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

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

STATE SURVEY REPORT

NAME OF FACILITY: Complete Care at Hillside LLC

DATE SURVEY COMPLETED: February 06, 2025

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: 02/03/25 to 02/06/25 Survey Census: 96 Sample Size: 47 Supplemental Residents: 9	Please cross reference Form CMS-2567 for Provider's Plan of Correction.	April 8, 2025
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 February 6, 2025: F554, F558, F610, F656, F677, F680, F686, F690, F695, F700, F758, F760, F761, F880, F883 and F919.		

Provider's Signature Ruth N Ayo Title LNHA Date 3-11-25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085013	A. BUILDING _____ B. WING _____	C 02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HILLSIDE LLC	810 SOUTH BROOM STREET WILMINGTON, DE 19805

(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, Complaint, and Emergency Preparedness 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 on 02/03/25 through 02/06/25. The facility was found to be in substantial compliance with 42 CFR 483 subpart B.	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: 02/03/25 to 02/06/25 Survey Census: 96 Sample Size: 47 Supplemental Residents: 9	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and policy review, the facility failed to ensure medications were not left at bedside for a resident that was not assessed to self-administer medications for two resident (Resident (R) 24 and R298) out of 47 residents in the sample. This had	F 554	R24's aerosol breath inhalers were removed from her bedside and placed in the medication cart. R 298's aerosol breath inhaler was removed from his bedside and placed in	4/8/25

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

Electronically Signed | 03/03/2025

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F 554	Continued From page 1 the potential to affect all residents who received medications. Findings include: Review of the facility's policy titled, "Resident Self-Administration of Medication," undated, indicated, "It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medication may be self-administered safely ...Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication ...All nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage ..." 1. During an observation and interview on 02/03/25 at 3:26 PM of R24's room revealed two inhalation aerosols lying on the bedside table. The resident stated that they had been left there since the night before when the nurse brought in the treatment. Review of the "Face Sheet" located in the "Profile" tab of the electronic medical record (EMR) revealed R24 was admitted to the facility on 12/19/18 with diagnosis of stroke affecting the right dominant side and unspecified asthma. Review of R24's annual "Minimum Data Set (MDS), located in the EMR under the "MDS" tab with an Assessment Reference Date of 12/15/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated no cognitive impairment.	F 554	the medication cart. Current residents receiving aerosol inhalers have the potential be affected by this deficient practice. An audit of current residents receiving aerosol breath inhalers was conducted the the Director of Nursing (DON) on February 5, 2025 to ensure that aerosol breath inhalers were not at bedside. The root cause of this deficient practice was that two nurses failed to follow the facility's policy on self-administration of medication. These two nurses were educated by the DON on February 5, 2025 regarding leaving aerosol breath inhalers at the bedise when there is no physician order for self-administration of medication. Current licensed nursing staff will be educated by the Staff Development Coordinator (SDC) or designee on the policy of self-administration of medication. The DON and/or designee will conduct rounds on residents who are receiving aerosol breath inhalers to verify that they are not left at the resident's bedside. This audit will be done daily until the facility reaches 100% success over three consecutive evaluations. Then, the audit will occur three times a week until the facility reaches 100% success over 3 consecutive evaluations. Finally, the audit will be conducted one more time a month late. If the facility reaches 100% success, the facility's QAPI Committee can conclude that the deficient practice has been sucessfully addressed.	

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F 554	Continued From page 2 Review of R24's "Orders" located in the "Orders" tab of the EMR revealed the inhaler "Beclomethasone Diprop HFA Inhalation Aerosol Breath Activated 80 MCG/ACT, to be given two times a day (one puff) for asthma." The other inhaler was "Olodaterol HCl Inhalation Aerosol Solution 2.5 MCG/ACT, to be given (two puff) one time a day for asthma. There were not orders for self-administration." On 02/03/25 at 4:02 PM, the Director of Nursing (DON) observed the two inhalers on R24's bedside table. The resident again told the DON that they had been left since the night before by the nurse. The DON stated, "R24 does not have orders to have these at bedside. I am removing these and putting them back on the medication cart." 2. Review of R298's "Face Sheet," located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was re-admitted to the facility on 01/23/25 with diagnoses which included muscle weakness, and polyneuropathy. Review of R298's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/23/25 and located in the resident's EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident's cognition was not impaired. Review of R298's "Care Plan," dated 01/23/25 and located in the resident's EMR under the "Care Plan" tab, revealed the resident was not care planned for self-administration of	F 554		

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F 554	Continued From page 3 medications. Review of R298's "Physician Order Summary," dated 01/23/25 and located in the resident's EMR under the "Orders" tab revealed, resident "MAY NOT administer own medications." During an observation on 02/04/25 at 9:35 AM and again on 02/05/25 at 9:50 AM, R298 had an inhaler lying on the bedside table that was in plain sight. R298 stated he has had the inhaler since he was admitted, and that staff were aware. During an interview on 02/05/25 at 9:55 AM, Registered Nurse (RN)1 stated R298 was assessed to self-administer medications, but she was unaware he had an inhaler. She asked R298 if he had an inhaler, and he lifted the inhaler up that was lying on the bedside table. She said he should not have the inhaler and corrected herself and stated he was not assessed to self-administer medications. RN1 stated again that he should not have the inhaler at all. During an interview on 02/05/25 at 10:27 AM, the Infection Preventionist (IP) said she was made aware of the inhaler on Monday by a nurse. The IP said she spoke with R298, and he agreed to put the inhaler away, but she did not document anything about the conversation. During an interview on 02/06/25 at 12:33 PM, the Director of Education stated any medications a resident is admitted with would have had to be checked in by the nurses and that staff should be observing anything in the room and removing any medications they find in the resident's room.	F 554		
F 558 SS=D	Reasonable Accommodations Needs/Preferences	F 558		4/8/25

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F 558	Continued From page 4 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, interviews, and facility policy review, the facility failed to ensure call lights were within reach for one(Residents (R)85) out of a sample of 47 residents reviewed for accommodation of needs and preferences. Specifically, the facility failed to ensure residents had access to their call lights to best assist the residents in maintaining and/or achieving their independent functioning, dignity, and well-being to the extent possible. Findings include: 1. Review of R85's "Admission Record," found in the "Profile" tab of the electronic medical record (EMR), revealed he was originally admitted on 11/17/23, with diagnoses including diabetes mellitus type two, polyneuropathy, epilepsy, and acquired absence of left leg below the knee. Review of R85's quarterly "Minimum Data Set (MDS)" assessment located in the "MDS" tab in the EMR, with an Assessment Reference Date (ARD) of 12/04/24, revealed a "Brief Interview for Mental Status (BIMS)" assessment with no recorded score due to the resident refused to participate in the BIMS portion of the MDS. R85's quarterly MDS with an ARD of 09/04/24 revealed a BIMS score of 15 out of 15 indicating that R85	F 558	R85's call bell was placed within reach on February 5, 2025. An observation audit of all current residents was conducted on February 6, 2025 by the Maintenance Director to ensure that all resident call bells were within reach. No other residents were identified to be affected by this deficient practice. RN's, LPN's and CNA's will be educated by the SDC or designee on having resident call bells within reach. The root cause of this deficient practice was the failure to have the resident's call bell within reach. An observation audit to ensure that call bells are within reach of all current residents will be done daily until the facility reaches 100% success over three consecutive observations. Then, the audit will be conducted three times a week until 100% success at three consecutive observations. Then, an observation audit will be done once a week until the facility reaches 100% success over three	

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F 558	Continued From page 5 was cognitively intact. R85 was dependent for toileting hygiene, shower/bathing, dressing, and personal hygiene. R85 was observed on 02/04/25 at 9:01 AM in bed with the call light button clipped to the call system on the wall behind the resident, out of reach. He stated he could not reach it from his bed and was able to use the call light. Additional observations on 02/04/25 at 4:50 PM and 02/05/25 at 8:59 AM, revealed R85 in bed with his call light button again clipped to the call system on the wall behind him out of reach. During an interview on 02/05/25 at 9:00 AM, Licensed Practical Nurse (LPN 4 stated that call lights should be kept in close reach of residents when they were in their bed. LPN4 observed R85's call light attached to the call system on the wall and stated it should be attached and within his reach. LPN4 moved the call light to within reach of R85. She said that she was not sure why his call light had not been placed appropriately. She confirmed the resident was alert and oriented and able to use the call light. During an interview on 02/06/25 at 10:20 AM, the Administrator stated that call lights should be answered as promptly as possible. If the residents were in their room, the call light should be reachable. The Administrator stated R85 was an interviewable resident. She stated she would want the resident to have access to his call light. During an interview on 02/06/25 at 10:40 AM, Infection Preventionist/Educator Nurse Practice (IP/ENP) stated that the call lights should always be in reach of the resident when they were in their	F 558	consecutive observations. Finally, an observation audit will be conducted one more time a month later. If the facility reaches 100% success, the QAPI Committee will determine that they have successfully addressed the deficient practice.	

