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

Cambridge Building, 263 Chapman Rd, Suite 200
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Regency Healthcare and Rehabilitatioin Ctr DATE SURVEY COMPLETED: December 15, 2023

STATEMENT OF DEFICIENCIES SECTION	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, complaint, and emergency preparedness survey was conducted at the facility from December 6, 2023 through December 15, 2023. 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 89. The investigative sample totaled 30 residents.	Please refer to the CMS 2567 survey completed 12/15/23: F550, F561, F600, F602, F644, F656, F657, F684, F688, F689, F695.		
3201	**Regulations for Skilled and Intermediate Care 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 December 5, 2023: F550, F561, F600, F602, F641, F644, F656, F657, F684, F686, F688, F689, F695, F812.			

Provider's Signature Brian Mud Title NHA Date 1/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	C 12/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Survey was conducted at this facility from December 6, 2023 through December 15, 2023. The facility census the first day of the survey was 89 residents. In accordance with 42 CFR 483.73, an Emergency Preparedness Survey was also conducted during the same time period. There were no emergency preparedness deficiencies identified based on observation, interviews and document review.	E 000		
F 000	INITIAL COMMENTS An unannounced annual, complaint, and emergency preparedness survey was conducted at the facility from December 6, 2023 through December 15, 2023. 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 89. The investigative sample totaled 30 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DCS - Director of Clinical Services; DON - Director of Nursing; NHA - Nursing Home Administrator; NP - Nurse Practitioner; PA - Physician Assistant; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator;	F 000		

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

Electronically Signed | 01/12/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 UM - Unit Manager; Activities of daily living (ADLs) - tasks needed for daily living, such as dressing, hygiene, eating, toileting, bathing; Anticoagulant - blood thinning medication; Antipsychotic- class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; Bi-pap machine - machine to assist with breathing; BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions) 8-12: Moderately impaired (decisions poor; cues/ supervision required) 13-15: Cognitively intact (decisions consistent/reasonable; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation OR loss of mental functions such as memory and reasoning that interferes with a person's daily functioning; Hoyer lift - a mechanical lift used to assist residents with transfers; Inservice - training intended for those actively engaged in the profession or activity concerned; Lactacted Ringer's - an intravenous fluid given to patient's that helps restore electrolytes and fluid balances; MAR - Medication Administration Record; MDS assessment - federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional	F 000		

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F 000	Continued From page 2 capabilities and health needs; PASARR - Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; PRN - "pro re nata" Latin for as needed; Pulse oximeter - a device used to monitor oxygen levels; Supratherapeutic - a medication dosage that exceeds the therapeutic range, the administration of a drug at a level higher than what is considered optimal for the desired therapeutic effect; Tracheoesophageal - relating to or connecting the trachea and the esophagus; Tracheostomy - A surgically created hole in the throat to assist with breathing; Tracheostomy care - A nursing task that includes cleaning, and changing dressings for the tracheostomy.	F 000		
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	F 550		1/23/24

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F 550	Continued From page 3 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 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 for one (R27) out of four residents reviewed for dignity the facility failed to ensure treatment of R27 with respect and dignity and care. Findings included: Review of R27's clinical record revealed: 5/26/22 - R27 was admitted to the facility with diagnoses including non-Alzheimer's dementia	F 550	A. R27 continues to reside at the facility. There is no opportunity to correct the deficiency. DON or designee will be responsible for corrective action. B. Residents at this facility needing extensive assistance or dependent on care have the potential to be affected by this deficient practice. Audit will perform audit on current resident to assess those that are dependent for incontinence care	

