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: Cadia Rehabilitation Broadmeadow **DATE SURVEY COMPLETED:** January 22, 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. An unannounced Annual and Complaint Survey was conducted at this facility from January 13, 2025, through January 22, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 112. The investigative sample totaled (twenty-seven) 27 residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed January 22, 2025: F550, F558, F600, F641, F644, F646, F656, F657, F661, F685, F690, F692, F712, F756, F758, F773, F812, F842, F847 and F880.		

Provider's Signature Stefani Hylton Title Administrator Date 2/26/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

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E 000	Initial Comments An unannounced annual and complaint survey was conducted at this facility from January 13, 2025 through January 22, 2025 The facility census was 112 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from January 13, 2025 through January 22, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 112. The investigative sample totaled 27 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; ALF - assisted living facility; Apical pulse - pulse point on a person's chest; BIMS - Basic Inventory of Mental Status, a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cogntiion deficit, 8-12 refflects moderate cognition deficit and 13-15 score is reflective of normal cognition;	F 000		

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

Electronically Signed | 02/14/2025

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F 000	Continued From page 1 bpm - beats per minute; BUN - Blood urea nitrgoren, a serum lab study that reflects the liver and kidneys' function as well as hydration status; CBC - complete blood count/blood test used to evaluate your overall health and detect a wide range of disorders, including anemia and infection; Cdiff - Clostridium Difficile/highly contagious bacterial infection in the colon; CMP - comprehensive metabolic panel/blood test that measures sugar (glucose) level, electrolyte and fluid balance, kidney function, and liver function; CMS - Centers for Medicare and Medicaid Services; CNO - Chief Nursing Officer; COO - Chief Operating Officer; DHSS - Department of Health And Social Services; dL - deciliters; DMMA - Division of Medicaid and Medical Assistance; DON - Director of Nursing; d/t - due to; DTI - Deep Tissue Injury/Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; eMAR - electronic Medication Administration Record; EMR - electronic medical record; enteral - pertaining to the small intestines; ESBL - extended spectrum beta-lactamase, a MDRO bacteria that required Enhanced Barrier precautions; HHC - home health care; MDRO - multi-drug resistant organisms;	F 000		

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F 000	Continued From page 2 MDS assessment - federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; MD - Medical Director; Mg - Magnesium/test to check the level in a person's blood; mg - milligrams; ml - milliliters; NF - nursing facility NHA - Nursing Home Administrator; NP - Nurse Practitioner; OT - occupational therapist; PASARR- Pre-Admission Screening and Record Review; a federally requireed form utilized for patients with mental health and cognitive disabilities when they apply to reesdie at a nursing home; PEG - percutaneous gastrostomy tube; an indwelling medical device that allows direct feeding of the stomach via a tube; PRN - as needed; r/t - related to; RN - Registered Nurse; S/P - status post; tachypneic- rapid breathing beyond the normal rate; UM - Unit Manager; Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed); VRE - vancomyocin- resistant enterococcus, a MDRO organism that requires Enhanced Barrier Precautions.	F 000		

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F 550	Continued From page 3	F 550		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and	F 550		3/8/25

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F 550	Continued From page 4 reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that that for one (R1) out of four residents reviewed for _____,the facility failed to ensure residents were treated with respect and dignity. Findings include: Review of R1's clinical record revealed the following: 9/1/22 - R1 was admitted to the facility with diagnoses including traumatic brain injury and hemiplegia (half - body paralyzed). 9/2/22 - R1's activity care plan documented that R1 was independent/dependent with meeting activity preferences related to physical limitations with interventions including R1's preference to socialize with loved ones, caregivers and peers as tolerated. 9/9/22 - R1 was care planned for adjustment to her stay in the long term care facility. Interventions included providing R1 with as many situations as possible, with control over her environment and health care delivery. 9/14/22 - R1 had a care plan developed for ADL (Activities of Daily Living) self care performance deficit related to right sided weakness. R1's interventions included but were not limited to R1's use of a power chair (motorized wheelchair) with back cushion on her wheelchair to maximize safety, comfort, and independence in mobility	F 550	F550 Resident Rights A. No residents were adversely affected by the deficient practice. Resident R1 stated, Im okay. B. All residents have the potential to be affected by this practice. The facility completed an audit to ensure that all residents have their preferred name documented. C. The root cause analysis determined that the facility failed to address a resident by their first, last, or preferred name. Education was provided to all staff immediately upon notification from the surveyor by the DON and/or designee on treating residents with respect and dignity. D. The NHA and/or designee will conduct random observation audits to ensure residents are being addressed with dignity and respect. The audit will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will	

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F 550	Continued From page 5 throughout the facility. 11/12/24 - R1's quarterly MDS (Minimum Data Set) assessment revealed that R1's cognition was moderately impaired with a BIMS score of 11. R1 used a motorized wheelchair to make turns and wheel in corridors. 1/17/25 11:07 AM - R1 was observed operating the motorized wheelchair in the hallway and slowed down to navigate a right turn. E20 (Activity Staff) was heard and observed calling to R1. "Keep going, slow poke". There were other residents present when this comment was made. 11/17/24 11:08 AM - When asked how R1 felt about the interaction, R1 stated, "I'm okay". 1/17/25 11:12 AM - In an interview, E1 (NHA) confirmed that it was not acceptable for the staff be calling R1 a "slowpoke" as it was disrespectful. 1/22/25 at 3:04 PM - The finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 550	be reviewed by the Quality Assurance Committee.	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to	F 600		3/8/25

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F 600	Continued From page 6 treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documents, it was determined that for one (R66) out of six residents reviewed for abuse, the facility failed to ensure that that R66 was free from resident to resident physical abuse by R78. Findings include: A review of the facility's abuse policy titled, "Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime," revised January 12, 2023, indicated," ... It is the policy of Cadia Healthcare to protect residents and prevent occurrences of abuse ...." Cross refer F657 A review of R78's clinical record revealed the following: 2/22/23 - R78 was admitted to the facility with diagnoses including but not limited to dementia, depression, and anxiety disorder. 3/6/23 - R78 was care planned for impaired cognition and interventions included to cue, reorient and supervise as needed and to "...monitor/document/report when necessary any changes in cognitive function,...changes in:...difficulty expressing self, difficulty	F 600	F600 Free from Abuse and Neglect A. The RNAC reviewed and updated R78's care plan for physically aggressive behaviors. R66 was evaluated by the nurse practitioner on 3/25/24, R66 sustained no significant injury. B. All residents have the potential to be affected by this deficient practice. C. The root cause analysis identified that R78 bumped wheelchairs with R66 in the dining room and struck R66 in the face. Nursing staff will be educated by DON or designee to monitor and document physically aggressive behaviors to ensure that the patient centered interventions are implemented when the resident is displaying aggressive behavior. D. The DON and/or designee will conduct random audits of residents with physically aggressive behaviors to ensure interventions are effective to keep residents free from abuse. The audit will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is	

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F 600	Continued From page 7 understanding others..." 4/25/23 - R78 was care planned for potential physically aggressive behaviors as evidenced by yelling, kicking, hitting, slapping, striking out, etc. Interventions included: allowing R78 10 - 15 minutes to calm down and then reapproach, redirecting when visibly irritated and speaking in a calm voice to keep R78 calm and feel non threatened. 1/25/24 - A review of R66's quarterly MDS assessment revealed that R66's cognition was moderately intact and had used a manual wheelchair for mobility during the review period. 2/15/24 - R78's annual MDS assessment revealed that R78's cognition was moderately impaired, had physical and verbal behaviors occurring 1 to 3 days and had used a manual wheelchair for mobility during the review period. 3/25/24 9:37 PM - A facility incident report submitted to the State Agency documented that on 3/25/24 at 6:20 PM, "...After dinner resident [R66] reported to the charge nurse that another resident [R78] hit her on the face and found redness on the left eyelid." 4/2/24 - A facility 5 day follow up summary submitted to the State Agency documented, "Were changes made to Care Plan? Yes... Medication changes; Q 1 hr (hour) safety check." 1/16/25 4:00 PM - Finding was discussed with E1 (NHA) and E2 (DON). The facility failed to ensure that R66 was free from physical abuse by R78 when R66's face was	F 600	achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 600	Continued From page 8 hit by R78 on 3/24/24. 1/22/25 at 3:04 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R69 and R98) out of 27 sampled residents reviewed for assessments, the facility failed to accurately reflect each residents' status. Findings include: 1. R69's clinical record revealed: 12/19/24 - R69 was admitted to the facility. 12/24/24 7:00 AM - A physician's order stated, "Skin prep bilateral heels every shift for redness bilateral heels and DTI (deep tissue injury) right heel." 12/24/24 3:00 PM - A physician's order stated, "green or blue boots ON at all times while in bed every shift for redness bilateral heels and DTI right heel." Review of the December 2024 eMAR revealed that nursing staff were signing off that the two aforementioned physician orders were completed as ordered.	F 641	F641 Accuracy of Assessments 1. A. The admission assessment for R69 was modified by the RNAC on 2/17/25 to reflect a DTI to the right heel. B. Residents with pressure ulcers have the potential to be affected by this deficient practice. C. The root cause analysis revealed that the admission nurse did not accurately document the resident had a DTI to her right heel. The facility completed lookback of residents admitted in the last 30 days to ensure accuracy of the admission assessment for pressure ulcers and skin issues. Education was provided to nurses by the DON or designee on completing admission assessments accurately and assuring that a full skin check has been completed.	3/8/25

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F 641	Continued From page 9 12/26/24 - The admission MDS assessment, under Section M - Skin Conditions, documented that R69 had no unhealed pressure ulcers and/or unstageable - deep tissue injury. The facility failed to accurately reflect R69's status regarding the right heel DTI on the assessment. 1/22/24 1:00 PM - Finding was reviewed with E2 (DON) and E15 (CNO). 2. R98's clinical record revealed: 12/16/24 - R98 was admitted to the facility with diagnoses, including but were not limited to, stroke, swallowing difficulties and S/P percutaneous gastrostomy tube (PEG) in place. 12/22/24 - R98's admission MDS in Section L Oral/Dental Status, in which option A is "Broken or loosely fitting full or partial denture", documented "Z. None of the above were present". 1/13/25 2:09 PM - During an interview, F5 (R98's daughter) stated, "[R98] is on a pureed diet. When she had a stroke, she lost weight and her dentures don't fit well anymore. I tried to take her to get new dentures ...". 1/21/25 11:59 AM - During an interview, E9 (RNAC) stated, "The nurses' assessments did not document any problems with her teeth. So I didn't know there was an issue ... [R98] has two teeth so she is not edentulous. I spoke with her daughter and did let Social Work know to put her to be seen by the dentist once she converts to long term care."	F 641	D. The DON and/or designee will conduct random audits of admission assessments to ensure accurate documentation is in place for wounds and skin issues. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. A. The MDS for R98 was modified by the RNAC on 2/17/2025. No other MDS miscodings were identified. B. All residents with dentures have the potential to be affected by this deficient practice. C. The root cause analysis determined that the RNAC did not receive information from the family to code the MDS accurately. The corporate RNAC will educate the facility RNAC on interviewing the family prior to coding the MDS. A facility wide sweep was conducted with no other issues identified. D. The corporate RNAC and/or designee	