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F 558	Continued From page 6 room.	F 558		
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 record review, interview, and facility policy review, the facility failed to investigate misappropriation of property for two of four residents (Resident (R)84 and R108), This failure has the potential to affect all residents who choose to keep money and/or personal property in their rooms. Findings include: Review of the facility policy titled "Abuse, Neglect, Exploitation," dated 09/12/24 indicated "Investigation. . . the facility will investigate all allegations and types of incidents as listed above	F 610	R108 no longer reside at the facility. Unable to Correct. R84 remains at the facility and no longer smokes. The facility ensured that he has a key to his lock box and re-educated to use his lock box. Failure to investigate misappropriation of property has the potential to affect current residents. An audit of the facility reported incidents (FRI) for the last ninety days was completed to determine if a thorough investigation was completed. The audit revealed that a thorough investigation was	4/8/25

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F 610	Continued From page 7 in accordance with facility procedure for reporting/response as described below. . .the facility will perform an investigation that focuses on whether abuse or neglect occurred and to what extent, clinical evaluation for any signs of injury, causative factors, and interventions to prevent further injury. . ." 1. Review of R84's "Admission Record" located in the electronic medical records (EMR) under the "Profile" tab indicated the resident was admitted to the facility on 10/11/23. 2. Review of R108's "Admission Record" located in the EMR under the "Profile" tab indicated the resident was admitted to the facility on 04/10/24. Review of the "Facility Reported Incident (FRI)" dated 05/01/24 which revealed R84 had informed the Administrator that Certified Nurse Aide (CNA)1 took cigarettes from him and in addition, took money from R108. The FRI failed to contain evidence of interviews with other residents or potential staff as witnesses. During an interview on 02/06/25 at 12:32 PM, the Administrator stated she did not remember how CNA1 accessed R108's secured drawer. The Administrator stated she typically does interview other residents and staff during the investigation. The Administrator was provided with an opportunity to identify additional information on the investigations of theft that involved R84 and R108, and no further information was provided by the end of the survey.	F 610	completed. This occurrence was reported and investigated by the State Survey Agency in May 2024. The root cause of this occurrence is that a more thorough investigation was not done since R108 had been discharged to home and CNA1 had been terminated. Residents with a BIMs of 12 and above will be educated to the risks of entrusting their key to their lock box to staff. Education will be done by the Administrator and/or designee. The facility will investigate and have evidence that all alleged violations were thoroughly investigated. A review of all allegations will be done monthly by the QAPI Committee for the next six months to ensure adherence to the facility's policies and procedures.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F 656		4/8/25

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F 656	Continued From page 8 §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 (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	F 656		

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F 656	Continued From page 9 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 interview, record review, and facility policy review, the facility failed to develop comprehensive care plans related to nebulizer treatment for one resident (Resident (R) 12) out of a total sample of 47 residents. This failure had the potential to negatively impact the resident's quality of life, as well as the quality of care and services received. Findings include: Review of the facility-provided policy titled "Care Plans, Comprehensive Person-Centered," dated 10/2019, revealed "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident ...Assessments of residents are ongoing and care plans are revised as information about the residents and residents condition change ..." Review of the "Face Sheet" located in the "Profile" tab of the Electronic Medical Record (EMR) revealed R12 was admitted to the facility on 11/18/22 with diagnosis of heart failure, diabetes, and cancer of the left breast. Review of the "Orders" located in the "Orders" tab of the EMR revealed R12 had an order for	F 656	R12's nebulizer treatment was added to resident's care plan. An audit of current residents receiving nebulizer treatments was done by the Assistant Director of Nursing (ADON) on February 4, 2025 to ensure that nebulizer treatments are listed as an intervention on the resident's care plan. The root cause of this deficient practice was that the facility failed to care plan for nebulizer treatments. The ADON was educated by the DON on February 5, 2025 regarding the need to care plan nebulizer treatments. The ADON will now be responsible for care planning nebulizer treatments. The respiratory care plan of residents receiving nebulizer treatments will be reviewed and revised by the ADON if necessary, daily for three consecutive evaluations until the facility reaches 100% success. Then, three times a week until 100% success for three consecutive evaluations. Then, once a week until the facility reaches 100% success for three consecutive evaluations. Finally, one	

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F 656	Continued From page 10 Ipratropium-Albuterol Solution 0.5-2.5 MG/3ML orally via nebulizer two times a day for wheeze/cough. Review of the "Care Plan" located in the "Care Plan" tab of the EMR revealed R12 did not have a Comprehensive Care Plan for nebulizer treatment and care. Interview with the Assistant Director of Nursing (ADON) on 02/05/25 at 2:40 PM revealed "Myself and nursing document care plans. I do not know why this was not care planned. It should have been."	F 656	more time a month later. If 100% success, the QAPI Committee can conclude that the facility has addressed the deficient practice.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure two residents of five residents (Resident (R) 31 and R200) who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene (showers per personal preference) out of a total sample of 47 residents. Findings include: Review of a facility policy "Resident Showers" dated 03/14/23 indicated ". . .It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and	F 677	R31 refused a shower on February 6, 2025 and received a shower on February 10, 2025. R200 no longer resides at the facility. Current residents receiving showers have the potential to be affected by this deficient practice. The root cause of this deficient practice is the lack of proper documentation by the CNA's in the Point of Care. The shower schedule will be reviewed daily by the DON and/or designee who will	4/8/25

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F 677	Continued From page 11 help prevent skin issues as per current standards of practice. . ." 1. Review of R31's "Admission Record" located in the electronic medical records (EMR) under the "Profile" tab indicated the resident was admitted to the facility on 05/06/22 a stroke which affected the right side. Review of R31's "Care Plan" located in the EMR under the "Care Plan" tab dated 06/13/24 indicated that the resident identified it was important for her to take showers. Review of R31's annual "Minimum Data Set (MDS)" located in the EMR with an Assessment Reference Date (ARD) of 12/12/24 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated the resident identified it was extremely important for her to decide whether she received a bath, shower, or a bed bath. The assessment indicated that the resident was dependent on staff for baths/showers. Review of a document provided by the facility titled "Shower/Bathing/Personal Care Shower Monday and Thursday 7-3" and as needed for the month of 12/24. The document failed to show that the resident received a shower on 12/09/24, 12/16/24, 12/23/24, 12/26/24, and on 12/30/24. Review of a document provided by the facility titled "Shower/Bathing/Personal Care Shower Monday and Thursday 7-3" and as needed for the month of 01/25. The document failed to show that the resident received a shower on 01/06/25 and on 01/27/25.	F 677	review with each nursing unit that same day. At the end of the day shift and evening shift the nurse on each unit will verify that showers were completed as scheduled and properly documented in Point of Care. The nurse will then initial the assignment sheet form that this has been completed. The SDC and//or designee will educate licensed nursing staff to this new process and expectation. Showers/documentation will be monitored daily by the DON and/or designee until the facility reaches 100% success at three consecutive evaluations. Then, showers/documentation will be monitored three times a week until the facility reaches 100% success at three consecutive evaluations. Then, showers/documentation will be monitored once a week until the facility reaches 100% success over three consecutive evaluations. Finally, showers/documentation will be audited one more time a month later. If the facility reaches 100% success, the QAPI Committee will conclude that the deficient practice has successfully been addressed.	