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F 550	Continued From page 4 and arthritis. 5/30/23 - The annual MDS assessment for dressing showed extensive assistance for self-performance and limited assistance for support and functional limitation in range of motion indicated upper and lower extremity impairment on both sides. 12/8/23 at 12:18 PM - Observation while care was being given to R27, the brief being worn underneath the gown was visible from the hallway. The observation was confirmed with E14 (CNA). The facility's failure to ensure the dignity of R27 by not closing the door and or pulling the curtain to provide privacy. 12/15/23 at 3:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E23 (Corporate Risk Manager) and E24 (Corporate Director Clinical Reimbursement).	F 550	have dignity and privacy preserved when care is being provided. C. The root cause analysis indicates that E14 providing care to R27 failed to provide privacy by not closing curtain all the way and by not closing the door, thus resulting in residents brief being visible from the hallway. CNA not aware and did not check to ensure that the curtain was not fully closed around resident thus preventing anyone in the hallway to observe care being rendered. UM and/or designee will perform rounding to ensure nursing staff are compliant with ensuring resident dignity and privacy when providing care to residents dependent for incontinence care. Facility educator or designee will in-service nursing staff by closing curtain and/or door when care is being provided. D. The UM or designee will perform audit of residents undergoing care to ensure dignity is visibly being upheld by door being closed and/or privacy curtain pulled all the way when providing care: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination.	F 561		1/23/24

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F 561	Continued From page 5 The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R27) out of three residents reviewed for choices, the facility failed to ensure the promotion and facilitation of resident self-determination through support of resident choice for bathing. Findings included: Review of R27's clinical record revealed: 5/26/22 - R27 was admitted to the facility with	F 561	A. R27 continues to reside at the facility and is receiving her preferred method of bathing when she desires. There is no opportunity to correct the deficiency. Unit Manager or designee will be responsible for corrective action. B. All residents have the potential to be affected by this deficient practice. The Unit Manager or designee will audit current residents requiring assistance for	

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F 561	Continued From page 6 diagnoses including non-Alzheimer's dementia and arthritis. 5/30/23 - The annual MDS assessment indicated R27's preference of bathing method was very important. It showed that for bathing R27 required total dependence for self-performance and for support physical help limited to transfer only. 10/3/23 - (Initiated 5/31/22) R27 was care planned for personalized care with a goal of accommodating/supporting R27's valued activities in care routine as able. Interventions included a bathing preference for showering. 12/8/23 at 12:41 PM - An interview regarding R27's preference for showering was conducted with E14 (CNA). Per E14, "We (R14 and R27) just talked about that today. [R27] told me today when her shower days were and said she does want to shower on shower days." For R27, the bathing preference was for showering and was scheduled for Tuesdays and Fridays. A review of R27's Documentation Survey Report for June to December 2023 revealed R27 did not receive showers in July or in the first twelve days of December; received one shower in June, September and November; and two showers in August and October. The facility failed to ensure R27 was given her preferred method of bathing. 12/15/23 at 3:00 PM - Findings were reviewed during the Exit Conference with E1 (NHA), E2 (DON), E23 (Corporate Risk Manager) and E24 (Corporate Director Clinical Reimbursement).	F 561	self-performance and functional limitation to ensure bathing preferences are upheld. C. The root cause analysis indicates that the facility failed to ensure showering occurred on scheduled shower days. Alternate methods were documented in POC, but not documented in progress notes to provide information as to why resident received alternated method of showering. Aide failed to communicate to licensed staff as to why resident did not receive her preferred method of bathing and as a result, was not documented accordingly in the progress notes. Facility educator or designee will in-service nursing staff to ensure resident preference for bathing are honored and adhered to. If resident refuses, documentation will reflect such in POC. If resident refuses their preference and accepts an alternate method, aide is to inform licensed staff so that it can be documented accordingly within the progress note. D. The UM or designee will review the shower list and perform audits by communicating with residents during clinical rounds to ensure that they received their preferred method of bathing: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	

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F 600	Continued From page 7	F 600		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation it was determined that for one (R37) out of twelve residents reviewed for abuse, the facility failed to prevent abuse. For R37 sexual abuse by a staff CNA (Certified Nursing Assistant). An immediate jeopardy (IJ) was identified starting on 6/5/23. Due to the facility's corrective measures following the incident, this is being cited as immediate jeopardy, past non-compliance with an abatement date of 6/10/23. R37 had sustained psychosocial harm as R37 was still affected by the abuse. Findings include: A facility policy and procedure titled "Identifying Types of Abuse" documented... "1. As part of the abuse prevention strategy, volunteers, employees, and contractors hired by this facility are expected to be able to identify the different	F 600	Past noncompliance: no plan of correction required.	