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F 641	Continued From page 10 1/22/25 3:04 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 641	will conduct random audits to ensure proper coding of dentures on the MDS. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 646 SS=D	MD/ID Significant Change Notification CFR(s): 483.20(k)(4) §483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R39, R62) out of two residents reviewed for PASARR, the facility failed to notify the appropriate state-designated authority when the resident's new diagnosis of mental disorder was identified. For R62, the facility failed to request a new PASARR after R62 was diagnosed with visual hallucinations. Additionally, for R39, the facility failed to notify the state-designated authority of a new order for an antipsychotic medication. Findings include: 1. Review of R62's clinical record revealed:	F 646	F646 MD/ID Significant Change Notification 1. A. Resident R62 was not adversely affected by this deficient practice. The PASSR for R62 was updated by the Social Service Director on 1/30/2025. B. All residents with short-term approved PASSRs have the potential to be affected.	3/8/25

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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 646	Continued From page 11 12/4/19 - R62's PreAdmission Screening and Resident Review (PASARR) documented, " ...This patient does not require a Level II PASARR ... The individual does have a documented serious mental illness (SMI) or a mental illness other than SMI but further review of level of impairment, recent treatment history, or other circumstances demonstrates a full level II is not required by 42 CRF 483.102 standards ...". 12/6/19 - R62 was admitted to the facility, with diagnoses including but not limited to, multiple sclerosis, bipolar disorder and anxiety disorder. 3/28/24 - R62 hospitalized for an infection. 4/5/24 - R62's PASARR documented, " ... Level I Outcome: Convalescence Categorical ...Rational: 60 Day Convalescent Care Approval - a 60 day or less stay in the NF (nursing facility) is authorized. Re-screening must occur by or before the 60 day if the individual is expected to remain in the NF beyond the authorization timeframe." 5/8/24 - R62's care plan updated to include, " ... [R62] has socially inappropriate behavior as evidenced by hallucinations and delusion; claiming there are bugs crawling all over her ...". 6/6/24 - R62 was diagnosed with delusional disorder. 6/13/24 - R62 hospitalized at [geropsychiatric hospital] for management of her delusions/hallucinations. 6/20/24 - R62 re-admitted to the facility. R62's PASARR stated, " ... Date Short Term Approval	F 646	C. The root cause analysis determined that the facility did not have a process in place to track when a new PASSR needed to be completed. The Social Services Director will have a tracking tool to determine when a new PASSR is required. The NHA or Designee will educate the Social Services Director on the new tracking tool. D. The NHA and/or designee will conduct audits of new admissions to ensure a new PASSR is not required. The audit will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. A. Resident R39 was not adversely affected by this deficient practice. The PASSR for R39 was updated by the Social Service Director on 1/30/2025. B. Residents with new diagnosis of mental disorders have the potential to be affected by this deficient practice. C. The root cause analysis determined that the facility did not have a process in	

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F 646	Continued From page 12 Ends: July 18, 2024 ... Due to this being a remote PASARR assessment, your admitting nursing facility must submit a Resident Review to [PASARR company] so you may have an in-person PASARR review ... At this time, you meet PASARR inclusion criteria. You have a Level II PASARR condition of Bipolar disorder, mixed with psychotic features ... Level I Outcome: Refer for Level II Onsite. Rationale: A PASARR level II evaluation must be conducted. That evaluation will occur as an onsite/face-to-face evaluation." 1/15/24 7:02 AM - During an email correspondence, C1 (DHSS DMMA nursing supervisor) stated, " ...[R62] should have had a resident review PASARR prior to the expiration of the PASARR on 7/20/24. She was only given a short-term approval NF stay by PASARR. The facility is out of PASARR compliance. You have a resident residing at the facility without a current PASARR on file." 2. Review of R39's clinical records revealed: R39's admission PASSAR dated 2/23/23 documented, "Level 1 PASSAR, no PASSAR Level 2 recommended." 4/10/23 - R39 was admitted to the facility with diagnoses including anxiety disorder, major depressive disorder, and dementia. 4/20/23 - R39's admission MDS documented, "No dx [diagnoses] of bipolar disorder." 5/19/23 - R39's clinical records documented, "Aripiprazole [antipsychotic medication] oral tablet 5 mg, give 1 tablet by mouth daily for	F 646	place to track when a new PASSR needed to be completed. Moving forward the DON or designee will review all new psych med order and will forward results to the Social Services Director to have a new PASSR completed. A facility wide sweep was conducted with no other issues identified. NHA or designee will educate the Social Services director on the new process for obtaining a new PASSR for new psych orders or medication changes. D. The DON and/or designee will conduct random audits of residents with new psych orders or medications to ensure they do not need a new PASSR. The audit will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 646	Continued From page 13 Bipolar/severe anxiety." 6/24/23 - R39's quarterly MDS documented, "Yes bipolar dx [diagnoses.]" 6/26/23 - R39's care plan documented, " ... Uses antipsychotic medications r/t [related to] bipolar disorder ..." 10/1/23 - R39's quarterly MDS documented, "Yes bipolar dx [diagnoses.]" 1/9/24 - R39's quarterly MDS documented, "Yes bipolar dx [diagnoses.]" 4/9/24 - R39's annual MDS documented, "Yes bipolar dx [diagnoses.]" 7/24/24 - R39's quarterly MDS documented, "Yes bipolar dx [diagnoses.]" 9/26/24 - R39's quarterly MDS documented, "Yes bipolar dx [diagnoses.]" 12/26/24 - R39's significant change MDS documented, "Yes bipolar dx [diagnoses.]" 1/16/25 2:00 PM - A review R39's clinical records lacked evidence that a referral was made to the state mental health authority for an updated PASSAR to reflect the new diagnosis of bipolar disorder, and the use of aripiprazole (anti-psychotic medication). 1/17/25 1:00 PM - Findings were confirmed with E8 (RNAC). 1/22/25 3:04 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3	F 646		

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F 646	Continued From page 14 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 646		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (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	F 656		3/8/25

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F 656	Continued From page 15 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R28, R97 and R165) out of twenty seven residents reviewed for care plans, it was determined that the facility failed to develop and implement comprehensive, person centered care plans. For R97, the facility failed to implement R97's need for an adaptive cup during non-meal times. For R28 and R165 the facility failed to ensure care plans included non pharmacological interventions prior to the use of PRN antianxiety medication. Findings include: 1. R97's clinical record revealed: Cross refer F692 and F810 12/19/24 - R97 was admitted to the facility with diagnoses including but were not limited to, dementia and difficulty swallowing. 12/20/24 10:05 AM - E13 (dietician) ordered in R97's EMR, "Regular diet ...Adaptive equipment: please issue divided plate, built up utensils and Kennedy cup with straw at all meals". 12/20/24 - R97 was care planned for " ...a	F 656	F656 Develop/Implement Comprehensive Care Plan 1. A. No residents were adversely affected by this deficient practice. The care plan for R97 was updated by the registered dietician on 2/17/25. B. All residents that require an adaptive cup have the potential to be affected by this practice. C. The root cause analysis revealed that when the facility failed to follow the protocol to update the care plan when a new order of adaptive equipment is obtained. The DON or designee will educate the registered dietician on updating the resident care plan following new orders of adaptive equipment. The facility completed an audit of residents with new orders of adaptive equipment to ensure their care plan has been updated. No further issues identified.	

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F 656	Continued From page 16 potential nutritional problem r/t (related to) advanced age ... self-feeding difficulty requiring adaptive equipment ...[R97] has an ADL (activities of daily living) self-care performance deficit r/t limited mobility." 1/15/25 1:01 PM - During an interview, E30 (LPN) stated, [R97] gets an adaptive cup on her meal trays. 1/15/25 1:07 PM - During an interview, E32 (OT) stated, "[R97] is ordered specialized dining utensils. It is part of the diet order ... She is ordered a Kennedy cup because the handle allows her to pick the cup up independently ..." 2. R28's clinical records revealed: 6/14/24 - R28 was admitted to the facility with diagnoses including major depressive disorder and anxiety. 6/14/24 - R28's care plan documented, " ... [R28] uses anti-anxiety medications r/t [related to] anxiety disorder ..." The interventions included. "Administer ANTI-ANXIETY medications as ordered by physician .... Monitor for side effects and effectiveness ...." 12/10/24 - R28's quarterly MDS assessment documented a BIMS score of "00", indicating severe cognitive impairment. 12/24/24 - R28's clinical records documented, " ... Lorazepam [antianxiety medication] 0.5 mg/ 1 ml Gel .... Apply 1 mg transdermally [on the skin] every 6 hours as needed for GAD [general anxiety disorder.]" 1/17/25 12:30 PM - A review of R28's anti-anxiety	F 656	D. The DON and/or designee will conduct random audits of care plans to ensure they include appropriate adaptive equipment. The audit will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 2. A. No residents were adversely affected by this deficient practice. The care plan for R28 was updated by the RNAC on 2/17/25. B. All residents that receive PRN antianxiety have the potential to be affected. C. The root cause analysis determined that the facility did not have an updated care plan in place to address non-pharmacological approaches prior to administering PRN antianxiety medications. Moving forward, the facility will modify all resident centered care plans to include nonpharmacological measures for PRN antianxiety medications. The CNO or designee will educate nurse management on this new process. A facility wide audit of residents with PRN	