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F 677	Continued From page 12 During an interview on 02/03/25 at 10:55 AM, R31 stated she has not had a shower in one week. The resident also stated she receives bed baths but prefers to have a shower instead. During an interview on 02/04/25 at 12:47 PM, Certified Nurse Aide (CNA)5 stated that R31 preferred showers instead of bed baths and verified on the shower/bath document that the resident did not receive showers on her assigned days. CNA5 stated R31 rarely refuses showers. During an interview on 02/04/25 at 12:50 PM, the Resource Nurse confirmed the shower/bath document had gaps in the documentation. During an interview on 02/05/25 at 10:14 AM, the Resource Nurse stated that she has been addressing the documentation aspect with CNAs to reflect cares. During an interview on 02/05/25 at 10:55 AM, the Director of Nursing (DON) stated residents should be offered a shower twice a week. 2. Review of R200's "Admission Record," dated 02/06/25 and found in the EMR under the "Admissions" tab, indicated the resident was admitted to the facility on 01/10/25. The resident's diagnoses included spinal stenosis and type 2 diabetes. Review of R200's admission MDS assessment, with an ARD of 01/16/25 and found in the EMR under the "MDS" tab, indicated a BIMS score of 12 out of 15, which indicated the resident was mildly cognitively impaired. The assessment indicated R200 required partial/moderate	F 677		

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F 677	Continued From page 13	F 677		

assistance from staff to complete her bathing.

Review of R200's "ADL Care Plan," dated 01/16/25 and found in the EMR under the "Care Plan" tab, indicated the resident was at risk for a decline in her ADLs related to activity intolerance, fatigue and impaired balance. The care plan indicated R200 was to receive baths/showers twice weekly on Wednesdays and Saturdays on the evening shift. Interventions included, "The resident requires assistance by (1) staff with bathing/showering as necessary."

Review of R200's bathing records, dated 01/10/25 through 02/05/25 and found in the EMR under the "Tasks" tab revealed the resident received a bath/shower only once during that time, on 01/18/25. There was nothing in the resident's record to indicate the resident refused to bathe during that period of time.

During an interview with R200 on 02/05/25 at 9:10 AM, she stated she had only been bathed once since her admission to the facility on 01/10/25. She stated she would like to be bathed.

During an interview with CNA6 on 02/06/25 at 11:43 AM, she confirmed she was familiar with R200 and stated the resident was supposed to be bathed twice weekly on the evening shift. CNA6 stated she usually worked on the day shift and staff tried to keep up with showers on that shift, but it was not uncommon for residents to report they had not been showered on the evening shift.

During an interview with the Administrator on 02/06/25 at 12:51 PM, she stated her expectation was residents would be bathed according to their plan of care and bathing was to be documented

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F 677	Continued From page 14 in the EMR. The Administrator stated refusals to bathe were also expected to be documented in the EMR.	F 677		
F 680 SS=C	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that a qualified activity professional was hired. This has the potential to affect the 96 residents' quality of life who currently reside in the facility. Findings include: Review of an undated facility document titled "Activities Director Job Description "indicated ". . . The activities program must be directed by a	F 680	No individual/area was cited in this deficiency. All residents have the potential to be affected by this deficient practice. The current acting activity director will become a qualified activity director in March 2025. The current acting activity director has a qualifed activity director availabe as a resource to her if needed.	4/8/25

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F 680	Continued From page 15 qualified professional who is a qualified therapeutic recreation specialist or an activities professional who...Is licensed or registered, if applicable, by the state in which practicing. . .Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October I, 1990; or o Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or o Is a qualified occupational therapist or occupational therapy assistant; or o Has completed a training course approved by the State. . ." Review of a facility document titled "Employee Action Form," dated 11/24/24, indicated the Activity Assistant had a change in pay status to the Activity Director. During an interview on 02/03/25 at 12:20 PM, the Activity Director (who was the previous Activity Assistant) stated she was currently working on her certification, and the certification would be completed in March 2025. The Activity Director stated she would be sitting for the federal exam after completion of her courses. During an interview on 02/05/25 at 8:49 AM, the Administrator said her expectation was to have a qualified activity professional, but the previous Activity Director had unexpectedly passed away. The Administrator stated after recruiting for the past two months she decided to give the current acting Activity Director the opportunity to complete her training to become a qualified Activity Director.	F 680	If for any reason the current acting activity director does not become a qualified activity director in March 2025, recruitment will take place for this position.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		4/8/25

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F 686	Continued From page 16 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and review of the facility policy, the facility failed to ensure one of three residents (R)85 reviewed for prevention of skin breakdown, received treatment and interventions according to physician orders out of a total sample of 47 residents. This failure placed the resident at an increased risk for a worsening pressure ulcer, pain, and a decrease in quality of life. Findings include: Review of the facility's policy titled, "Pressure Injury Prevention and Management," revised 05/26/23, revealed, "This facility is committed to the prevention of avoidable pressure injuries, unless clinically unavoidable, and to provide treatment and services to heal the pressure ulcer/injury, prevent infection and the development of additional pressure ulcers/injuries ...The facility shall establish and utilize a	F 686	R85 was placed on an air mattress on February 6, 2025 and his pressure injury to scrotum was resolved on February 25, 2025 and the Santyl ointment was discontinued. An audit of all current residents with pressure injuries was completed on February 26, 2025 by the DON to ensure that an air mattress was in place if appropriate. No additional issues were noted. The root cause of this deficient practice is the facility's failure to carry out the order of an air mattress. The DON and/or designee will review the wound care notes weekly to identify if an air mattress is recommended. The SDC and/or designee will re-eduate	

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F 686	Continued From page 17 systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate ... Evidence-based interventions for prevention will be implemented for all residents who care assessed at risk or who have a pressure injury present. Basic or routine care interventions could include ...redistribute pressure (such as repositioning, protecting, and/or offloading heels ...provide appropriate, pressure-redistributing, support surfaces ...Compliance with interventions will be documented in the weekly summary charting." Review of R85's "Admission Record," found in the "Profile" tab of the electronic medical record (EMR), revealed he was originally admitted on 11/17/23, with diagnoses including diabetes mellitus type two, polyneuropathy, epilepsy, and acquired absence of left leg below the knee. Review of R85's quarterly "Minimum Data Set (MDS)" assessment located in the "MDS" tab in the EMR, with an Assessment Reference Date (ARD) of 12/04/24, revealed a "Brief Interview for Mental Status (BIMS)" assessment with no recorded score due to the resident refused to participate in the BIMS portion of the MDS. R85's quarterly MDS with an ARD of 09/04/24 revealed a BIMS score of 15 out of 15 indicating that R85 was cognitively intact. R85 received pressure reducing devices to his chair and bed. R85 was dependent for toileting hygiene, shower/bathing, dressing, and personal hygiene. A review of a "Progress Note" by the Wound Care	F 686	current licensed nurses on the importance of timely implementation of pressure relieving interventions recommended by providers and ensuring current licensed nursing staff understand the proper application of Santyl ointment to enhance wound healing and avoid incorrect use. Also, the root cause of this deficient practice is that LPN 5 did not follow the physician order to apply Santyl to the wound only. LPN 5 was educated by the SDC on February 6, 2025 regarding Santyl application to the scrotum. The DON and/or designee will audit the wound care notes weekly to determine whether an air mattress was recommended. This audit will be done weekly until the facility reaches 100% success over three months. The audit will be performed one more time a month later. If the facility reaches 100% success, the QAPI Committee will conclude that the deficient practice has successfully be addressed. The SDC and/or designee will observe one pressure injury wound treatment weekly until the facility reaches 100% success over three months. The observation will be performed one more time a month later. If the facility reaches 100% success, the QAPI Committee will conclude that the deficient practice has successfully been addressed.	