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F 600	Continued From page 8	F 600		

types of abuse that may occur against residents... 2. Abuse of any kind against residents is strictly prohibited... 3. Abuse towards a resident can occur as staff to resident abuse... 4. Sexual abuse is non-consensual conduct of any type with a resident... 5. Abuse may result in psychological, behavioral, or psychosocial outcomes."

1. Review of R37's clinical record revealed:

3/8/22 - R37 was admitted to the facility with a diagnosis of stroke, left side weakness, and difficulty in walking.

3/23/23 - R37's annual MDS assessment documented R37 required extensive physical assistance of two staff persons for bed mobility, transfers, dressing, toileting, and personal hygiene. Additionally, R37 required limited physical assistance of one staff person for locomotion on the unit.

6/19/23 - Review of R37's quarterly MDS assessment revealed R37's cognition was intact.

The facility investigation documented the following timeline for R37's allegation of sexual abuse on 6/5/23.

6/4/23 10:57 PM - E21 (CNA) clocked in for the 11:00 PM - 7:00 AM shift for work.

6/5/23 8:00 AM - E21's shift ended.

6/5/23 10:30 AM - R37 reported to E1 (NHA) and E18 (SW) that E21 (CNA) had sexually abused R37 multiple times since a week or two before Mother's Day. In addition, R37 stated, "[R37] was emotionally distraught (distressed) and wanted

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F 600	Continued From page 9 counselling." 6/5/23 11:00 AM - E19 (HR) called E21, during the verbal interview E21 had been suspended pending the facility investigation related to R37's allegation that E21 had sexually abused R37. 6/5/23 10:51 AM - The facility submitted a report to the State of Delaware for a staff to resident allegation of sexual abuse. 6/5/23 1:00 PM - The facility initiated mandatory educations related to abuse, and the importance of staff to resident appropriate conversations and staff to resident relationships. 6/5/23 1:22 PM - E3 (PA) examined and interviewed R37. 6/5/23 1:50 PM - R37's family had been notified by the facility of the allegation of sexual abuse. 6/5/23 2:54 PM - R37 was transported to the hospital for further evaluation and treatment. 6/5/23 4:08 PM - The facility notified the police department. 6/5/23 4:12 PM - R37 had a sexual assault examination performed at the hospital. 6/5/23 4:15 PM - All current residents interviewed to identify concerns related any type of inappropriate sexual behavior from staff. 6/5/23 11:15 PM - R37 was transported back to the facility from the hospital. 6/6/23 1:15 AM - Police officers were dispatched	F 600		

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F 600	Continued From page 10 to the facility to interview R37. 6/7/23 - A care plan initiated for R37 titled "Bedside Care" documented ... "1. Two female staff to always provide care." 12/11/23 11:41 AM - During an interview R37 stated, "E21 had sexual intercourse with [R37] on the weekends when E21 was scheduled to work." In addition, R37 revealed E21 attempted to have R37 perform oral sex on E21. Further into the interview R37 had become emotionally upset and tearful. R37 revealed that the sexual contact with E21 occurred multiple times. 12/11/23 12:32 PM - An interview with E1 revealed being notified of R37's allegation of sexual contact with E21. In addition, E1 revealed R37 reported being in a sexual relationship with E21. 12/12/23 10:42 AM - During a phone interview E21 confirmed, E21 had sexual contact with R37. Additionally, E21 revealed, the sexual contact happened more than one time. 12/13/23 10:06 AM - 10:17 AM - Staff interviews with E13 (Receptionist), E11 (CNA) and E20 (LPN) confirmed staff educations had been provided on different types of abuse, staff to resident appropriate conversations and staff to resident relationships/boundaries. In addition, staff interviewed verbalized indicators of sexual abuse, and the steps of reporting the allegation. Review of the facility's action plan and audits to identify concerns related to inappropriate sexual behaviors from staff continued for four weeks and monthly for three months and until no issues had been identified. Additionally, audit results were	F 600		