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F 656	Continued From page 17 care plan lacked evidence of non-pharmacological interventions prior to the use of the anti-anxiety medication. 1/17/25 1:00 PM - Findings were confirmed with E2 (DON). 3. R165's clinical record revealed: 12/23/24 - R165 was admitted to the facility. 12/23/24 - R165 was ordered PRN Oxycodone every four hours for moderate pain and Tylenol every six hours for pain. 12/24/24 - R165's was care planned for "acute/chronic pain related to osteoarthritis to right knee, osteoporosis, fall and decreased mobility." R165's interventions included: -"Administer analgesia as per orders; - Evaluate the effectiveness of pain interventions; - Monitor/document for side effects of pain medication. Report occurrences to the physician. - Monitor/record/report to Nurse any s/sx (signs/symptoms) of non-verbal pain...; - Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. - Pain evaluation on admission, quarterly, and with significant change." Review of R165's pain care plan revealed that the facility failed to include non-pharmacological interventions in R165's pain care plan. 1/22/24 at 1:00 PM - Finding was reviewed with E2 (DON) and E15 (CNO). 1/22/25 at 3:04 PM - Finding was reviewed during	F 656	antianxiety medications was completed and the care plans were updated. D. The DON and/or designee will conduct random audits of care plans to ensure they include non-pharmacological interventions for PRN antianxiety medications. The audit will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee. 3. A. No residents were adversely affected by this deficient practice. Unable to correct this deficient practice, R165 no longer resides in the facility. B. All residents that receive PRN pain medications have the potential to be affected. C. The root cause analysis determined that the facility did not have an updated care plan in place to address non-pharmacological approaches prior to administering PRN pain medications. Moving forward, the facility will modify all resident centered care plans to include nonpharmacological measures for PRN	

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F 656	Continued From page 18 the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 656	pain medications. The CNO or designee will educate nurse management on this new process. A wide audit of residents with PRN pain medications was completed and the care plans were updated. D. The DON and/or designee will conduct random audits of care plans to ensure they include non-pharmacological interventions for PRN pain medications. The audit will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		3/8/25

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F 657	Continued From page 19 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R78) out of twenty seven sampled residents, the facility failed to ensure that R78's comprehensive care plan was reviewed and revised based on preferences and needs of the resident and in response to current interventions. Findings include: Cross refer F600 R78's clinical record revealed: 4/25/23 - R78 was care planned for potential physically aggressive behaviors as evidenced by yelling, kicking, hitting, slapping, striking out, etc. Interventions included: - allowing R78 10-15 minutes to calm down then reapproach, - redirecting when visibly irritated and, - speaking in a calm voice to keep R78 calm, and feel non threatened.	F 657	F657 Care Plan Timing and Revision A. R78 was not adversely affected by this deficient practice. The care plan for R78 was updated by the RNAC on 2/17/25. B. Residents that are care planned for the potential for physical aggression have the potential to be affected. C. The root cause analysis determined that nursing staff did not update the care plan after physical aggression occurred. Nurses and RNAC will be educated by the DON or designee on revising care plans timely and assuring that an actual care plan for physical aggression is added to the chart when an incident of physical aggression occurs. A facility wide sweep was conducted and no other issues identified.	

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F 657	Continued From page 20 3/25/24 9:37 PM - A facility incident report submitted to the State Agency documented that R78 hit R66 on the face. 4/2/24 - A facility 5 day follow up summary documented, "Were changes made to Care Plan? Yes... Medication changes; Q 1 hr (hour) safety check." 1/16/23 11:05 AM - A review of R78's potential for physical aggression care plan revealed that it was not revised to include the new safety check interventions. 1/16/2 1:46 PM - In an interview, E2 (DON) confirmed that R78's care plan for physical aggression was not revised and updated after the 3/25/24 resident - to - resident physical altercation between R78 and R66. 1/22/25 at 3:04 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 657	D. The DON and/or designee will conduct random audits of residents that are care planned for physical aggression to ensure that new interventions are added to the care plan timely when behaviors occur. The audit will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for	F 661		3/8/25

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F 661	Continued From page 21 release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconcil ation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R113) out of one resident rev ewed for discharge, the facility failed to have a discharge summary that included a reconciliation of medications. Findings include: Review of R113's clinical record revealed: 11/6/24 - R113 was admitted to the facility with diagnoses, including but were not limited to, dementia, heart failure and difficulty walking. 11/13/24 9:21 AM - E10 (Director of Social Work) documented in a progress note in R113's EMR, "DON (Director of Nursing) from [assisted living facility (ALF)] contacted SSD (social services director) to nform that resident is at baseline and is able to be re-admitted to ALF setting. DON requested c/c (discharge) for Thursday 11/14/24 ... Resident will return to [ALF] with her spouse	F 661	F661 Discharge Summary A. R113 was not adversely affected by this deficient practice. Unable to correct the deficient practice as the resident no longer resides in the facility. B. Residents discharging from the facility have the potential to be affected when a med reconciliation list is not completed. C. The root cause analysis determined that the facility did not have a process in place for keeping a copy of the medication reconciliation list in the medical record when the resident was discharged. Going forward, the facility will have a new process of scanning the discharge summary, including the medication reconciliation, into the electronic health	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

(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 661	Continued From page 22 using [home health agency] for HHC (home health care) ... ** SSD explained to new DON at [ALF] that [nursing facility] request 48 hours notice for all d/c's. IDT (interdisciplinary team) made aware SS (social Services) will remain available." 11/14/24 10:00 AM - R113 was discharged back to [ALF]. 11/14/24 11:06 AM - E31 (LPN) documented in a progress note in R113's EMR, "Resident discharged with her belongings, medication, prescriptions and discharge summary. Reviewed mediation administration, prescriptions and discharge instructions with resident/ daughter [F4] and she verbalized understanding." 12/8/24 11:16 AM - E22 (NP) completed R113's Discharge Summary in R113's EMR documenting, " ... Medication List: see D/C medication list ...Plan: ...Discharge mediations - see discharge instructions; prescriptions provided ...". Of note, this provider discharge summary was completed and accessible in R113's EMR twenty-four days after her discharge from the facility. 1/21/25 10:15 AM - Surveyor reviewed the [facility] Discharge Summary V6 completed by E31 (LPN). The facility discharge summary provided the name and contact information for the home health agency and the community based primary care physician. [Facility] discharge summary documented that "Medications given to resident or resident's representative, reviewed directions of use and drug storage with resident	F 661	record when a resident is discharging. Medical records and nurses will be educated by the DON or designee on the new process to scan the discharge summary, including the medication reconciliation, into the electronic health record. D. The NHA or designee will audit all Discharge Summaries to assure summaries are completed prior to discharge. Audits will be completed Daily x 3 days until 100% compliance is achieved, then Weekly x 3 until 100% compliance is achieved, then Monthly X 3 month until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	

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F 661	Continued From page 23 or residents (sic) representative, prescriptions sent and care plans given to resident or resident's representative." The [facility's] discharge summary lacked evidence of R113's list of medications and a reconciliation of all pre-discharge medications with R113's post- discharge medications. 1/22/25 3 15 PM - E2 (DON) stated that the facility provided R113's daughter with a printout of R113's active medication orders at the time of discharge, which included escitalopram 5 mg by mouth daily, ferrous sulfate 325 mg by mouth daily, omeprazole 40 mg by mouth daily, pregabalin 75 mg by mouth daily and calcium + vitamin D3 600-5 mg- mcg by mouth daily. Of note, neither the facility discharge summary nor the provider discharge summary documented the names, doses and routes of R113's discharge medications. 1/22/25 3:04 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 661		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and	F 685		3/8/25

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F 685	Continued From page 24 §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that for one (R101) out of three sampled residents, the facility failed to ensure that care was provided to support R101's hearing loss. Findings include: Review of R101's clinical records revealed: 9/17/24 - R101 was admitted to the facility with diagnoses including stroke, cognitive communication deficit and major depressive disorder. 9/23/24 - R101's admission MDS documented, "Minimum hearing difficulty." 9/30/24 - R101's admission BIMS documented a score of 15, indicating a cognitively intact status. 9/30/24 - R101's communication care plan documented, " ...[R101] has a communication problem r/t [related to] hearing deficit ...." The interventions included, "Allow adequate time to respond, repeat as necessary, do not rush, request clarification from the resident to ensure understanding, face when speaking, make eye contact, turn off tv/radio to reduce environmental noise, ask yes/no questions if appropriate, use simple, brief, consistent words/cues, use alternative communication tools as needed..." 11/16/24 - R101 clinical records documented,	F 685	F685 Treatment/Devices to Maintain Hearing/Vision A. R101 was not adversely affected by this deficient practice. The Unit Manager offered R101 hearing aides on 1/21/25. B. All residents with a hearing deficit have the potential to be affected. C. The root cause analysis determined that R101 was seen by an ENT on 11/6/24 and 12/18/2024. During a care conference meeting on 12/19/24 R101 was offered hearing aids and declined. OT evaluated R101 on 9/18 upon admission and determined no other methods of communication were needed to communicate. Speech therapy will evaluate R101 for a communication device. All residents identified with a hearing deficit will be evaluated by the provider for further interventions. Nursing staff will be educated by the DON or designee on identifying residents with hearing deficits and notification to the provider for evaluation for additional interventions. D. The DON or designee will complete random audits of residents with hearing deficits to ensure there is no need for	

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F 685	Continued From page 25 "Seen by audiologist - recommendation for debrox [ear wax softening medication] 5 drops to both ears x 7 days." 12/18/24 - R101's clinical records documented, " ...Seen by audiologist - [wax] was removed from ears." 12/19/24 - R101's quarterly MDS documented a BIMS score of 14, indicating a cognitively intact status. 12/19/24 - R101's clinical document titled, "Cadia Social Services Assessment" documented, "[E101] declined dentist, hygienist, hearing, sight this quarter ...." R101's clinical records documented eye doctor and audiologist visits in November and December 2024. 12/24/24 - R101's quarterly MDS documented, "Moderate hearing difficulty .... follow up with audiology. " 1/14/25 9:00 AM - During an interview the Surveyor attempted to speak with R101, but she pointed to both of her ears and shook her head. The surveyor wrote the questions on paper and asked R101 if she could hear what was being said. R101 wrote, "No" and pointed to her right ear and, "little" for her left hear. The surveyor further inquired if R101 had any tools e.g. white board or writing paper to communicate with staff, R101 shook her head from side to side, and wrote "No. I asked for hearing aids but did not hear back. I would really like to hear a little better."	F 685	communication devices or additional interventions needed. Audits will occur daily x 3 until 100% compliance is achieved, then Weekly x 3 until 100% compliance is achieved, then Monthly X 3 month until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	