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F 686	Continued From page 18 Nurse Practitioner on 01/08/25 documented that R85 "has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. All prevention measures were discussed with the staff at the time of the visit. The patient is incontinent of urine and stool and is at an increased risk of skin breakdown. Recommend continuing ongoing interventions and protocol for incontinence management ... New Recommendations: Recommend an alternating air/low air loss mattress for pressure redistribution. Ensure settings are maintained at an appropriate level based on the patient's needs and body habitus." Review of R85"s "Care Plan," located in the EMR under the "Care Plan" tab and initiated 11/18/23, revealed R85 had impaired tissue or potential for impaired skin tissue lower abdomen redness. It was revised 01/03/25 for a scrotum unstageable pressure injury and converted to stage three on 01/14/25. Interventions included air mattress to bed check function and placement every shift, initiated on 11/20/23; offload heels while in bed, initiated on 11/20/23; treatment as ordered, initiated 11/18/23; and turn and reposition every 2 hours and as needed with skin checks, last revised 01/26/24. During an observation and interview on 02/04/25 at 9:04 AM, R85 said he had a sore on his bottom and now had a catheter because of it. He was observed lying in bed on a regular mattress, which he confirmed was the only mattress he used.	F 686		

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F 686	Continued From page 19 Review of R85's "Physician Order," dated 11/20/23, located in the EMR under the "Orders" tab revealed R85 had an order for an air mattress to bed, check function and placement every shift. This was discontinued 02/13/24. During an observation on 02/04/25 at 1:51 PM, it was again confirmed the mattress for R85 was a regular mattress. During additional observations on 02/04/25 at 4:50 PM and 02/05/25 at 8:59 AM, R85 was again observed lying on a regular mattress in his room. During an interview on 02/05/25 at 3:20 PM, Licensed Practical Nurse (LPN)4 said that the wound nurse went around with the wound doctor. LPN4 stated the doctor would document notes and orders, and the wound care nurse would put those recommendations in the system directly. LPN4 stated the other floor nurses would not place the orders. During an interview on 02/06/25 at 9:20 AM, LPN5 stated that R85 did not use an air mattress, but that the facility had a lot of them available. LPN5 said that an air mattress would be a good idea, but she had not heard of R85 being offered one. During an additional interview with 02/06/25 at 9:25 AM, R85 stated no one had offered him an air mattress for his wound healing. During an interview on 02/06/25 at 9:41 AM, the Resource Nurse said that the wound care nurse would write in her progress notes when she did rounds with the wound doctor. She stated the wound doctor would put in their notes and	F 686		

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F 686	Continued From page 20 recommendations and should put in their own orders. She said the wound nurse should also note the concern. The Resource Nurse said if the resident had a history or risk of pressure ulcers, an air mattress would have been appropriate. During an observation on 02/06/25 at 10:01 AM with LPN5 and IP/ENP, R85 was observed resting on a regular mattress. During an interview on 02/06/25 at 10:40 AM, Infection Preventionist/Educator Nurse Practice (IP/ENP) stated that the wound care team went around the facility and a nurse that went with them would write in the notes and the orders into the EMR. She stated R85 had been using the same Broda chair since admission, and he was not currently using an air mattress. IP/ENP said the facility had plenty of air mattresses, and one was going to be taken to him. IP/ENP confirmed the wound care team made a request for an air mattress on 01/08/25, but the nurse had forgotten to write the order to get the new mattress placed for him. Review of R85's "Physician Order," dated 01/14/25, located in the EMR under the "Orders" tab revealed a treatment order for Santyl External Ointment 250 Unit/GM (gram), "apply to posterior scrotum topically everyday shift for stage three wound. Cleanse open area posterior scrotum with soap and water, dry and apply Santyl ointment and cover with dry dressing daily and as needed." During a treatment observation on 02/06/25 at 12:01 PM, LPN5 was observed applying Santyl to the scrotum of R85. Per LPN5, she "put the Santyl on the whole scrotum", which was observed.	F 686		

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F 686	Continued From page 21 During an interview on 02/06/25 at 12:42 PM, the Director of Education stated that the wound care team came to the facility once a week to review residents. She said the team looked at all wounds, and that a nurse went with them who would do the dressings as they went along, as well as take measurements. She stated that at the end of the day the administration received a wound tracker to indicate if there were any changes or if there were any order changes that needed to go into the EMR before they left. The Director of Education stated that the nurse providing the treatment should not put Santyl all over the scrotum. She confirmed that the wound tracker would go to the Director of Nursing, and she would get it at the regional level, which would be how the facility would ensure they catch the order if it was missed initially.	F 686		
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. §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;	F 690		4/8/25

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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 690	Continued From page 22 (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 observations, interviews, record review, and policy review, the facility failed to ensure that a resident with a urinary catheter bag was properly positioned in a manner to prevent potential urinary tract infections due to contamination for one of two residents (R)85 reviewed for urinary catheters and urinary tract infections out of a total sample of 47 residents. Findings include: Review of the facility's policy titled, "Indwelling Catheter Care," revised 08/11/24, revealed "It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use ...Catheter care will be performed every shift and as needed by nursing personnel ...Privacy bags	F 690	R85's indwelling catheter was removed on February 26, 2025 due to the healing of his wound. Residents who have an indwelling catheter have the potential to be affected by this deficient practice. An audit was conducted on February 26, 2025 by the Resource Nurse of current residents with an indwelling catheter. No additional issues were identified. The root cause of this deficient practice was that staff did not follow the facility's policy titled "Indwelling Catheter Care." The SDC and/or designee will educate nursing staff on the proper positioning of	

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F 690	Continued From page 23 will be available and catheter drainage bags will be covered at all times while in use ...Ensure drainage bag is located below the level of the bladder to discourage backflow of urine ...Assist resident to a comfortable, appropriate position ...Document care and report any concerns noted to the nurse on duty." Review of R85's "Admission Record," found in the "Profile" tab of the electronic medical record (EMR), revealed he was originally admitted on 11/17/23, with diagnoses including diabetes mellitus type two, polyneuropathy, epilepsy, and acquired absence of left leg below the knee. Review of R85's quarterly "Minimum Data Set (MDS)" assessment located in the "MDS" tab in the EMR, with an Assessment Reference Date (ARD) of 12/04/24, revealed a "Brief Interview for Mental Status (BIMS)" assessment with no recorded score due to the resident refused to participate in the BIMS portion of the MDS. R85's quarterly MDS with an ARD of 09/04/24 revealed a BIMS score of 15 out of 15 indicating that R85 was cognitively intact. R85 was dependent on toileting hygiene. He was documented always incontinent of urine and bowel. Review of the "Physician Orders" located in the EMR under the "Orders" tab revealed a 01/13/25 order for "Foley catheter 16 French ...for diagnosis: Wound healing." The resident's goal was to be free from catheter-related trauma. Interventions included positioning the catheter bag and tubing below the level of the bladder and away from the entrance room door, and providing catheter care every shift. During an observation 02/04/25 at 8:58 AM, the	F 690	indwelling catheter bags and tubing to be below the level of the bladder and not placed onto the floor. The DON and/or designee will observe/audit indwelling catheter bags to verify correct positioning. This observation/audit will occur daily until the facility reaches 100% success over three consecutive evaluations. Then, the observation/audit will occur three times a week until the facility reaches 100% success at three consecutive evaluations. Then, the observation//audit will occur once a week until the facility reaches 100% success over three consecutive evaluations. Finally, the observation/audit will occur one more time a month later. If the facility reaches 100% success, the QAPI Committee will conclude that the deficient practice has been successfully addressed.	

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F 690	Continued From page 24 catheter bag was observed lying directly on the floor on the left side of the resident's bed. During an observation on 02/04/25 at 11:30 AM, the resident was observed in the common area of the unit, resting in his Broda chair. The catheter tubing was observed lying across his lap and over the left arm rest of his chair. The catheter bag was observed hanging freely with gravity approximately 18 inches off the floor, visibly weighted down with urine. The catheter bag was not supported. During a concurrent interview on 02/04/25 at 11:35 AM, Licensed Practical Nurses (LPN) 6 and LPN5 stated that the catheter bag should be attached to R85's Broda chair when the resident was up in his chair and should be off the ground. LPN5 stated she was going to find something to lift the catheter bag off the left arm rest and give it support. LPN5 returned with a clip to attach the catheter bag to the side of the Broda chair. Both LPN5 and LPN6 said that the catheter bag should not be left unsupported when R85 was in his chair. During an interview on 02/06/25 at 10:23 AM, the Administrator stated that catheter bags should not be placed onto the facility floors for proper catheter care. During an interview on 02/06/25 at 10:40 AM, Infection Preventionist/Educator Nurse Practice (IP/ENP) said that catheter bags should always be hanging off of the floor and with a hook to the side of the resident bed or the chair they are using. During an additional observation on 02/06/25 at	F 690		