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F 600	Continued From page 11 reviewed at weekly QAPI meetings. It has been determined that the facility abated the IJ on 6/10/23. Findings were reviewed during the Exit Conference with E1 (NHA) and E2 (DON) pn 12/15/23 at 3:00 PM.	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R438 & R47) out of three residents reviewed for pain, the facility failed to ensure PRN narcotic pain medications were not inappropriately diverted to an agency nurse on 8/23/23. Due to the facility's corrective measures following the incident, this is being cited as past non-compliance. Findings include: 1. Review of R438's clinical record revealed: 7/25/23 - R438 was admitted to the facility with diagnoses including but not limited to multiple sclerosis and diabetes. 7/26/23 - R438 was ordered Oxycodone (narcotic pain relief medicine) 5 mg (milligrams) by mouth every 6 hours PRN (as needed order) for pain	F 602	Past noncompliance: no plan of correction required.	

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F 602	Continued From page 12 level 5-10. 8/23/23 1:28 PM - E44 (LPN) documented administering oxycodone 5mg by mouth to R438. Review of R438's medication administration record (MAR) by this surveyor revealed R438's pain scale was assessed every shift for the month of August 2023 and 100 percent of the time the pain level was documented as 0. R438 had only 4 doses of oxycodone in the month of August 2023; two of those four doses were administered by E44 on 8/2/23 and 8/23/23. 8/24/23 - E3 (PA) informed E7 (unit manager) of a conversation with R438 in which R438 stated that she had not received any pain meds on Wednesday, 8/23/23 despite E44 documented that he gave oxycodone 5mg on 8/23/23 at 1:28 PM. 8/25/23 - R438's PRN oxycodone pain medication order was discontinued. 10/30/23 - R438's Minimum Data Set (MDS) assessment documented R438's Basic Inventory of mental status (BIMS) score as 15, which was reflective of normal cognition. 12/13/23 9:59 AM - During an interview, E3 stated, "That day (8/24/23) he [E44, LPN] was acting odd, out of character, talking loudly...I know him from other buildings. Then he went into the bathroom with a small bag, if a woman did that I would not think twice about it, but for a guy that was odd...and he came out of the bathroom still acting out of character. I was afraid to leave my bag at the nurses' station ...because I had a script (prescription) pad in it. He used to be a	F 602		

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F 602	Continued From page 13 good nurse when he worked at [another facility]. Then when I spoke with the resident [R438] about her pain medication on the previous day (8/23/23), she typically was not taking pain medicine ... she had a PRN order for oxycodone 5 mg PO every 6 hours as needed so it was unusual that she requested the pain meds the day before (8/23/23). She [R438] denied taking it the day before (8/23/23) but E44 (LPN) had documented that he had given it to her. I reported it to [E7] the Unit manager." 12/13/23 11:09 AM - During a telephone interview, R438 stated when asked about the medications that she received on 8/23/23, "My nurse was a Caucasian male and he wore glasses, not a big man. He gave me some pills. They were trying to get me to have a bowel movement. Then he came back and gave me a clear liquid (lactulose) to make me go. I had a big BM. Didn't request pain medicine. To my knowledge, I was not given any pain medicine. He gave me my meds and made sure I was OK." 2. Review of R47's medical record revealed: 4/5/23 - R47 was admitted to the facility with diagnoses including but not limited to stroke, history of cancer of the larynx and S/P (status post) laryngectomy (removal of the voice box). 7/17/23 - R47's MDS assessment documented a BIMS score as 13, which was reflective of normal cognition. 8/17/23 - E3 (PA) ordered R47, "Percocet 10-325 mg (oxycodone with Tylenol) (narcotic pain relief medicine) give one tab by mouth every 8 hours as needed for pain."	F 602		