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F 685	Continued From page 26 R101's room lacked evidence of writing paper, white board, or any other type of communication devices. 1/15/25 9:10 AM - The Surveyor communicated with R101 using pen and paper. R101 wrote that she was not offered any type of communication tools and denied refusal of hearing aids or medical appointments. R101's room lacked evidence of any type of communication devices. 1/17/25 11:10 AM - During an interview R4 (UM) stated, "[R101] was offered hearing aids but she refused. She would say she wants them but refuses when offered." 1/21/25 8:07 AM - R101 was observed in her room, no evidence of communication tools or devices were seen in the room. 1/21/25 9:30 AM - During an interview E18 (CNA) stated, "I have to get very close to [R101] and talk loudly to her in her left ear. It's hard because her roommate sometimes think I am talking to her." 1/21/25 10:30 AM - During a telephone interview F3 (Family member) stated, "I had brought an amplifier to use during the admission in September. They [the facility] had asked me and my aunt about getting her hearing aids. We said "yes" but I did not hear anything back about it since then. I would like her to be able to hear better." 1/22/25 at 3:04 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and	F 685		

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F 685	Continued From page 27 E15 (CNO).	F 685		
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; (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.	F 690		3/8/25

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F 690	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that for two (R73 and R66) out of three residents reviewed for bowel and bladder, the facility failed to provide appropriate treament and services to achieve or maintain as much nomal bladder function as possible. For R73, the facility failed to ensure that R73's urinary catheter care was monitored in a manner to prevent infection. For R66, the facility failed to maintain or restore continence. Findings include: 1. Review of R73's clinical record revealed: 2/20/22 - R73 was admitted to the facility with diagnoses including obstructive and reflux uropathy (blockage in the tubes that carry urine to the bladder), and retention of urine. 9/24/23 - R73's clinical records documented, " ...Catheter Care q [every] shift." 10/26/23 - R73's urinary care plan documented, "[R73] has an indwelling catheter ..." The interventions included, " ...Position catheter bag and tubing below the level of the bladder ..." R73's Kardex (electronic document for the residents' care) documented, "Position catheter bag and tubing below the level of the bladder." 1/9/25 - R73's annual MDS documented a BIMS score of 13, indicating a cognitively intact status. 1/13/25 10:30 AM - R73 was observed sitting in the wheelchair in his room. The urinary collection bag was hanging above the bladder, below the left arm rest of the wheelchair.	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI 1. A. R73 was not adversely affected by this deficiency. The catheter bag was repositioned on the wheelchair below the bladder by the unit manager. B. All residents with foley catheters have the potential to be affected by this deficient practice. C. The root cause analysis determined that the nurse□s aides did not follow the protocol for foley catheter bag placement. The DON or designee educated certified nurse aides on proper foley bag positioning. A review of residents with foley catheters was completed with no further issues identified. D. The DON or designee will complete random audits of residents with foley catheters to ensure proper bag placement. Audits will occur daily x 3 until 100% compliance is achieved, then Weekly x 3 until 100% compliance is achieved, then Monthly X 3 month until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee. 2. A. R66 was not adversely affected by this	

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CADIA REHABILITAT ON BROADMEADOW	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

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F 690	Continued From page 29 1/13/25 12:00 PM - R73 was observed sitting in the wheelchair in the dining room eating lunch. The urinary collection bag was hanging above the bladder, below the left arm rest of the wheelchair. 1/13/25 12:45 PM - R73 was observed sitting the wheelchair in the dining room eating lunch. The urinary col ection bag was hanging above the bladder, below the left arm rest of the wheelchair. 1/13/25 1:00 PM - Findings were confirmed with E8 (UM.) 2. A review of R66's clinical records revealed the following: 10/19/23 - R66 was admitted to the facility. 11/1/23 - R66 was care planned for the potential for falls related to...incontinence...with interventions including education on call bell use and calling for help prior to attempting transfer... (12/12/23) and keeping pathway to the bathroom clear and clutter free (12/11/23). 11/1/23 - R66 was care planned for bladder incontinence with interventions including on toileting program as ordered (1/30/24). 1/25/24 - R66's quarterly MDS revealed that R66's cognition was moderately impaired and was occasionally incontinent of urine. 4/25/24 - R66's quarterly MDS revealed that R66 had intact cognition and was occasionally incontinent of urine.	F 690	deficiency. The person-centered toileting program for R66 was reviewed and updated by the Unit Manager on 1/18/25. B. All residents that require a toileting program have the potential to be affected. C. The root cause analysis determined that while a voiding diary and toileting program was completed upon admission, due to the R66's frequents falls related to the bathroom, a new voiding diary should have been completed to identify the frequency of assistance needed for toileting. For all residents who fall while attempting to go bathroom will be reviewed by the facility fall committee to establish if a revision to the toileting program needs to be completed. A facility review was completed with no other issues identified. The DON will educate the ADON and fall committee on this new process. D. The DON or designee will complete random audits of all residents with falls attempting to go to the bathroom. Audits will occur daily x 3 until 100% compliance is achieved, then Weekly x 3 until 100% compliance is achieved, then Monthly X 3 month until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	

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F 690	Continued From page 30 7/23/24 - R66's quarterly MDS revealed that R66's cognition was moderately impaired and was occasionally incontinent (loss of control of bladder) of urine. 1/17/25 - A review of R66's fall incident reports from January 2024 through December 2024 revealed the following: - 3/2/24 6:30 AM - Patient found sitting on floor next to her bed...states she was "trying to go to the bathroom" - just toileted at 5:00 AM - 5/8/24 12:12 AM - Patient found sitting on the floor next to her bed and stated "I was going to the bathroom" - 7/2/24 11:30 AM - Patient found lying prone on the floor in her room - bed to floor...patient toileted and assisted back to bed..." - 8/16/24 1:29 AM - Patient found sitting on the floor next to the toilet in her bathroom - back leaning against the toilet. Last toileted 12:00 AM. toilet after fall. 1/17/25 - A review of Fall Risk Evaluations from January 2023 through January 2025 revealed that R66 needed assistance with toileting. 1/17/25 3:06 PM - During an interview E24 (CNA) stated that, "[R66] is a limited assist with toilet, has fallen a lot. She is continent of bladder and she would ask me to take her to the bathroom. She tells me when she wants me to take her to the bathroom." 1/21/25 9:54 AM - In an interview E23 (LPN) stated that "[R66] is mostly continent and she transfers herself to the bathroom. We toilet her...sometimes every hour but she also lets us know if she wants to use the bathroom."	F 690		

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F 690	Continued From page 31 1/21/25 2:35 PM - During an interview, E2 (DON) confirmed that R66's person centered toileting program was not revised. E2 presented to the surveyor a copy of R66's incontinence care plan with interventions reviewed and revised on 1/17/25. The facility failed to ensure R66's person centered care plan interventions and a personalized toileting program were reviewed to address R66's falls related to R66's need to use the bathroom. 1/21/25 2:40 PM - Findings were discussed with E1 (NHA) and E2. 1/22/25 at 3:04 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 690		
F 692 SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;	F 692		3/8/25

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F 692	Continued From page 32 §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that for two (R97 and R114) out of two residents reviewed for hydration, the facility failed to offer R97 sufficient fluid intake in an accessible manner for her to maintain proper hydration. For R114, the facility failed to ensure that R114 received sufficient fluids to maintain proper hydration or provide additional interventions when R114's oral intake significantly dropped. This failure resulted in harm with R114 being transferred to the hospital on 2/28/24 with a BUN of 100. Findings include: The BUN (blood urea nitrogen) lab measures the amount of urea nitrogen in the blood. The BUN is directly related to the metabolic function of the liver and the excretory function of the kidney ... BUN levels also may vary according to the state of hydration, with increased levels seen in dehydration and decreased levels seen in overhydration. Mosby's Diagnostic and Laboratory Test Reference 2023 1. Review of R114's clinical record revealed: 6/17/22 - R114 was admitted to the facility with diagnoses including but were not limited to, dementia and stroke with resultant difficulty swallowing and language/speech deficits. 6/20/22 - R114 was care planned for several	F 692	F692 Nutrition/Hydration Status Maintenance 1. A. Unable to correct the deficient practice as R114 is no longer in the facility. B. All residents that do not meet their fluid intake goals have the potential to be affected by this practice. Future residents will be protected from the deficient practice by the measures taken below in section C. C. The root cause analysis determined that the facility did not implement new interventions when R114's meal and fluid intake decreased while on droplet precaution isolation. All residents on droplet precaution isolation will be placed on daily meal consumption and fluid monitoring by the dietitian. All residents who consume 50% or less of a meal or fail to meet their fluid goals on any given day will be reviewed daily by the dietitian, as well as weekly during High Risk meeting, until their meal and fluid goals are met and they are removed from droplet isolation precautions. The dietitian will run a report from PCC daily five days per week to identify residents on isolation	

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F 692	Continued From page 33 problems including: "has nutritional problem d/t (due to) ... hx (history) need for feeding assistance, advanced age, ...poor intake...Interventions for this problem included: ... Monitor intake and record q (every) meal...provide assistance cueing meals as needed...". 6/29/22 - R114's care plan was updated with several additional problems including: "...(1) has the potential for pressure ulcers, decreeased functional mobility ...Interventions for this problem included : ...encourage adequate nutrition/hydration ... (2) has an ADL (activities of daily living) self- care performance deficit r/t (related to) weakness... Interventions for this problem included: ... Eating- [R114] is supervision of one person with feeding...". 6/19/23 - E33 (dietician) documented in R114's EMR, " ... [Facility] Nutrition Risk Assessment ... Estimated fluids - ml (milliliter) -1200 - 1440 ... Feeding status - Needs some assistance with meal set up or eating ... Assessment - ...[R114] is able to feed herself after set up with some cueing ... [R114] meets criteria for malnutrition d/t (due to) dementia and variable intake ...". 8/10/23 - E27 (MD) ordered in R114's EMR, " ...Med Pass (medication pass) three times a day 120 ml (additional water) ...". This order added 360 mls of additional water that R114 consumed each day. 1/19/24 - E34 (NP) documented in R114's EMR a follow up progress note, " ...History of present illness: Pt (patient) appears clinically stable ... Labs 8/2/23 ... Na (sodium) 141 mmol	F 692	that fail to meet their fluid and caloric needs. The Staff Educator will re-educate C N As to document meals <50% consumed and fluid volume intake in PCC. Dietitian will implement appropriate interventions as needed based on her assessment of the residents consumption and their caloric and fluid needs prn and weekly during High Risk meeting. The Staff Educator will educate nursing management on this new process. The root cause anyalyis revealed that the unavailability of provider notes did not adversely affect R114. The facility has reviewed and put a plan in place to address the timely completion of physician documentation, as outlined in the plan of correction for F842-Resident Records. D. All residents on droplet precautions and isolation will be audited by the dietitian for meal consumption and fluid intake volume until they are removed from isolation status. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is achieved, the deficient practice will be considered resolved. Audit results will be reviewed at the Quality Assurance Committee. 2. A. R97 was not adversely affected by this	