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F 690	Continued From page 25 12:01 PM, R85's catheter bag was observed in contact with the floor upon entrance to his room during wound care. During an interview on 02/06/25 at 12:42 PM, the Director of Education stated that she would not want to see catheters placed onto the floor.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure that one resident (Resident (R) 12) out of 47 sampled residents was provided with the necessary respiratory care and services in accordance with professional standards. This failure had the potential to impact the residents treatment and interventions. Findings include: Review of the facility-provided policy titled "Nebulizer Therapy," dated 03/13/23, revealed, "It is the policy of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions ...Correctly assemble	F 695	R12's nebulizer unit was replaced on February 3, 2025. LPN 3 was educated on February 3, 2025 regarding the proper technique and standard precautions of the nebulizer unit. Residents with nebulizer units have the potential to be affected by this deficient practice. The root cause of this deficient practice is that LPN 3 failed to follow the facility policy "Nebulizer Therapy." An audit of current residents receiving nebulizer treatments was conducted by the Resource Nurse on February 3, 2025	4/8/25

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F 695	Continued From page 26 the tubing, nebulizer cup, and mouthpiece and ensure connections are secured tightly ...Observe the resident during the procedure for any change in condition ...When medication delivery is complete, turn the machine off ...Disassemble and rinse the nebulizer with sterile or distilled water and allow to air dry ...Air dry on an absorbent towel ...Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag ...Change the nebulizer tubing every seven days or per facility policy ...Periodically disinfect unit per manufacturer's recommendations ..." Review of the "Face Sheet" located in the "Profile" tab of the Electronic Medical Record (EMR) revealed R12 was admitted to the facility on 11/18/22 with diagnosis of heart failure, diabetes, and cancer of the left breast. Review of R12's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/10/25 located in the EMR under the "MDS" tab revealed R12 had a "Brief Interview for Mental Status (BIMS)" score of 15/15, which indicated the resident was cognitively intact. Observation on 02/03/25 at 2:30 PM of R12's room revealed the residents nebulizer sitting on the nightstand beside the bed. The mouthpiece was wrapped in paper towels. The nebulizer unit was dirty with white, crusty debris. The inside of the tubing was wet. The tubing and mouthpiece were not in a plastic bag. Interview with observation with R12 revealed "This nebulizer is old. I wrap the mouthpiece in paper towels when I am done with it. Nursing does not turn it off when finished, I do. I have no idea the last time the tubing or mouthpiece was changed."	F 695	to ensure policy compliance. No compliance issues identified. RN's and LPN's will be educated by the SDC and/or designee on the proper technique and standard precautions of the nebulizer unit. The DON and/or designee will observe nebulizer treatments to verify that the facility is in compliance with its Nebulizer Treatment Policy. This observation will be done daily for three days until the facility reaches 100% success at three consecutive evaluations. Then, the observation will occur three times a week until the facility reaches 100% success at three consecutive evaluations. Then, the observation will occur once a week until the facility reaches 100% success over three consecutive evaluations. Finally, the observation will occur one more time a month later. If the facility reaches 100% success, the QAPI Committee will conclude that the deficient practice has been addressed.	

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F 695	Continued From page 27 Observation and interview with the Director of Nursing (DON) on 02/04/25 at 11:54 AM revealed "This nebulizer is filthy, and the mouthpiece is wrapped in paper towels. I am going to get the resident a new system." The DON confirmed the nebulizer should have been cleaned after each use. Interview with Licensed Practical Nurse (LPN)3 on 02/04/25 at 11:57 AM revealed "I gave R12 her treatment this morning." When asked if she saw anything wrong with the nebulizer, LPN 3 stated "The mouthpiece and tubing is not in a bag and the machine is dirty." When asked if she saw the machine was dirty when she gave the treatment, LPN 3 stated "I didn't look. I did not stay in the room while the machine was on." When asked if she turned the machine off and cleaned it, LPN 3 stated "I wiped the mouthpiece off." During an interview with the Administrator on 02/06/25 at 10:44 AM revealed, "We need to take a look at nebulizers and see what is going on. This should not have happened."	F 695		
F 700 SS=D	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.	F 700		4/8/25

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F 700	Continued From page 28 §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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents received alternative measures prior to installation of side rails for two residents reviewed for side rails (Resident (R) 83 and R298) of 31 sampled residents. The lack of alternate side rail measures could lead to potential safety concerns related to bed rail use for residents with bed rails. Findings include: 1. Review of R83's "Face Sheet," located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was re-admitted to the facility on 10/09/23 with diagnoses which included paraplegia, and complete traumatic amputation of right shoulder and upper arm. Review of R83's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/05/24 and located in the resident's EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident's cognition	F 700	R298 no longer resides at the facility. R83 was immediately reassessed to determine the necessity of bed rails. Since the resident was using a trapeze, our team evaluated whether alternative interventions could be implemented instead of bed rails. The resident was interviewed and stated he desires both bed rails to remain in place as they assist with his bed mobility. He was informed of the risks and benefits of bed rail use. Documentation in the EHR was updated to reflect the new assessment. Current residents utilizing 1/4 side rails have the potential to be affected by this deficient practice. A facility-wide audit was conducted on February 27, 2025 by the DON to identify current residents currently using bed rails. Each resident was reassessed for the need for bed rails, ensuring that alternative interventions were attempted and documented prior their use. Any necessary changes were made to care plans, and physician orders	

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F 700	Continued From page 29 was not impaired. Review of R83's "Care Plan," dated 10/09/23 and located in the resident's EMR under the "Care Plan" tab revealed, "The resident required assistance and was dependent with ADL care related to bed mobility." Interventions in place were bed rails as an enabler. Observation on 02/03/25 at 11:15 AM R83 sitting in bed with head of bed upright and side rail were in the up position on both sides of bed. Review of R83's "Bed Rail Evaluation" dated 10/09/23 and located in the EMR under the "Assessments" tab revealed no alternates were attempted prior to the placement of the siderails. Further review revealed the determination was no bed rails should be used. 2. Review of R298's "Face Sheet," located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was re-admitted to the facility on 01/23/25 with diagnoses which included muscle weakness, and polyneuropathy. Review of R298's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/23/25 and located in the resident's EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident's cognition was not impaired. Review of R298's "Care Plan," dated 01/23/25 and located in the resident's EMR under the "Care Plan" tab revealed, "The resident required assistance and was dependent with ADL care	F 700	were updated accordingly. Root Cause: The facility determined current licensed nurses need re-education on F700 regulations, emphasizing the requirement to attempt alternative interventions before utilizing bed rails. SDC and/or designee will re-educate current licensed nursing staff on F700 with the focus on attempted alternative interventions prior to utilizing bed rails. The DON and/or designee will conduct an audit of 20% of the resident population to determine whether alternative interventions were attempted prior to putting bed rails in place. Audits will be completed daily over three consecutive evaluations until facility reaches 100% success then the sample will be audited three times a week until the facility reaches 100% success for three evaluations then the sample will be audited once a week until the facility reaches 100% success over three consecutive evaluations. Finally, the audit will be conducted one more time a month later. If the facility reaches 100% success, the facility's QAPI Committee can conclude that the deficient practice has been successfully addressed.	

