/18/22 with diagnosis of toxic encephalopathy, alcohol	F 600	provoke increased verbal or physical aggression. The residents will be protected from this deficient practice by taking the corrective action outline in number three. No residents were negatively impacted by this deficient practice 3. A full house education to be completed on monitoring and intervene for behaviors that might provoke increased verbal and or physical aggression. 4. The DON or designee will conduct audits of resident behaviors and documentation of interventions daily x 3, weekly x 3 then monthly x 3 until 100% compliance is achieved. At this time the deficient practice will be considered resolved. All audits and findings will be presented and reviewed at the facility's quarterly QA meeting.	

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F 600	Continued From page 5 abuse, anxiety disorder, depression, and dementia. Review of the quarterly "MDS" located under the "MDS" tab with an ARD of 10/25/24 indicated a "BIMS" score of nine out of 15 indicating the resident was moderately cognitively impaired. The assessment indicated the resident exhibits verbal behaviors directed at others. Review of the resident's care plan located under "Care Plan" tab in the EMR revealed R63 was identified with behaviors of resisting care with use of his walker and wheelchair. R37 was admitted to the facility on 02/02/21 with diagnosis of subarachnoid hemorrhage, dementia, depression, and traumatic brain injury. Review of R37's Annual "MDS" located under the "MDS" tab in the EMR indicated a "BIMS" of four out of 15 indicating the resident was severely cognitively impaired. Review of the resident's "Care Plan" located in the EMR under the "Care Plan" tab indicated the resident exhibited verbal behavior toward others. Review of the facility's investigation of the incident revealed that on 05/07/24 at 17:00, R63 and R37 were reported to have gone for the same chair at dinner. R63 stated that R37 got smart with him, and he smacked her on the left side of the face. No redness, swelling or any other injury noted. R37 denied having said or done anything to R63. During an interview on 12/12/24 at 08:59 AM, the DON stated that the incident with R63 slapping R37 was resident to resident abuse.	F 600		

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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 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 record review, interview and policy review, the facility failed to ensure an incident of resident-to-resident abuse was reported to the State Agency (SA) within two hours of the incident as required for one residents (R)71) from six residents reviewed for abuse.	F 609	1.R 52 and R71 were not negatively impacted by this deficient practice. The allegation of abuse was reported to Delaware Healthcare (DHCQ) upon becoming aware of the allegation of abuse. 2.All residents have the potential to be	1/24/25

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F 609	Continued From page 7 Findings include: Review of the facility's policy titled, "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime," revised January 12, 2023, indicated," ... It is the policy of Cadia Healthcare to protect residents and prevent occurrences of abuse ...Guidelines ...Reporting and Response ...Allegations of resident abuse shall be reported to the appropriate state regulatory authority within 2 hours ..." 1 Review of R52's electronic medical record (EMR) revealed a "Face Sheet" located under the "Profile" tab indicated the resident was admitted to the facility on 08/08/22 with diagnosis of depression, dementia, anxiety disorder and Alzheimer's. Review of the quarterly "Minimum Data Set" (MDS) located under the "MDS" tab with an Assessment Reference Date (ARD) of 11/09/24 indicated a "Brief Interview for Mental Status (BIMS) of 0 out of 15 indicating the resident was severely cognitively impaired. Review of R71's EMR revealed a "Face Sheet" located under the "Profile" tab indicated the resident was admitted to the facility on 03/13/21 with diagnosis of alcohol abuse, schizophrenia, anxiety, and depression. Review of the quarterly "MDS" located under the "MDS" tab with an ARD of 09/05/24 indicated a "BIMS" score of four out of 15 indicating the resident was severely cognitively impaired. Review of the "facility incident report" dated	F 609	affected by this deficient practice. 3.A root cause analysis was conducted, and it was determined the facility failed to report a resident-to-resident abuse case within the required 2-hour time frame. A facility wide was conducted and it was determined that no other incidents met the requirement for reporting abuse in 2 hours. A weekly audit will be completed to ensure all reportable events have been reported as outlined in the regulation. Education will be conducted by the DON for all supervisors outlining the regulation for reporting incidents of abuse within 2-hours and to notify the DON/ADON immediately after an incident occurs. 4.The Don or designee will conduct daily audits of clinical notes x 3, weekly x3 then monthly x3 until 100% compliance is achieved and at that time the deficient practice will be considered resolved. All audit findings will be presented in the facility's quaterly QA meeting.	