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F 692	Continued From page 34 (millimole)/L (liter) (normal range 137-145) ... BUN 20.0 mg (milligram) /dL (deciLiter) (normal range 7.0-17.0), creatinine 0.70 mg/dL (normal range 0.52 - 1.04) ... Plan: weight stable: appetite variable but mostly acceptable ... Continue Remeron ...and encourage fluids ...". R114's BUN at the time of this encounter was elevated at 20.0, which was reflective of R114 being intravascularly dry or dehydrated. Of note, this note was not signed by the provider until 5/2/24, which was five and a half months after the encounter. The notes are only available to be read in the resident's EMR after they are signed off by the provider so this note was not available to be read until 5/2/24. 2/1/24 - E22 (NP) reviewed R114's labs, which documented a sodium level of 141, a BUN of 18 and a creatinine level of 0.90. The BUN was slightly elevated at 18, where the normal range was 7.0 to 17.0. The daily totals of R114's oral intake was: 2/18/24 - 1560 mls, 51-75% consumption of meals for 2 out of 3 meals, dinner was 0 - 25% consumed, 2/19/24 - 1440 mls, 51-75% consumption of meals for 2 out of 3 meals, dinner was 0 - 25% consumed, 2/20/24 - 1320 mls, 51-75% consumption of meals for 2 out of 3 meals, dinner was 76 -100% consumed, 2/21/24 - 1320 mls, 26- 50% consumption of 2 out of 3 meals, dinner was 76 - 100% consumed. 2/21/24 - E35 (RN supervisor) documented in	F 692	deficient practice. R97 was provided with a Kennedy cup by the registered dietician on 1/17/25. B. All residents that have an order for a Kennedy cup for hydration have the potential to be affected by this practice. Future residents will be protected from the deficient practice by the measures taken below in section C. C. The root cause analysis revealed that nursing staff did not have a Kennedy cup on the unit to fill for R97 during non-mealtimes. Moving forward, dietary staff will send two Kennedy cups during breakfast and dinner, so that one cup can be used during the meal, and the other will stay at the bedside to be used during non-mealtimes. Dietary staff will be educated by the Food Service Director and/or designee on this new process. A review of all residents requiring a Kennedy cup was completed. No further issues identified. D. The DON and/or designee will randomly audit residents requiring a Kennedy cup to ensure the cup is available during non-mealtimes. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is achieved, the deficient	

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F 692	Continued From page 35 R114's EMR, "[R114] is asymptomatic. Roommate with positive results [COVID]. Resident with room change to [room number] and contact/droplet isolation precautions initiated per protocol ...". 2/22/24 - 1380 mls, 26 - 50% consumption of breakfast, lunch and dinner were 0-25% consumed, 2/23/24 - 1080 mls, 0 - 25% consumption of breakfast and lunch, dinner was 26-50% consumed. CNA documented under ADL - Eating Self performance task that the "Activity (eating) did not occur" for lunch. 2/24/24 - 960 mls, 0 - 25 % consumption of all 3 meals, 2/25/24 - 880 mls, 0 - 25 % consumption of breakfast and lunch, dinner was 26-50% consumed. CNA documented under ADL - Eating Self performance task that the "Activity (eating) did not occur" for lunch. 2/26/24 - 1080 mls, 0 - 25 % consumption for all 3 meals. CNA documented under ADL - Eating Self performance task that the "Activity (eating) did not occur" for breakfast. 2/27/24 - 780 mls, 0 - 25 % consumption for breakfast, lunch and dinner were 26-50% consumed. Of note, R114's oral intake dramatically dropped after she was placed on isolation precautions for a COVID exposure on 2/21/24. R114's oral intake for the four days prior to the isolation precautions all fell with n R114's normal oral intake range. For the seven days that R114 was on isolation precautions prior to her transfer tot he hospital, on six of those days R114's oral intake was documented to be significantly lower then normal.	F 692	practice will be considered resolved. Audit results will be reviewed at the Quality Assurance Committee.	

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F 692	Continued From page 36 Additionally from 2/22/24 to 2/28/24, out of the twenty meals offered during these seven days, R114 was documented as not eating an entire meal five times. R114 failed to eat twenty-five percent of her meals during this period. The facility failed to ensure R114 met her stated hydration goals by supervising, cueing and monitoring R114's intake at meals. R114's EMR lacked evidence that the facility notified the providers of R114's decrease in oral intake. 2/28/24 6:17 AM- E22 gave a verbal telephone order entered into R114's EMR, "CBC (complete blood count) CMP (complete metabolic panel) one time only for increase in lethargy for 1 day". 2/28/24 6:23 AM - E36 (LPN) documented in R114's EMR progress note, "Noted with increase lethargy. Hydration unsuccessful. New order for CBC, CMP ...". Until this 2/28/24 note, despite five days (2/23 to 2/27/24) of R114 poor oral intake, the facility lacked evidence that this decrease in R114's oral intake was acknowledged by the staff and/or reported to the providers. 2/28/24- 300 mls, 0 - 25 % consumption of breakfast and lunch prior to transfer to the hospital. CNA documented under ADL - Eating Self performance task that the "Activity (eating) did not occur" for both breakfast and lunch. 2/28/24 12:58 PM - Per the [county paramedic's] Prehospital Care Report, R114 was transferred to the hospital for an altered mental status "... patient is noted to be in Atrial fibrillation at a rate of 170 bpm (beats per minute). Patient is also tachypnic (sic) (rapid breathing) at a rate of about	F 692		

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F 692	Continuec From page 37 40. Patient is an obligate mouth breather and her oral cavity is noted to be dry ...". 2/28/24 2:27 PM - R114's facility lab results documented a sodium of 158 mmol/dL (normal range 137-145), creatinine 1.80 mg/dL (normal range 0.52- 1.04). There was no reported BUN value on this lab report. 2/28/24 2:01 PM - [Hospital] laboratory report documented R97's admission/emergency room labwork with a BUN result of 101mg/dL, with this lab's normal range as 8- 22 mg/dL. From 2/1/25 to 2/28/25, R114's BUN elevated from 18 (2/1/25 lab work) to 100 (2/28/25 hospital lab work). 2/29/24 00:25 AM - C2's [hospital] history and physical documented in R114's hospital EMR, " ... [R114]'s lab work was significant for sodium of 157 and a creatinine of 2.21 from a baseline of 0.9, and a BUN of 101 ...Assessment/Plan: Sepsis, unspecified organism- unclear source but patient has mulit-organ failure including her kidneys, her liver as well as evidence of new onset A-fib ...". 2/29/24 - R114 expired at [hospital] on hospice service. 1/21/25 11:45 AM - Review of R114's EMR progress notes lacked evidence of any notation regarding R114's decreased oral fluid intake or any notification of R114's providers regarding her decreased oral intake until 2/28/24 6:23 AM progress note in which E36 (LPN) documented, "...Hydration unsuccessful...".	F 692		

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F 692	Continued From page 38 1/21/25 2:33 PM - During an interview, E4 (RN/unit manager) stated, "It was not unusual for [R114] to ignore you if she did not want to deal with you. She played possum. She often refused her meds. Her vital signs were normal but as the day [2/28/25] progressed she became tachycardic and her breathing changed so we sent her out. She had had labs drawn that morning but they were not back when we sent her out." 1/22/25 8:16 AM - During an interview, E36 (LPN) stated, " ... [R114] was her normal self. (neurologically) I was trying to give her water to drink because I was worried about dehydration." Cross refer F656 and F810. 2. Review of R97's clinical record revealed: 12/19/24 - R97 was admitted to the facility with diagnoses including but were not limited to, dementia and difficulty swallowing. 12/20/24 9:56 AM - E13 (dietician) documented on the [facility] Nutrition Risk Assessment in R97's EMR, " ... Estimated fluids- ml (milliliter) - 1500 - 1800 ml (25-30 ml/kg) (kilogram) ... Feeding status - Needs some assistance with meal set up or eating ... Assessment - ...Daughter reports good oral intake but has had to assist with meals ...". 12/20/24 10:05 AM - E13 (dietician) ordered in R97"S EMR, "Regular diet...Adaptove equipment: please issue divided plate, built up utensils ands kennedy cup with straw at all meals." 12/20/24 1:00 PM - E27 (MD) ordered in R97's	F 692		

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F 692	Continued From page 39 EMR, "Med Pass one time a day 120 mls" and "Juven two times a day for 4 weeks. Mix with 240 mls water". These two orders accounted for 600 mls of R97's documented oral intake during this time period. 12/20/24 - R97 was care planned for several problems including: " ...(1) a potential nutritional problem r/t (related to) advanced age, ... self-feeding difficulty requiring adaptive equipment ... Interventions for this problem included: provide adaptive equipment for feeding as needed...Monitor intake and record...[R97] has an ADL (activities of daily living) self-care performance deficit r/t limited mobility... (2) has impaired cognitive function/dementia... Interventions for this problem included: Cue, reorient and supervise as needed... (3) has an ADL (activities of daily living) self-care performance deficit r/t (related to) limited mobility...Interventions for this problem included: Assist with eating as needed...". The daily totals of R97's fluid intake were: 1/2/25 - 1440 mls 1/3/25 - 1200 mls. 1/4/25 - 1680 mls. 1/5/25 - 1080 mls. 1/6/25 - 1800 mls. 1/7/25 - 1410 mls. 1/8/25 - 1800 mls. 1/9/25 - 1760 mls. 1/10/25 - 1560 mls. 1/10/25 1:31 PM - R97's lab revealed a BUN (blood urea nitrogen) level of 61.0 mg(milligrams)/ dL (deciliter). The BUN normal reference level for this lab was 7.0 to 17.0 mg/dL	F 692		