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F 700	Continued From page 30 related to impaired balance." Interventions in place were ¼ side rails to assist with bed mobility. Observation on 02/04/25 at 9:35 AM R298 sitting up in bed with head of bed upright and side rails were in the up position on both sides of bed. Review of R298's "Bed Rail Evaluation" dated 01/23/25 and located in the EMR under the "Assessments" tab revealed no alternates were attempted prior to the placement of the siderails. Further review revealed the determination was no bed rails should be used. During an interview on 02/05/25 at 1:10 PM Licensed Practical Nurse (LPN)6 said during admission on all residents are provided with a bed rail use consent form to sign and all residents have bedrails unless they sign refusing. Staff do not discuss alternatives and alternatives are not explored prior to bedrail use but the form they sign discusses risk versus benefits. Staff only complete the bedrail assessment on admission and not again after that. He stated they do complete ongoing reassessment for continued bedrail use. He was not aware that the residents' bed rail assessment indicated not to use bed rails. He stated when he completes the assessment that it is not what he sees. But he stated he was unsure what the assessment was supposed to say. During an interview on 02/06/25 at 12:33 PM the Director of Education stated that bed rail assessments should be completed on admission and yearly after that. She also stated that staff should always be looking at bed rail alternates prior to bed rail use. She was unaware that both residents bed rail assessments indicated bed	F 700		

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F 700	Continued From page 31 rails should not bed used. A review of the facility's policy "titled" Use of Bed Rails" revised 01/14/23 revealed, it is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails.	F 700		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		4/8/25

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F 758	Continued From page 32 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure the medical necessity of psychotropic medication administration for one Resident (R)48 of five residents reviewed for Psychotropic Medication Administration and a total of 47 residents reviewed in the sample. Informed consent was not obtained from the resident and/or resident's representative related to administration of psychotropic medication. This failure created the potential for the resident to receive unwanted medications. The findings include: Review of the facility's policy titled "Use of Psychotropic Medications," revised in 07/11/24 read, in pertinent part, "Residents and/or representatives shall be educated on the risks	F 758	R48's responsible party was educated and gave consent on February 28, 2025. Current residents receiving psychotropic drugs are at risk of being affected by this deficient practice. DON conducted an initial audit on February 7, 2025 to determine if consent was present for current residents receiving psychotropic medications. No other issues noted. Root Cause: The facility determined current licensed nursing staff need re-education on F758 with a focus on obtaining informed consent prior to administering psychotropic drugs. SDC and/or designee will provide re-education on F758 to RNs and LPNs as it relates to	

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F 758	Continued From page 33 and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions." Review of R48's "Admission Record," dated 02/06/25 and found in the EMR under the "Admissions" tab, revealed the resident was admitted to the facility on 04/19/23. The resident's diagnoses included End Stage Renal Disease (ESRD), depression and anxiety. Review of R48's annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/16/24 and found in the EMR under the "MDS" tab, indicated a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated R48 did not exhibit any behaviors during the assessment reference period, however the document revealed R48 did exhibit signs and symptoms of depression nearly every day of the assessment reference period. Review of R48's physicians orders, dated 02/06/24 and found in the EMR under the "Orders" tab, revealed an order, with an original order date of 11/02/24, for Trazadone (an antidepressant medication) 50 MG (milligrams) by mouth twice daily for "sedation" and an order, with an original order date of 10/30/24, for hydroxyzine (an antianxiety medication) 50 MG by mouth one time daily on Monday, Wednesday and Friday before dialysis for anxiety. Review of R48's undated "Psychotropic Medication Care Plan," found in the EMR under the "Care Plan" tab, revealed the resident was receiving psychotropic medications for anxiety	F 758	obtaining informed consent prior to administering psychotropic medications. DON and/or designee will conduct an audit of new psychotropic medication orders to determine if informed consent was present prior to the administration of the ordered drug. Audits will be completed daily over three consecutive evaluations until the facility reaches 100% success then the sample will be audited three times a week until the facility reaches 100% success for three evaluations then the sample will be audited one a week until the facility reaches 100% success over three consecutive evaluations. Finally, the audit will be conducted one more time a month later. If the facility reaches 100% success, the facility's QAPI Committee can conclude that the deficient practice has been successfully addressed.	

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F 758	Continued From page 34 and depression. Interventions included giving medications as ordered and "Discuss with MD (Medical Doctor), family regarding ongoing need for use of medication. Review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy." Review of R48's "Medication Administration Record (MAR)" dated 01/01/25 through 02/05/25 and found in the EMR under the "Orders" tab, revealed the resident was receiving her psychotropic medication as ordered. Review of R48's comprehensive record revealed nothing to show risks and benefits of the resident's Trazadone or hydralazine were discussed with the resident and/or her representative or that informed consent had been obtained for the administration of the medication. During an interview with the Director of Nursing (DON) on 02/05/25 at 03:04 PM, she confirmed she was not able to locate R48's informed consent for her psychotropic medications in the resident's record. During an interview with the Administrator on 02/06/25 at 12:55 PM, she stated her expectation was informed consent was to be obtained for any psychotropic medication administered to a resident.	F 758		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors.	F 760		4/8/25

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F 760	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on interview, observations, record review, and review of facility policy, the facility failed to ensure one Resident (R)201 of seven residents reviewed during medication pass observations was free from a significant medication error. The resident's insulin (a medication used to control blood sugar) was not properly administered, creating the potential for the resident to receive an inaccurate dose. A total of 47 residents were reviewed in the sample. Findings include: Review of the facility's policy titled "Insulin Pen Procedure," dated 03/13/23 read, in pertinent part, "j. Injecting the insulin: v. While still pressing the plunger, keep the needle in the skin for up to 6 to 10 seconds and then remove the needle from the skin." Review of R201's "Admission Record," dated 02/05/25 and found in the EMR under the "Profile" tab, revealed the resident was admitted to the facility on 01/28/25. The resident's diagnoses included type 2 diabetes. Review of R201's admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 02/03/25 and found in the EMR under the "MDS" tab, indicated a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was mildly cognitively impaired. Review of R201's "Order Summary Report," dated 02/05/25 and found in the EMR under the "Orders" tab, indicated an order for Humulin	F 760	R201 was assessed for any adverse effects from the improper insulin pen administration. No adverse outcomes noted and LPN 7 was immediately educated on February 5, 2025 by the SDC on insulin pen administration steps. Current residents who receive insulin via insulin pens have the potential to be affected by this deficient practice. The root cause is the facility determined current licensed nurses need re-education due to a lack of awareness of this specific technique, despite general knowledge of insulin administration. The SDC and/or designee will provide re-education to current licensed nurses on proper insulin administration via insulin pens, including the requirement to hold the insulin pen in place for 6-10 seconds to ensure full dose delivery. DON and/or designee will conduct random observations of insulin pen administration to determine compliance with proper administration and steps when administering insulin via insulin pens. Observations will be completed daily over three consecutive evaluations until the facility reaches 100% success, then the sample will be audited three times a week until the facility reaches 100% success for three consecutive evaluations. Then, the sample will be audited one a week until the facility reaches 100% success over three consecutive evaluations.	

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F 760	Continued From page 36 Insulin "inject five units subcutaneously twice daily." Review of R201's "Medication Administration Record (MAR)," dated 02/01/25 through 02/06/25 and found in the EMR under the "Orders" tab, indicated the insulin was being administered routinely per physician's orders. Licensed Practical Nurse (LPN)7 was observed administering R201's insulin on 02/05/25 at 12:27 PM. LPN7 dialed up five units of insulin and then injected the insulin into the resident's left arm, holding the needle into the resident's subcutaneous tissue for approximately two seconds before removing the needle. During an interview with LPN7 on 02/05/25 at 12:31 PM, he stated he had never been told the insulin pen needle should remain in the resident's skin for six to 10 seconds after injecting the medication. During an interview with the Administrator and the Infection Preventionist and Educator (IP/ENP) on 02/06/25 at 1:00 PM, the IP/ENP stated the insulin pen needle was expected to be left in the resident's skin for 10 seconds after administration of the insulin.	F 760	Finally, the audit will occur one more time a month later. If 100% success is achieved, the QAPI Committee will conclude that the deficient practice has been successfuly addressed.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		4/8/25

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F 761	Continued From page 37 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on interview, observations, record review, and review of facility policy, the facility failed to ensure resident medication stored in facility medication carts was appropriately labeled to indicate the open date of the medication for three Residents (R)47, R110, and R298 out of a total resident sample of 47. This failure created the potential for residents to experience negative effects related to the administration of expired and/or out-of-date medication. Findings include: Review of the facility's procedure titled "Insulin Pen Procedure," dated 03/13/23 read, in pertinent part, "Insulin pens must be clearly labeled with the resident name, physician name, date dispensed, type of insulin, amount to be given,	F 761	R47, R110, R298 insulin pens were discarded and replacement pens were ordered from the pharmacy. Current residents who receive insulin via insulin pens have the potential to be affected by this deficient practice. On February 5, 2025 the DON conducted a facility-wide audit of all insulin pens to identify any additional pens without an open date or a discard date. The root cause is that LPN 8 failed to label the insulin pen with an open date and a discard date. SDC and/or designee will re-educate current licensed staff on the policy for Insulin Pen Procedure with a focus on labeling with an open date and a	