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F 609	Continued From page 8 11/25/23 revealed R71 was ambulating in the hallway outside of his room and started to urinate on the floor. R52 yelled at R71 then walked up to him, striking him in the back. During an interview on 12/12/24 at 12:59 PM, the Director of Nursing (DON) stated she became aware of the incident when she was reading notes from her home and called to find out what happened. The nurse that was on duty when the incident occurred failed to follow the reporting requirement to notify her of the incident. She stated that she reported the incident to the SA as soon as she was aware, but it should have been reported within two hours of the incident.	F 609		
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:	F 610		1/23/25

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F 610	Continued From page 9 Based on record review, interview and policy review, the facility failed to complete a through investigation of an allegation of abuse for one of six residents (Resident (R) 11) reviewed for abuse and neglect out of a total sample of 29. This failed practice had the potential to affect resident safety at the facility. Findings include: Review of R11's electronic medical records (EMR) revealed the quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/23/24 found under the "MDS" with an admission date of 03/26/23 and a "Brief Interview for Mental Status (BIMS)" score of 15 out 15 which indicated R11 was cognitively intact. Interview on 12/10/24 at 8:43AM, R11 stated that he has never had any problems with staff at the facility. R11 also stated that no one has ever been rough with him during care, and no one has ever pulled on his testicles. During an interview on 12/12/24 at 9:30AM, the Director of Nurses (DON) stated that R11 reported on 01/11/24 that while receiving care on 12/25/24, Certified Nurse Aide (CNA)9 was rough with him during care; forcefully pulling on his genitals. The DON stated that CNA9 was suspended pending an investigation. The DON stated that the investigation revealed that the facility could not substantiate R11's allegation due to lack of evidence. The DON stated that the facility interviewed a female resident and no other residents, whether there were any issues with CNA9 being rough during care. The DON was asked if the facility should have interviewed other male residents that CNA9 had provided care to	F 610	1.R11 was not negatively impacted by this by this deficient practice. R11 has had no further complaints of poor care or abuse. 2.All residents have the potential to be affected by this deficient practice. 3.A root cause analysis was conducted, and it was determined that facility failed to complete a thorough investigation on an abuse allegation. The facility□s investigation did not include interviewing like residents to determine if other residents were affected by this deficient practice. The Chief Nursing Officer will educate the DON/ADON on conducting a thorough investigation related to residents who present with allegations of abuse. 4.The DON or designee will conduct daily audits of reportable files to assure the proper investigation has been completed daily x3 until 100% compliance, then weekly x3 until 100% compliance and then monthly x3 until 100% compliance is achieved then the deficient practice will be considered resolved.The results of the audits will be presented and discussed at the facility's quarterly QA meeting.	

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F 610	Continued From page 10 on 12/25/24. The DON stated that other male residents should have been interviewed. Review of the facility's investigative document revealed that the facility had only interviewed one female resident about how CNA9 had provided care. There was no documentation of interview with other residents especially male residents regarding the care CNA9 provided. Review of the facility's policy titled "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime" dated 01/03/24 indicated, ...all alleged incidents involving abuse ... shall be reported to the NHA [Nursing Home Administrator] or designee immediately. The NHA or designee shall investigate allegations ... All persons identified as involved in or with knowledge of the occurrence will be interviewed."	F 610		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure one of 29 residents (Resident (R) 29 reviewed had a mattress that fit the bed frame. The failure created the potential for an injury if R29 's feet	F 689	1.R29 was not negatively impacted by this deficient practice. 2.All resident have potential to be effected by this deficient practice. 3.A root cause analysis was conducted	1/23/25

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	085048	A. BUILDING _____ B. WING _____	C 12/12/2024

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F 689	Continued From page 11 became tangled in the gap between the mattress and the footboard of the bed. Findings include: Review of the "Admission Record" located under the "Profile" tab in the electronic medical record revealed R29 was admitted on 07/16/20 with diagnoses that included hemiplegia and hemiparesis following a cerebral infarction, and disorders of bone density and structure. Review of the quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 10/19/24 revealed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 which indicated R29 was cognitively intact. On 12/10/24 at 11:56 AM, R29 was observed in bed with the head of the bed in an upright position. A large gap, which measured 11 inches from the mattress to the footboard was observed. The footboard was noted to be angled away from the mattress. R29 was asked if she ever slides down, toward the footboard, when in bed and stated, "Yes, I have many times when I am put in the bed." When asked if her feet had ever become entangled in the gap, R29 said, "Yes." On 12/11/24 at 10:37 AM, R29 was observed in bed with the head of the bed in an upright position and a six inch gap was noted between the mattress and the footboard. On 12/11/24 at 11:02 AM, the Administrator, Director of Nurses (DON), and Nurse Consultants (NC1 and NC2) observed the gap between the mattress and the footboard of R29's bed. The DON was asked to measure the gap which was	F 689	and the facility failed to conduct audits of all resident mattress to assure no possible entrapments related to the gab between the mattress and the foot board. A full house sweep was conducted to evaluate any potential entrapment issues, none was Identified. A weekly audit will be completed of all mattresses to assure no potential gabs that could cause an entrapment. 4.The DON or designee will completed a random audit of 10 beds to evaluate potential entrapments daily x3 until 100% compliance, then weekly x 3 then monthly x3, once 100% compliance is achieved the deficient practice will be considered resoled. All audits will be presented and reviewed at the facility's quarterly QA meeting.	