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F 692	Continued From page 40 so R97's BUN result of 61.0 was elevated and reflective of a state of dehydration. 1/10/25 2:32 PM - E29 (NP) documented in R97's EMR reviewing these lab results. R97's EMR lacked evidence of E29 addressing R97's elevated BUN in either a progress note or with any new orders. 1/11/25 - 1920 mls. 1/12/25 - 1680 mls. 1/13/25 - 1320 mls. 1/13/25 4:06 PM- The surveyor observed R97's bedside table with a full, white styrofoam cup with a straw and ice water in it. 1/14/25 10:30 AM - The surveyor observed R97's bedside table with a full, white styrofoam cup with a straw and ice water in it 1/14/25 - 1310 mls. 1/15/25 - 1430 mls R97's stated hydration goals were 1500 - 1800 mls per day. From 1/2/25 to 1/14/25, there were seven out of fourteen days, where it was documented that R97's oral fluid intake was less than her documented minimum fluid goal. The facility failed to ensure R97 met her stated hydration goal by failing to provide bedside water in a Kennedyadaptive cup that R97 could independently consume, failing to assist and cue R97 to drink her bedside water, and failing to address R97's decreased oral fluid intake with R97's provider. From 1/2/25 to 1/14/25, the CNA staff documented in R97's CNA tasks list report under	F 692		

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F 692	Continued From page 41 "Eating Self-performance- How resident eats and drinks, regardless of skill?" that for twenty-nine times of the thirty-nine recorded entries, R97 was "Total dependence - full staff performance" with regards to this task. 1/15/25 10:30 AM - Review of R97's EMR progress notes lacked evidence of any notation regarding R97's decreased oral fluid intake or any notification of R97's providers regarding her decreased oral intake. 1/15/25 1:01 PM - During an interview, E30 (LPN) stated, [R97] gets an adaptive cup on her meal trays. But I have never seen one on her bedside tray during non-mealtimes. She usually gets her bedside water in a white styrofoam cup...". 1/15/25 1:07 PM - During an Interview, E32 (OT) stated, "[R97] is ordered specialized dining utensils. It is part of the diet order... She [R97] is ordered a Kennedy cup because the handle allows her to pick the cup up independently." 1/16/25 1:35 PM - Review of R97's orders and CNA tasks list report lacked evidence of an order related to R97 utilizing a Kennedy adaptive cup outside of her meal tray. 1/16/25 2:45 PM - During an interview, E24 (CNA) stated, "When we pass the [bedside] water, we use the white styrofoam cups for [R97]. There is no any documentation in the tasks regarding specialty cups. There is not an order. If there3 is a specialty cup on her bedside table, I would pour the water from the styrofoam cup to the specialty cup. Most times, the specil cups come on the food trays."	F 692		

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F 692	Continued From page 42 1/21/25 3:28 PM - E15 (CNO) presented the surveyor with a copy of a new order for R97 stating "offer water in Kennedy cup q (every) shift". E15 also provided a copy of R97's CNA tasks list report with a new task "Provide Q (every) shift water in Kennedy cup". 1/22/25 3:04 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 692		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R91) out of twenty-seven	F 712	F712 Physician Visits-Frequency/Timeliness/Alt NPP	3/8/25

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F 712	Continued From page 43 residents reviewed for physician services, the facility failed to ensure that R91's required visits were coordinated and alternated between the physician and the NP. Findings include: Review of R91's clinical record revealed: 9/18/23 - R91 was admitted to the facility with diagnoses including, but were not limited to, dementia and anxiety disorder. 12/21/23 - E27 (MD) assessed and wrote a progress note for R91. 5/20/24 - E28 (NP) assessed and wrote a progress note for R91. R91 went 151 days without being seen by a provider at the facility. This reflected R91 missing two required 60 day visits by a provider. 6/20/24 - E29 (NP) assessed and wrote a progress note for R91. Based on the 5/20/24 encounter was provided by a nurse practitioner, R91 was required to be seen by the physician by 7/20/24. The facility was not able to provide evidence of R91 being seen by a physician on or around 7/20/24. 7/31/24 - E29 (NP) assessed and wrote a progress note for R91. 8/7/24 - E29 (NP) assessed and wrote a progress note for R91. 8/8/24 - E27 (MD) assessed and wrote a progress note for R91.	F 712	A. R91was not adversely affected by this practice. Unable to correct deficient practice. B. All residents that require a physician visit within 60 days have the potential to be affected by this practice. C. The root cause analysis revealed that the medical director did not follow the process that tracks the length of time in between physician visits. Going forward, the medical records clerk will track physician visits and send the tracker to the CNO, Medical Director and NHA to ensure residents are seen timely. The CNO or designee will educate the physician on seeing residents timely. D. The DON or designee will complete random audits of the electronic health record to ensure residents are being seen by the physician timely. Audits will occur daily x 3 until 100% compliance is achieved, then Weekly x 3 until 100% compliance is achieved, then Monthly X 3 months until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	

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F 712	Continued From page 44 R91 went 231 days between physician visits. 1/22/25 3:04 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 712		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		3/8/25

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F 756	Continued From page 45 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R78 and R90) out of five residents reviewed for medication review, the facility failed to ensure the provider documented that irregularities were reviewed. In addition, the facility failed to ensure the Drug Regimen Review policy included all of the time frame requirements. Findings include: 1. Review of R78's clinical record revealed: a. 2/25/24 - Review of R78's drug regimen reviews found the pharmacist identified an irregularity and asked if a repeat TSH (Thyroid Stimulating Hormone) test be of benefit at this time since R78's TSH drawn on 1/10/23 was high at 12.911 but improved from prior level on 12/11/23. There was no evidence that the physician reviewed this pharmacy concern. 1/16/25 10:00 AM - In an interview, E2 (DON) confirmed that the 2/25/24 pharmacy recommendation was not signed off by the physician and that a signed copy of the facility's response could not be found on R78's medical records. b. 1/16/25 8:42 AM - A review of the facility's policy titled, "Consultant Pharmacist Chart	F 756	F756 Drug Regimen Review, Report Irregular, Act On 1. A. R78 was not adversely affected by this practice, the pharmacist recommendation was completed on 3/29/24 by the NP. The CNO updated the facility policy to include a time frame in which the facility must respond to pharmacy recommendations. B. All residents have the potential to be affected by this practice. C. The root cause analysis revealed that the pharmacy recommendation was reviewed by the provider and followed through by the facility, but the signed recommendation was not scanned into the electronic health record. The DON or designee will educate the nurses to ensure the signed recommendation, once completed, is sent to the medical records staff timely to be scanned into the electronic health record. The facility completed a 30-day lookback for all residents to ensure all pharmacy recommendations were completed timely, signed by the medical provider and	

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F 756	Continued From page 46 Review Reports and Records", revealed a lack of information of the facility's time frame to respond to the pharmacy recommendations based on identified irregularities. 1/16/25 9:49 AM - In an interview, E15 (CNO) confirmed that facility's time frame to respond to the pharmacy recommendations based on identified irregularities was not identified in the current policy and that the policy will be reviewed and revised. 1/21/25 2:40 PM - Findings were discussed with E1 (NHA) and E2. 2. R90's clinical record revealed: 10/21/24 - R90 was admitted to the facility. 10/21/24 - The Consultant Pharmacist Admission Review recommended that R90 have an apical pulse parameter with the administration of Amiodarone medication. The undated handwritten response on the 10/21/24 pharmacist recommendation was signed by E22 (NP) and documented, "(Will refer to cardiology)." Review of R90's clinical record lacked evidence that this recommendation for cardiology were carried out and the documented action that was taken. 1/17/24 at 8:55 AM - During an interview, E6 (UM/RN) confirmed that the recommendation was signed but not dated by E22 (NP). E6 reviewed R90's cardiology consultant notes from 10/22/24 and 10/29/24 and confirmed that this pharmacy recommendation was not addressed in either of	F 756	scanned into the electronic health record. No further issues were identified. D. The DON or designee will complete random audits of the monthly pharmacy recommendations to ensure they are signed, completed timely, and scanned into the electronic health record. Audits will occur daily x 3 until 100% compliance is achieved, then Weekly x 3 until 100% compliance is achieved, then Monthly X 3 month until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee. 2. A. R90 was not adversely affected by this practice. Unable to correct this deficient practice, the resident is discharged from the facility. B. All Residents have the potential to be affected by this practice. C. The root cause analysis revealed that the pharmacy recommendation was reviewed by the provider, but the protocol for the Unit Manager to review the completed recommendation with the DON was not followed, and R90 was not referred to cardiology. The DON or designee will educate unit managers to review the pharmacy recommendations with the DON after the provider to ensure there are no further orders. The facility completed a 30-day lookback for all	

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F 756	Continued From page 47 those notes. 1/22/25 at 3:04 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 756	residents to ensure all pharmacy recommendations were completed timely, signed by the medical provider and scanned into the electronic health record. No further issues were identified. D. The DON or designee will complete random audits of the monthly pharmacy recommendations to ensure they are signed, completed timely, and scanned into the electronic health record. Audits will occur daily x 3 until 100% compliance is achieved, then Weekly x 3 until 100% compliance is achieved, then Monthly X 3 month until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	
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	F 758		3/8/25

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F 758	Continued From page 48 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 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 interview and record review, it was determined that for one (R28) out of five residents sampled for unneccary medication review, it was determined that the facility failed to ensure that the targeted behaviors were documented and non- pharmacological interventions were implemented prior to the use	F 758	F758 Free from Unnec Psychotropic Meds/PRN Use A. R28 was not adversely affected by this deficient practice. The care plan for R28 was updated on 2/17/25 by the RNAC to include non-pharmacological	

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F 758	Continued From page 49 administration of PRN antianxiety medication. Findings include: Review of R28's clinical records revealed: 6/14/24 - R28 was admitted to the facility with diagnoses including major depressive disorder and anxiety. 6/14/24 - R28's care plans documented, " ... [R28] uses anti-anxiety medications r/t [related to] anxiety disorder ..." The interventions included. "Administer ANTI-ANXIETY medications as ordered by physician .... Monitor for side effects and effectiveness ...." R28's care plan lacked evidence of non-pharmacological interventions prior to the use of the PRN antianxiety medication. 11/26/24 - R28's MAR documented, " ...Target behavior: sad, withdrawn, teary-eyed, restlessness, combative, agitation, At the end of each shift note: Frequency - #times behavior occurred; Interventions - A= Redirected, B= Activity provided, C= Refer to Nurses note, D=Toilet, E=Gave food, F=Gave fluids, G= Changed position, H= Back rub." 12/10/24 - R28's quarterly MDS assessment documented a BIMS score of "00", indicating severe cognitive impairment. 12/24/24 - R28's clinical records documented, " ... Lorazepam 0.5 mg/ 1 ml Gel .... Apply 1 mg transdermally [on the skin] every 6 hours as needed for GAD [general anxiety disorder.] 1/17/25 12:30 PM - A review of R28's Medication	F 758	interventions. B. All residents that are prescribed PRN antianxiety medications have the potential to be affected by this practice. C. The root cause analysis revealed that nurses for R28 administered the most effective intervention to decrease combative and aggressive behavior, bypassing a non-pharmacological intervention. The DON or designee educated nurses that non-pharmacological interventions must be attempted and unsuccessful prior to administering PRN antianxiety medication. A review of residents prescribed PRN antianxiety medications with aggressive behaviors were reviewed and no issues were identified. D. The DON or designee will complete random audits of the medication administration record of residents with PRN antianxiety mediations to ensure that a non-pharmacological intervention was used in advance. Audits will occur daily x 3 until 100% compliance is achieved, then Weekly x 3 until 100% compliance is achieved, then Monthly X 3 months until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	