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F 761	Continued From page 38 frequency, and expiration date;" and "Insulin pens should be disposed of after 28 days or according to manufacturer's recommendation." The medication cart on the facility's third floor was observed with Licensed Practical Nurse (LPN)8 on 02/05/25 at 9:20 AM. Open insulin glargine pens were found in the cart for R110 and R298. Neither of the insulin pens had an open date or a discard by date indicated on the pen to alert staff about when the insulin needed to be discarded. During an interview with LPN8 on 02/05/25 at 9:25 AM, she confirmed the insulin pens did not have open/discard dates indicated on them and stated the pens should have been dated to indicate when the pens needed to be discarded. The medication cart on the facility's fourth floor was observed with LPN9 on 02/05/25 at 09:45 AM. An open Lantus insulin pen was found in the cart for R47. The insulin pen did not have an open date or a discard by date indicated on the pen to alert staff about when the insulin needed to be discarded. During an interview with LPN9 on 02/05/25 at 9:50 AM, she confirmed the insulin pen did not have open/discard date indicated on it and stated the pen should have been dated to indicate when the pen needed to be discarded. During an interview with the Administrator and the Infection Preventionist and Educator (IP/ENP) on 02/06/25 at 1:00 PM, the IP/ENP stated insulin pens were expected to be labeled to indicate the date the insulin was opened so staff was able to determine when the insulin needed to be	F 761	discard date. DON and/or designee will conduct audits of each medication cart to determine if the insulin pens are labeled with an open and discard date. Audits will be completed daily over three consecutive evaluations until the facility reaches 100% success then the sample will be audited thee times a week until the facility reaches 100% success for three evaluations then the sample will be audited once a week until the facility reaches 100% success over three consecutive evaluations. Finally, the audit will be conducted one more time a month later. If the facility reaches 100% success, the facility's QAPI Committee can conclude that the deficient practice has been successfully addressed.	

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F 761	Continued From page 39 discarded.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		4/8/25

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F 880	Continued From page 40 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, record review, observations and interviews, the facility failed to ensure facility infection control procedures were followed related to Transmission Based Precautions (TBP)/Isolation for four Residents (R) R48, R93 and R199 of a total of 47 residents reviewed in the sample. This failure created the potential for residents to become ill related to	F 880	R48, R93 and R199 were immediately placed on transmission-based precautions. Current residents exhibiting respiratory symptoms were assessed by the SDC on February 4, 2025 and if met criteria were placed on transmission-based	

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F 880	Continued From page 41 facility outbreak of infection. The findings include: The facility's "Transmission-Based (Isolation) Precautions Policy" most recently revised 03/14/23 read, in pertinent part, "It is our policy to take appropriate precautions to prevent transmission of pathogens' modes of transmission;" and "Facility staff will apply Transmission Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission." 1. Review of R48's "Admission Record," dated 02/06/25 and found in the EMR under the "Admissions" tab, revealed the resident was admitted to the facility on 04/19/23. The resident's diagnoses included End Stage Renal Disease (ESRD) and history of stroke. Review of R48's annual Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/16/24 and found in the EMR under the "MDS" tab, indicated a Brief Interview for Mental Status (BIMS) score of six out of 15, which indicated the resident was severely cognitively impaired. Review of R48's "Physicians Orders", found in the EMR under the "Orders" tab, revealed an order, with an original order date of 02/01/25, for Guaifenesin (a cough syrup medication) give ten milliliters (MLs) every four hours as needed for cough and an order, with an original order date of 02/03/25, for the resident to be placed on isolation for her diagnosis of influenza. There was	F 880	precautions. Root Cause: While staff are generally aware of the protocols for transmission-based precautions, there was an identified gap in understanding the urgency of initiating these precautions at the first sign of respiratory symptoms. In particular, staff may not have consistently recognized the need to implement these precautions without waiting for confirmation of a specific diagnosis. The SDC and/or designee will re-educate current nursing staff on the policy for transmission-based precautions with a focus on placing residents exhibiting respiratory symptoms on transmission-based precautions at the first sign of respiratory symptoms. The DON and/or designee will audit those residents with change in conditions for respiratory symptoms to determine if they have been initiated on transmission-based precautions. Audits will be completed daily over three consecutive evaluations until the facility reaches 100% success then the sample will be audited three times a week until the facility reaches 100% success for three evaluations then the sample will be audited once a week until the facility reaches 100% success over three consecutive evaluations. Finally, the audit will be conducted one more time a month later. If the facility reaches 100% success, the facility's QAPI Committee can conclude that the deficient practice has been successfully addressed.	

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F 880	Continued From page 42 no order for isolation (Transmission Based Precautions) entered for the resident related to her respiratory symptoms prior to that date. Review or R48's progress note, dated 01/31/25 and found in the EMR under the "Notes" tab, revealed, "Constant coarse cough. COVID-19 test done and is negative." Review or R48's "Physician Encounter Progress Note," dated 02/03/25 and found in the EMR under the "Notes" tab, revealed, "Patient seen today per nurse request secondary to positive influenza swab with wheezing and cough." The note indicated the resident was to remain on isolation for flu and was to receive her as needed Guaifenesin as well as Tamiflu related to her symptoms. During an interview with Licensed Practical Nurse (LPN7) on 02/03/25 at 9:00 AM, he stated R48 had not been feeling well and had been experiencing upper respiratory symptoms (cough, congestion, and runny nose) for the last couple of days. LPN7 stated, "She really doesn't feel well." There was no signage on the resident's door to indicate the resident had been placed on isolation/TBP of any kind related to her symptoms as of that time. LPN7 stated he thought R48 should be on isolation related to her symptoms and advised the surveyor to wear a mask when entering the resident's room. During an interview with R48 in her room on 02/03/25 at 9:10 AM, she confirmed she had a cough and congestion and stated she had not been feeling well for two days. During an interview with the Infection	F 880		

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F 880	Continued From page 43 Preventionist (IP) on 02/03/25 at 1:20 PM, she stated R48 had been tested for influenza and the test results were positive. The IP stated R48 had been placed on isolation (Droplet TBP) as of that date related to the flu diagnosis. 2. Review of R93's "Admission Record," dated 02/06/25 and found in the EMR under the "Admissions" tab, revealed the resident was admitted to the facility on 12/31/24. The resident's diagnoses included fracture of the right lower leg. Review of R93's admission MDS assessment, with an ARD of 01/06/25 and found in the EMR under the "MDS" tab, indicated a BIMS score of 13 out of 15, which indicated the resident was cognitively intact. Review of R93's "Physicians Orders," found in the EMR under the "Orders" tab, revealed an order, with an original order date of 01/31/25, for resident to receive Guaifenesin Liquid (cough suppressing syrup) 100 milligrams per 5 milliliters (MG/5ML) give 10 milliliter by mouth every 4 hours as needed for Cough for 10 Days and an order, with an original order date of 02/04/25, for the resident to be placed on isolation related to her respiratory symptoms as of that date. Review of R93's "Physician Encounter Note," dated 01/31/25 and found in the EMR under the "Notes" tab, revealed, "Chief Complaint / Nature of Presenting Problem: Cough;" and "History Of Present Illness: Resident with cough and runny nose x 1 day. Resident reports she does have seasonal allergies and she takes an allergy pill ... states the cough has been here for 1 day. Her COVID test was negative. She denies a sore throat, fever, aches or chills."	F 880		

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F 880	Continued From page 44 During an interview with R93 on 02/04/25 at 9:17 AM, she stated, "I'm congested, and I don't feel good. They did a COVID test last Friday so I guess I have been congested since then." She stated she thought the results of the COVID test had been negative. R93 had a wet cough and appeared flushed and was weepy during the interview. There was no TBP signage on the resident's door and there was no PPE at or near the resident's door. During an observation of R93 on 02/04/25 at 12:01 PM, the resident was sleeping in her bed. She continued to have a wet cough. There was still no TBP signage on door or PPE available next to or near the resident's room. During an interview with the Director of Nursing (DON) and the IP on 02/04/25 at 1:07 PM, the IP stated R93 was being placed on isolation related to her respiratory symptoms. She stated the resident had not yet tested positive for any infection; however, the facility's process was to place symptomatic residents on isolation if there was suspected infection (such as influenza or COVID). The DON confirmed R93 should have been placed on isolation earlier based on her symptoms and the confirmation of influenza and COVID residents in the facility. 3. Review of R199's "Admission Record," dated 02/06/25 and found in the EMR under the "Admissions" tab, revealed the resident was admitted to the facility on 01/29/25. The resident's diagnoses included chronic kidney disease and colon cancer. Review of R199's admission MDS assessment,	F 880		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT HILLSIDE LLC	810 SOUTH BROOM STREET WILMINGTON, DE 19805