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F 689	Continued From page 12 noted to be six inches. R29 stated, "My feet have gotten down in the hole before, when I move the bed up." The DON stated, "Yes, six inches. We need a bolster." The Administrator and DON were asked to provide a policy on ensuring resident's mattress fits bed frames. No policy was provided as of the exit, on 12/12/24 at 5:45 PM.	F 689		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure that beard guards were worn during food production in accordance with professional standards for food service safety and failed to store food in	F 812	Beard Guards were not worn during food production 1.No residents were harmed by this deficient practice. 2.All residents have the potential to be	1/23/25

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F 812	Continued From page 13 accordance with professional standards for service safety with the potential to affect 109 of 109 residents who consumed food from the kitchen. This failure had the potential for physical contamination of the food in the facility. Findings include: 1. Review of the facility's policy titled, "Dress Code" dated August 30, 2017, revealed sanitary food preparation staff must wear: "hair net or a disposable hat while on duty. Any employee with facial hair must wear a beard guard." During observation of the lunch meal preparation on 12/09/24 at 11:45 AM, two male Dietary Aide (DA)2 and DA 3 with beards did not have beard nets covering their beard at the food preparation station. During observation of the dinner meal preparation on 12/09/24 at 4:45 PM, DA2 and DA3,with beards did not have beard nets covering their beard at the food preparation station. During observation of the breakfast meal preparation on 12/10/24 at 8:10 AM, DA2 and DA3 with beards did not have beard nets covering their beard at the food preparation station. During observation of the noon meal preparation on 12/10/24 at 11:30 AM, while accompanied by the Dietary Manager (DM), DA2 and DA3 with beards did not have beard nets covering their beard at the food preparation station. During an interview on 12/10/2024 at 11:40 AM, the Food Service Director (FSD) stated that staff	F 812	affected by this deficient practice 3.A root cause analysis was completed, and it revealed a deficient practice that beard guards were not worn by the dietary staff. Dietary staff will be educated on wearing proper hair covers (hairnet, hat, and/or beard guards during food production. 4.The Food Service Director or Designee will audit the dietary staff for wearing the beard guards once daily x 3 then weekly for 3 weeks then monthly x3 until 100% compliance is met. One 100% compliance is achieved the deficient practice will be considered resolved. Results of the audits will be presented and reviewed at the facility's quarterly QA meeting. Food Receiving and Storage _Refrigerator 1.No residents were harmed by this deficient practice. 2.All residents have the potential to be affected by this deficient practice. 3.A root cause analysis was completed and revealed the dietary staff not ensuring proper food storage and labeling to assure proper discarding of perishable food. Dietary staff will be educated to ensure proper food storage, tracking when to discard perishable food, and covering, labeling and dating all foods stored in the refrigerator and freezer. 4.The Food Service director or Designee will audit the main refrigerator for outdated and undated food items to ensure 100% compliance. Audits will be completed twice dailyx x3, then twice weekly x3 then	