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F 758	Continued From page 50 Administration Records (MAR) revealed a lack of documentation of the number of times that the targeted behaviors occurred, and non-pharmacological implemented for the following dates and times the PRN Ativan [lorazepam] 0.5mg gel was used: 12/4/24 at 1:34 PM 12/7/24 at 2:15 AM 12/26/24 at 2:48 PM 1/1/25 at 3:27 AM 1/3/25 at 8:03 AM 1/8/25 at 9:00 AM 1/9/25 at 8:32 AM 1/13/25 at 9: 00 AM 1/14/25 at 1:44 AM The facility failed to document the number of targeted behaviors and non-pharmacological interventions for nine out of sixteen opportunities for the use of PRN anti-anxiety medications. 1/17/25 1:30 PM - Findings were confirmed with E8 (RN). 1/22/25 at 3:04 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 758		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.	F 773		3/8/25

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F 773	Continued From page 51 (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R90) out of five residents reviewed for unnecessary medications, the facility failed to ensure that laboratory services were obtained only when ordered by a provider. Findings include: R90's clinical record revealed: 12/28/24 - R90 had a blood draw performed for three labs (CBC, CMP, Mg). Review of R90's clinical record lacked evidence of a physician order for the 12/28/24 labs. The facility failed to obtain laboratory services only when ordered by a provider. 1/22/24 at 1:00 PM - Finding was reviewed with E2 (DON) and E15 (CNO). 1/22/25 at 3:04 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 773	F773 Lab Services Physician Order/Notify of Results A. R90 was not adversely affected by this practice. Unable to correct the deficient practice, the resident is discharged from the facility. B. All residents newly admitted to the facility with orders to have labs drawn have the potential to be affected by this practice. C. The root cause analysis revealed that there was no stop date on the routine admission lab orders for R90. The DON or designee will educate nurses on adding stop dates on new admission lab orders. The facility completed 30-day lookback of new admissions to ensure there is a stop date on lab orders and no labs were drawn without a physician order. No further issues identified. D. The DON or designee will complete random audits on new admission lab orders to ensure there is a stop date and labs are only drawn when ordered by a physician. Audits will occur daily x 3 until	

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F 773	Continued From page 52	F 773	100% compliance is achieved, then Weekly x 3 until 100% compliance is achieved, then Monthly X 3 months until 100% compliance is achieved. If at that time compliance is achieved the deficient practice will be noted as resolved. Audits will be reviewed by our QA Committee.	
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that for one (R97) out of four residents reviewed for ADLs (activities of daily living), the facility failed to supply R97's bedside water in a Kennedy adaptive cup. Findings include: Facility Adaptive Feeding Equipment policy: "It is the policy of [facility] that residents requiring adaptive feeding equipment will receive such equipment." Cross refer F656 and F692 A Kennedy cup is an adaptive cup that prevents liquid from spilling even when turned upside down and has an ergonomic handle for ease of holding. Review of R97's clinical record revealed:	F 810	F810 Assistive Devices- Eating Equipment/Utensils A. Resident R97 was provided with a Kennedy cup by the registered dietician, to leave at bedside during non-mealtimes. B. All residents that have an order for a Kennedy cup have the potential to be affected by this practice. C. The root cause analysis revealed that nursing staff did not have a Kennedy cup on the unit to fill for R97 during non-mealtimes. Moving forward, the registered dietician will notify dietary staff of residents that require a Kennedy cup, and the dietary staff will send two Kennedy cups during breakfast and dinner, so that one cup can be used	3/8/25

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F 810	Continued From page 53 12/19/24 - R97 was admitted to the facility with diagnoses including but were not limited to, dementia and difficulty swallowing. 12/20/24 10:05 AM - E13 (dietician) ordered in R97's EMR, "Regular diet ...Adaptive equipment: please issue divided plate, built up utensils and Kennedy cup with straw at all meals". 12/20/24 - R97 was care planned for " ...a potential nutritional problem r/t (related to) advancec age ... self-feeding difficulty requiring adaptive equipment ...[R97] has an ADL (activities of daily living) self-care performance deficit r/t limited mobility." 12/31/24 - R97 was care planned for " ...[R97] has actual contracture ...decreased functional mobility ...". 1/13/25 4:06 PM - During an interview, F6 (R97's daughter) stated that her mom [R97] needs her bedside water in an adaptive cup. F6 stated, "The staff gives her water every shift in a Styrofoam white cup and she [R97] cannot pick it up due to her stroke. So only when the family or staff offer to hold her water cup can she drink it. She likes water and will drink it, if she could pick up the cup." 1/13/25 4:06 PM - The surveyor observed R97's bedside table with a full, white Styrofoam cup with a straw and ice water in it. 1/14/25 10:30 AM - The surveyor observed R97's bedside table with a full, white Styrofoam cup with a straw and ice water in it. 1/15/25 1:07 PM - During an interview, E32 (OT)	F 810	during the meal, and the other will stay at the bedside to be used during non-mealtimes. Dietary staff will be educated by the Food Service Director and/or designee on this new process. A review of all residents requiring a Kennedy cup was completed. No further issues identified. D. The DON and/or designee will randomly audit residents requiring a Kennedy cup to ensure the cup is available during non-mealtimes. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is achieved, the deficient practice will be considered resolved. Audit results will be reviewed at the Quality Assurance Committee.	

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F 810	Continued From page 54 stated, "[R97] is ordered specialized dining utensils. It is part of the diet order. The (Kennedy) cup is not left at the bedside because it has to be cleaned. Usually, I talk to the family and have them buy another (Kennedy) cup for the resident to use for their water cup." The facility failed to provide R97 with an adaptive cup that she could independently drink from during non-meal times. 1/22/25 3:04 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 810		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced	F 812		3/8/25

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F 812	Continued From page 55 by: Based on observation and interview, it was determined that the facility failed to ensure food was stored and served in a manner that prevents food borne Illness to the residents. Findings include: 1. 1/13/25 9:03 AM - An observation in the dry storage room revealed several food item bags that were opened but not dated. There were three bags of bread and a bag of cake mix powder. The findings were confirmed with E25 (Assistant Food Service Director) on site. 2. 1/13/25 9:11 AM - An observation in the walk-in freezer revealed some food debris on the floor. An opened bag of shrimp did not have a date. The findings were confirmed with E25 on site. 3. 1/13/25 9:15 AM - An observation in the walk-in refrigerator revealed a dated half bag of poultry meat stored together with two bags of un-opened same type of poultry meat without dates. The surveyors were not certain whether they belonged to the same batch. There were also a bottle of apple juice and a grape jelly undated, and a discolored vegetable salad dated 1/3/25 which was removed by E25 upon noticed. 4. 1/14/25 2:17 PM - A review of the three-month food temperature log from October to December, 2024 revealed that the temperature of 22 out of 279 (7.9%) meals were not recorded in the log. 1/15/25 11:20 AM - Findings were discussed and confirmed with E12 (Food Service Director), E25 and E13 (Registered Dietitian). 1/15/25 11:55 AM - Findings were discussed with	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary 1. A. No residents were adversely affected by the deficient practice. All unlabeled or undated food in the dry storage area was labeled or discarded by the Food Service Director. B. All residents have the potential to be affected by this practice. C. The root cause analysis revealed that staff failed to follow protocols for proper food storage, dating and labeling. All Dietary staff will be educated by the Food Service Director and/or designee on labeling, dating, and proper storage of foods. D. The Food Service Director and/or designee will audit dry storage areas to ensure proper labeling and dating of foods. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is achieved, the deficient practice will be considered resolved. Audit results will be reviewed at the Quality Assurance Committee.	

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F 812	Continued From page 56 E1 (NHA) and E2 (DON). 1/22/25 at 3:04 PM - Findings were reviewed during the exit conference with E1, E2, E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 812	2. A. No residents were adversely affected by this deficient practice. The floor of the walk-in freezer was cleaned immediately by a dietary aide. All undated food in the walk-in freezer was labeled or discarded by the Food Service Director. B. All residents have the potential to be affected by this practice. C. The root cause analysis revealed that staff failed to lift the floor mat when cleaning the freezer, as small debris can get in the crevasses. All Dietary staff will be educated by the Food Service Director and/or designee on completing a thorough cleaning of the freezer floor, including lifting floor mat to get small debris. D. The Food Service Director and/or designee will audit the freezer to ensure cleanliness proper storage. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is achieved, the deficient practice will be considered resolved. Audit results will be reviewed at the Quality Assurance Committee. 3. A. No residents were adversely affected	

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F 812	Continued From page 57	F 812	by the deficient practice. All unlabeled or undated food in the walk-in refrigerator was labeled or discarded by the Food Service Director. B. All residents have the potential to be affected by this practice. C. The root cause analysis revealed that staff failed to follow protocols for proper food storage, dating and labeling. All Dietary staff will be educated by the Food Service Director and/or designee on labeling, dating, and proper storage of foods. D. The Food Service Director and/or designee will audit the walk-in refrigerator to ensure proper labeling and dating of foods. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is achieved, the deficient practice will be considered resolved. Audit results will be reviewed at the Quality Assurance Committee. 4. A. No residents were adversely affected by this deficient practice. Unable to correct this deficient practice. B. All residents have the potential to be	

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F 812	Continued From page 58	F 812	affected by this deficient practice. C. The root cause analysis determined that the cook failed to follow the protocols for logging the food temperatures at mealtimes. The Food Service Director or designee will educate all cooks to log food temperatures at meal. A 30-day lookback at the meal temperature logs was completed with no further issues identified. D. The Food Service Director and/or designee will audit the food temperature logs to ensure completion at each meal. The audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is achieved, the deficient practice will be considered resolved. Audit results will be reviewed at the Quality Assurance Committee.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted	F 842		3/8/25

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F 842	Continued From page 59 to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities. judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or	F 842		