(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 880	Continued From page 45 with an ARD of 02/04/25 and found in the EMR under the "MDS" tab, indicated a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R199's "Physicians Orders", found in the EMR under the "Orders" tab, revealed an order, with an original order date of 02/04/25, for resident to receive "Guaifenesin Liquid give 10 ML by mouth every 4 hours as needed for Cough for 10 Days" and an order, with an original order date of 02/04/25, for the resident to be placed on isolation related to his respiratory symptoms as of that date. Review of R199's "Nursing Progress Note," dated 02/03/25 and found in the EMR under the Notes Tab, revealed the resident had anew order for Guaifenesin due to his complaint of having a cough. During an interview with R199 in his room on 02/04/25 at 9:06 AM he was observed to have a frequent wet cough. R199 stated he had been coughing and had not felt well for two days. He stated, "Last night they gave me a COVID test because of my cough." R199 stated he thought the COVID test results had been negative. There was no TBP signage on R199's door or PPE located in or near the resident's room. R199 was observed in his room on 02/04/25 at 12:01 PM. The resident still had a productive wet cough. There was no TBP signage on the resident's door. R199 was observed in his room as above on 02/04/25 at 2:00 PM. The resident continued to cough and stated he did not feel well. Signage to	F 880		

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F 880	Continued From page 46 indicate the resident was on isolation (Droplet TBP) had been placed on the resident's door and PPE was placed at the entrance to the resident's room. During an interview with the IP on 02/06/25 at 9:35 AM, she confirmed R199 had not been placed on TBP related to his respiratory symptoms until the afternoon of 02/04/24. She stated R199 had been tested for COVID again that morning and the result of the COVID test was positive. She confirmed R199 remained on isolation as of the time of the interview. During an interview with the DON and IP on 02/04/25 at 1:07 PM, the DON stated they were testing everyone in the facility with respiratory symptoms for COVID and influenza as of that time. She stated respiratory screening had been initiated for all residents as of the night of 02/03/25 after the survey team began inquiring about residents with respiratory symptoms. The DON confirmed testing was expected to be done for any resident with respiratory symptoms and confirmed her expectation was the facility policy indicating any resident with known or suspected infection was to be placed on isolation precautions. The DON confirmed R48, R93 and R199 had not been placed on isolation precautions timely related to their symptoms and this had created the potential for the spread of infection including flu and COVID. During an interview with the Administrator on 02/06/25 at 12:57 PM, she confirmed her expectation was symptomatic residents with suspected or confirmed infection were to be placed on isolation precautions immediately.	F 880		

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F 883	Continued From page 47	F 883		4/8/25
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 883		

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F 883	Continued From page 48 (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, record review, facility policy review, the facility failed to ensure that one (Resident (R) 9) of five residents, reviewed for influenza and pneumococcal vaccinations were provided risks verses benefits prior to the administration of the pneumococcal vaccine. Findings include: Review of a facility policy titled "Pneumococcal Vaccine," dated 08/02/24, indicated ". . .It is our policy to offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. . .Prior to offering the pneumococcal immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization with the education documented in the clinical record. . ."	F 883	R9's responsible party was contacted and informed prior to administration of the pneumococcal vaccine. The signed consent form cannot be located. On February 28, 2025 another informed consent form was signed. Current residents eligible to receive the pneumococcal vaccine have the potential to be affected by this deficient practice. On February 7, 2025 the DON conducted an audit of current residents who received the pneumococcal vaccine to determine if an informed consent was present. The root cause is that the informed consent was not found. Moving forward, all pneumococcal vaccine informed consents will be uploaded to the EHR.	

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F 883	Continued From page 49 Review of R9's "Admission Record," located in the electronic medical records (EMR) under the "Profile" tab indicated the resident was admitted to the facility on 08/16/19. The resident was over the age of 65 years old. Review of the "Medication Administration Record (MAR)" for the month of 10/23, provided by the facility, indicated R9 was administered the pneumococcal 20-valent (Prevnar 20) vaccine. Review of R9's EMR failed to contain evidence the risks verses benefits were explained to the resident and/or her representative and documented in the clinical record. During an interview on 02/04/25 at 1:06 PM, the Infection Preventionist confirmed that R9 had no risks verses benefits or consent to receive the Prevnar 20 vaccine.	F 883	The SDC and/or designee will provide the unit secretary with education related to ensuring the pneumococcal consents are uploaded in the EHR. The SDC and/or designee will conduct audits to those residents who are eligible to receive the pneumococcal vaccine to determine if a signed informed consent was obtained prior to administering the vaccine. Audits will be completed daily over three consecutive evaluations until the facility reaches 100% success. Then the audit will be done three times a week until the facility reaches 100% success for three evaluations. Then the audit will be done once a week until the facility reaches 100% success over three executive evaluations. Finally, the audit will be conducted one more time a month later. If the facility reaches 100% success, the facility's QAPI Committee will conclude that the deficient practice has been suceesfully addressed.	4/8/25
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:	F 919		

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F 919	Continued From page 50 Based on observation, interview, record review, and facility policy review, the facility failed to ensure that the room for one resident (Resident (R) 54) of 47 sampled residents was equipped with a functioning call light. This failure had the potential to result in a delayed response to the needs of the resident. Findings include: Review of the facility-provided policy titled "Call Lights: Accessibility and Timely Response," dated 034/14/23, revealed "The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance ...Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied ..." Review of the "Face Sheet" located in the "Profile" tab of the Electronic Medical Record (EMR) revealed R54 was admitted to the facility on 08/24/24 with diagnosis of heart failure, chronic bronchitis, and chronic kidney disease. Review of R54's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/25/24 located in the EMR under the "MDS" tab revealed R54 had a "Brief Interview for Mental Status (BIMS)" score of 09/15, which indicated the resident was moderately cognitively impaired. Observation on 02/03/25 at 2:12 PM in R54's room revealed the call light was not working. R54 asked the surveyor to get him help due to	F 919	R54's call bell was immediately reported to the maintenance department and necessary repair was made. All current residents have the potential to be affected by this deficient practice. Upon identification of the issue all resident call bells were inspected the the Maintenance Director to determine functionality. No further issues were identified. The Maintenance Director audits each call bell on a weekly basis to ensure each call bell is working. However, since the audits are weekly, issues may arise between audits. The SDC and/or designee will provide education to current staff to immediately report call bell malfunctions to the maintenance department as well as place a work order into the TELS electronic work order program and to provide the affected resident with alternative ways to call for assistance until the call bell malfunction is corrected. Results of these audits are recorded in the TELS work order system. Audit results will be reviewed by the QAPI Committee for 3 months. If 100% success is reached, the audit will be conducted one more time a month later. If the facility reaches 100% success, the facility's QAPI Committee can conclude that the deficient practice has been successfully addressed. If an issue with a call bell is identified between the Maintenance Director's weekly audits, staff place a work order in the TELS work	

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F 919	Continued From page 51 wheezing and coughing. The call light was pressed twice and did not work. The light outside the room did not work and the call light did not register at the nurse's desk. The Director of Nursing (DON) was notified immediately and came to R54's room. The DON pressed the call light several times and it came on but would not shut off. Interview with the DON on 02/03/25 at 2:20 PM in R54's room revealed "I am calling maintenance now and getting this fixed. R54 is wheezing and coughing and needs to be able to use his call light." Observation on 02/04/25 at 1:43 PM in R54's room revealed the call light working when pressed. Review of the logbook for the call system testing was provided by the facility. The call lights are randomly checked on each of the three floors. Interview with the Administrator on 02/06/25 at 10:38 AM revealed "Our call lights are checked monthly. If a call light is reported as non-functioning, a work order is placed and fixed immediately. I am not sure why this was not reported."	F 919	order system.	