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F 812	Continued From page 14 with beards must wear a beard net to cover their beard. "I did not observe the two male kitchen staff members not wearing beard nets until I observed them today." During an interview on 12/10/24 at 1:25 PM, the Dietary Aide (DA) 2 stated, "Yes, I know that I must wear a beard guard when I'm in the kitchen. I just forgot." During an interview on 12/10/24 at 1:30 PM, the Dietary Aide (DA) 3 stated, "Yes, I know that I must wear a beard guard when I'm in the kitchen. I just forgot." 2. During the observation of the main refrigerator on 12/09/24 at 09:30 AM, while accompanied by the FSD the following food items were expired or had no current dates after being used: Cardboard box with black substance on the right side of the outside of the cardboard box. Inside the cardboard were two 64 oz containers of potato salad that were split open. Outside the cardboard box was a dated 08/28/24. One gallon size plastic container of Thousand Island salad dressing was dated 08/28/24. Twenty peeled, hard-boiled eggs were wrapped individually in plastic wrap without a date. One 64-ounce grape jelly glass jar with half a jar remaining contained no date. Chicken salad in a 64-ounce metal container was half full and undated. 3. During the observation of the main freezer on 12/09/24 at 10:30 AM, while accompanied by the FSD the following food items that were expired or had no current dates after being used:	F 812	monthly until 100% compliance is achieved, once this is achieved the deficient practice will be considered resolved. The Food Services Director or Designee will present and review all audits at the facility's quarterly QA meeting. Food Receiving and Storage-Freezer 1.No residents were harmed by this deficient practice. 2.All residents have the potential to be affected by this deficient practice. 3.A root cause analysis was completed, and the dietary staff were not properly labeling and dating food items. Dietary staff will be educated to ensure proper food storage, tracking when to discard perishable food, and covering, labeling and dating all foods stored in the refrigerator and freezer. 4.The Food Service director or Designee will audit the main refrigerator for outdated and undated food items to ensure 100% compliance. The Dietary refrigerator will be audited daily x 3 then weekly x 3 and monthly x 3 months until 100% compliance. Once this is achieved this deficient practice will be considered resolved. The Food Services Director or Designee will present and review all audits at the facility's quarterly QA meeting	

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F 812	Continued From page 15 An open cardboard box revealed an open plastic bag of 32 frozen chicken cutlets with no date. Open cardboard box revealed an open plastic bag of 40 frozen hamburger patties with no date. During an interview on 12/09/2024 at 10:55 AM, the FSD stated that the weekend kitchen staff are supposed to check and throw out food items that are out of date.	F 812		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of 29 sample residents (Resident (R) 50 had an alternative call light device available when the call light system malfunctioned. The failure created the potential for the resident's care needs to be unmet. Findings include: Review of the "Admission Record" located under the "Profile" tab in the electronic medical record (EMR) revealed R50 was admitted on 09/27/19 with diagnoses that included chronic obstructive pulmonary disease, congestive heart failure with	F 919	1.R50 was not harmed by this deficient practice 2.R50 was provided a tap bell/doorbell for her bedside and for the toilet and bathing facilities. 3.A route cause analysis was conducted, and it was determined the facility failed to assure all residents had an accessible call bell. Staff will be educated in the process of checking and reporting nonworking call bell or missing tap bell/ doorbell. 4.The Maintenance Director or Designee will audit rooms for a functioning call bell or alternative call bell. A audit will be completed daily x3, weekly x3 then	1/23/25

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F 919	Continued From page 16 hypoxia, and interstitial pulmonary disease. Review of the quarterly "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 10/03/24 revealed a "Brief Interview for Mental Status (BIMS)" score of six out of 15 which indicated R50 was severely cognitively impaired. Observation on 12/11/24 at 10:46 AM, R50 had no call light plugged into the wall unit, or a substitute call device available. R50 stated, "I haven't had one, the other one broke." When asked how she would call staff for assistance, R50 stated, "I don't have anything, just my voice." During an interview on 12/11/24 at 11:10 AM, the Administrator, Director of Nurses (DON), and nurse consultants (NC1 and NC2) were notified of R50 not having a call bell device. R50 stated to the administrative staff, "I guess I could try to yell." The DON looked for the "doorbell" device in the resident's room, however none was located. During an interview on 12/11/24 at 11:59 AM, the Administrator identified that the call light system had failed in May 2024. All but two rooms returned to normal functioning. R50 resided in one of the two rooms that did not have a functioning call light system. The Administrator stated, "Due to the wiring. [R50's] room could not be fixed." The DON stated, "we gave them all a doorbell." Observation of the two rooms identified not having a functioning electronic call light system, on 12/11/24 at 12:13 PM, revealed three of the four residents (R4, R12, and R14) had "doorbell" like devices which rang into the hall. R50 had no	F 919	monthly x 3 until 100 % compliance is achieved then this deficient practice will be considered resolved. All audits will be presented and reviewed at the facility's quarterly QA meeting.	

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F 919	Continued From page 17 such device. On 12/11/24 at 4:30 PM, the Administrator stated, "The Certified Nurse Aides (CNAs) know to check on the residents. We will make sure they check for the bell too." Interview on 12/12/24 at 8:47 AM, CNA3 stated, "Yes, we check for the bell. I don't know what happened to it."	F 919		