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F 842	Continued From page 60 (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R109) out of twenty seven residents reviewed, the facility failed to ensure that the electronic health record was complete and readily accessible. Findings include: R109's clinical record revealed: 11/27/24 - R109 was admitted to the facility for a principal diagnosis of a fracture and short term therapy. 12/16/24 - R109 was diagnosed with clostridium difficile (Cdiff) and was placed on an antibiotic for 10 days. 12/27/24 at 2:21 PM - A Physician progress note documented, "Pt seen and examined. Progress note to follow."	F 842	F842 Resident Records- Identifiable Information A. Unable to correct this deficient practice. R109 discharged from the facility. B. All residents have the potential to be affected by this deficiency. C. The root cause analysis revealed that the physician did not complete a follow up note timely. The CNO or designee will educate the physician on ensuring the electronic health record is completed timely and readily accessible. A review of physician progress notes was completed to ensure completion. No further issues identified. D. The DON and/or designee will	

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F 842	Continuec From page 61 1/16/25 - Review of R109's clinicial record lacked evidence of the detailed 12/27/24 Physician progress note. 1/17/25 - R109 was discharged from the facility. 1/22/25 at 1:51 PM - During an interview, E27 (Physician) was asked about the 12/27/24 progress note. E27 stated that since the resident was discharged, she was unable to access it at the time of the interview on her cell phone. When asked about how the resident's Physician progress notes are included into the facility's electronic clinical record, E27 stated that the progress notes migrate over to the facility's clinical record after they are electronically signed by the Provider. E27 stated that she was not aware how often the migration occurs. 1/22/25 at 3:04 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 842	randomly audit physician documentation to ensure timely completion. Audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is achieved, the deficient practice will be considered resolved. Audit results will be reviewed at the Quality Assurance Committee.	
F 847 SS=D	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly	F 847		3/8/25

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F 847	Continued From page 62 inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was	F 847	F847 Entering into Binding Arbitration	

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F 847	Continued From page 63 determined that for two (R3 and R31) out of five residents reviewed for arbitration agreements, the facility failed to ensure that R3 and R31 were capable of understanding the arbitration agreement prior to signing it. Findings include: Basic Interview for Mental Status (BIMS) test is a standardized cognitive assessment tool mandatory in long-term care facilities in accordance with the Centers for Medicare and Medicaid Services (CMS). The BIMS score interpretation categorizes scores into groups by cognitive status. Any score of 13 to15 is classified as intact ndicating normal cognitive response. The moderate impairment classification describes a score from 8 to 12 and suggests that the resident may need assistance with daily activities and may be in cognitive decline. The Severe impairment score indicates that the resident will have significant trouble with cognitive tasks and will likely need extensive help to navigate daily life. A BIMS score from 0 to 7 falls within this classification. CMS website, 2025 1. Review of R3's clinical record revealed: 5/1/24 - R3 was admitted to the facility with diagnoses including, but were not limited to, dementia, anxiety disorder and cognitive communication deficit. R3's Resident Information sheet named F1 (R3's son) as emergency contact #1. 5/1/24 - E16 (admission representative) completed the facility admission documents with R3. R3 signed the legally binding arbitration agreement, which stated, " ... The parties understand and agree that by signing this arbitration agreement, they are giving up and	F 847	Agreements A. No residents were adversely affected by the deficient practice. The admission director completed a new arbitration agreement with responsible party's of R3 and R31 on 2/12/2025. B. New admissions to the facility have the potential to be affected by this practice. C. The root cause analysis revealed that admission staff did not follow the proper protocol to verify the residents BIMS score prior to signing the agreement. All admission staff will be educated by the NHA and/or designee on the verification of the residents cognition prior to signing an agreement. A review of all arbitration agreements was conducted with no further issues identified. D. The NHA and/or designee will audit new admission arbitration agreements to ensure completion by residents with a BIMS of 13 or higher or the resident representative. Audits will be performed daily or until 100% compliance is achieved for 5 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is achieved, the deficient practice will be considered resolved. Audit results will be reviewed at the Quality Assurance Committee.	

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F 847	Continued From page 64 waiving their statutory and constitutional rights to have any claim, including malpractice and wrongful death claims, decided in a court of law before a judge and jury ... If this Agreement is not rescinded within thirty (30) days of the date upon which it is signed, it is binding upon the parties in all matters regarding care and services provided to the resident by the Facility, regardless of subsequent discharges and readmissions ... This agreement does not terminate upon the end of the facility's provision of health care or other services to the Resident or upon termination of any other contract or agreement ...". Despite having a diagnosis of dementia, the facility had R3 sign multiple documents, including her Resident Admission agreement, Consent for Treatment and the binding arbitration agreement. 5/8/24 - R3's admission MDS assessment revealed a Brief Interview for Mental Status (BIMS) score of seven, which was reflective of severe cognitive impairment. The facility was unable to provide evidence of approaching R3's emergency contact [F1] to review the binding arbitration agreement after determining R3 had a severe cognitive impairment. This determination occurred just seven days after R3's admission to the facility and was still within the 30 day window for the binding arbitration agreement to be rescinded. 2. Review of R31's clinical record revealed: 7/3/24 - R31 was admitted to the facility with diagnoses including, but were not limited to, atrial fibrillation, cognitive communication deficit and adjustment disorder with anxiety. R31's Resident	F 847		

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F 847	Continuec From page 65 Informatic n sheet named F2 (R31's daughter) as her emergency contact #1. 7/5/24 - E17 (admission assistant representative) completed the facility admission documents with R31. R31 signed the legally binding arbitration agreement, which stated, " ... The parties understand and agree that by signing this arbitration agreement, they are giving up and waiving their statutory and constitutional rights to have any claim, including malpractice and wrongful death claims, decided in a court of law before a judge and jury ... If this Agreement is not rescinded within thirty (30) days of the date upon which it is signed, it is binding upon the parties in all matters regarding care and services provided to the resident by the Facility, regardless of subsequent discharges and readmissions ... This agreement does not terminate upon the end of the facility's provision of health care or other services to the Resident or upon termination of any other contract or agreement ...". The facility had R31 sign multiple documents including the Resident Admission agreement, Consent for Treatment and the binding arbitration agreement. 7/10/24 - R31's admission MDS assessment revealed a BIMS score of ten, which was reflective of moderate cognitive impairment. The facility was unable to provide evidence of approaching R31's emergency contact [F2] to review the binding arbitration agreement after determining R31 had a moderate cognitive impairment. This determination occurred just 7 days after R31's admission to the facility and was still within the 30 day window for the binding	F 847		

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F 847	Continued From page 66 arbitration agreement to be rescinded. 1/22/24 - 11:15 AM - During an interview, E1 (NHA) stated that the facility did not have a policy regarding the process/procedure of obtaining consents from resident with impaired cognition/below normal BIMS scores. E1 did confirm that all facility employees must complete training annually on compliance and ethics as part of the facility's corporate compliance program. 1/22/25 3:04 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 847		
F 880 SS=D	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	F 880		3/8/25

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F 880	Continued From page 67 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 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	F 880		

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	085050	A. BUILDING _____ B. WING _____	C 01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

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F 880	Continued From page 68 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 record review, observation and interview, it was determined that for one (R98) out of four residents reviewed for medication administration, the facility failed to ensure the staff wore appropriate PPE while administering R98's medications via her PEG tube. Findings include: Facility's Infection Prevention and Control Policy Program: "It is the policy of [facility] to maintain an Infection Prevention and Control program (IPCP) to provide a safe and sanitary environment and to help prevent the development and transmission of communicable diseases and infections ...". "Prevention/Isolation: Individuals with suspected or diagnosed communicable disease are placed on the appropriate precaution for that disease, as recommended by the Centers for disease Control and prevention (CDC)." Review date: January 2, 2025 3/20/24 - CMS Memorandum (ref QSO-24-08-NH) stated, " ...In 2019, CDC introduced a new approach to the use of personal protective equipment (PPE) called Enhanced Barrier Precautions (EBP) as a strategy in nursing homes to decrease the transmission of CDC-targeted and epidemiologically important MDROs (multi-drug resistant organisms) when contact precautions do not apply ... EBP are used in conjunction with standard precautions and	F 880	F880 Infection Prevention and Control A. Unable to correct the deficient practice. R98 was not adversely affected by this practice. B. All residents with a PEG tube have the potential to be affected by this practice. C. The root cause analysis revealed staff did not follow the protocols for Enhanced Barrier Precautions for a PEG tube. All nurses will be educated by the DON or designee on wearing the appropriate PPE when administering medications via a PEG tube. A review of all residents with a PEG tube was conducted to ensure Enhanced Barrier Precautions are in place. No further issues were identified. D. The DON and/or designee will complete medication administration audits for residents with a PEG tube to ensure proper PPE is being used. Audits will be performed daily or until 100% compliance is achieved for 3 consecutive days. Random audits will continue once weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once	

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F 880	Continued From page 69 expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing... EBP are indicated for residents with any of the following: infection or colonization with CDC-targeted MDRO when contact precautions do not otherwise apply; or wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO ...Indwelling medical device examples include central lines, urinary catheters, feeding tubes and tracheostomies ...". 12/16/24 - R98 was admitted to the facility with diagnoses, including but were not limited to, stroke, swallowing difficulties and S/P percutaneous gastrostomy tube (PEG) in place. 12/18/24 - E27 (MD) ordered in R98's electronic medical record (EMR), " ...Enhanced Barrier precautions r/t (related to) presence of enteral (pertaining to small intestines) tube, history of VRE (vancomycin resistant enterococcus, a MDRO bacteria) and ESBL (extended spectrum beta-lactamase, a MDRO bacteria) ...". The indwelling medical device (feeding tube) and the two CDC-targeted MDROs require the use of PPE for Enhanced Barrier precautions. 1/14/25 11:30 AM - the facility was unable to provide evidence of a specific Enhanced Barrier Precaution policy when requested by the surveyor. 1/15/25 10:11 AM - Surveyor observed E30 (LPN) administer nine medications to R98 via R98's PEG feeding tube during med pas facility task. E30 failed to don the required yellow isolation	F 880	100% compliance is achieved, the deficient practice will be considered resolved. Audit results will be reviewed at the Quality Assurance Committee.	

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F 880	Continued From page 70 gown while accessing R98's indwelling medical device (PEG feeding tube). 1/15/25 10:35 AM - During an interview, E30 (LPN) stated, "...That was high-contact care. You're right. I should have had a yellow gown on...". 1/22/25 3:04 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E8 (Staff Educator), E14 (COO) and E15 (CNO).	F 880		