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F 602	Continued From page 14 8/23/23 9 AM - E47 signed a [facility] Leave of Absence form stating that she [R47] was out of the facility from 9 AM until 4:30 PM. 8/23/23 12:47 PM - E44 (LPN) documented administering percocet to R47, stating the pain relieve was effective. Review of R47's MAR revealed R47 had a documented pain level of 3 on 8/23/23 by E44 (LPN) on the pain scale but on the PRN percocet order, E44 (LPN) documented R47's pain as a level of 7 and that E44 administered percocet to R47 at 12:47 PM on 8/23/23. Of note, R47 was documented as being out of the facility on a leave of absence with her granddaughter at this time. 8/24/23 4:30 PM - E3 (PA) alerted E49 (former DON) of the possibility of a documentation error vs. possible medication diversion. An investigation was initiated and included a 90 day look back. 8/25/23 - The facility's corrective actions at the time of the incident included: - E44 (agency LPN) was removed from the facility schedule - E44's staffing agency was notified about the investigation - interviews of residents in E44's assignments to assure that residents had not suffered uncontrolled pain - notification of the State agency (DHSS) of a possible medication diversion - notification of the State Board of Licensure when investigation revealed a pattern of more	F 602		

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F 602	Continued From page 15	F 602		

PRN medications being documented as administered for the residents that E44 cared for
- E44 was placed on the company's Do Not Return list so he would not be able to work in any of the company's facilities
- all nurses were educated regarding medication diversion
-audit of all narcotic sheets 30 days prior to date of discovery
-unit managers monitoring with review narcotic sign out sheets weekly and investigation any abnormalities

Correction was verified onsite by review of facility documents and interview with facility staff.

12/13/23 9:44 AM - During an interview, R47 who speaks using a tracheoesophageal voice prosthetic, stated that she remembered speaking to an investigator about this incident. After being shown the 8/23/23 Leave of Absence form, R47 confirmed that was her signature on the form and that she left at approximately 9 AM and returned "close to dinner around 4:30 PM". "My granddaughter was rushing me so I did not get my pain meds (percocet PRN) prior to going." When asked why R47 is prescribed pain medications, R47 stated, "I get pain meds for low back pain ... at the time took it intermittently. Now I get it every day". R47 also denied that she received the pain medication when she returned to the building "but he (E44) was gone by then, I had a different nurse."

12/13/23 12:29 PM - During an interview when asked if he [E1] felt E44 was diverting narcotics, E1 (NHA) stated, "What do you think? He [E44] is not working here anymore. That one lady was not even in the building when he signed out narcotics

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F 602	Continued From page 16 for her." 12/15/23 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E23 (Corporate risk manager) and E24 (Corporate Director of Clinical reimbursement) at the exit conference .	F 602		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R62 & R65) out of three residents reviewed for PASARR, the facility failed to ensure a referral for a new PASARR screening after changes to each resident's diagnoses. Findings include: 1. Review of R62's clinical record revealed:	F 644	A. R62 and R65 continue to reside at the facility. There is no opportunity to correct the deficiency. Social Worker responsible for corrective action has already entered the necessary PASRR. B. Residents with a change in mental status diagnosis from the prior Level 1 review or when the PASARR is no longer	1/23/24

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F 644	Continued From page 17 8/17/22 - R62 was admitted to the facility with diagnoses including but not limited to diabetes, hypertension (high blood pressure) and gait abnormality. 8/17/22 11:09 AM - R62's Preadmission Screening and Resident Review (PASARR) stated "Review Date 7/26/2022 ... Does the individual have a diagnosis of dementia/neurocognitive disorder? Yes. Are the deficits due to dementia/neurocognitive disorder so severe that the individual cannot live in the community because of those deficits? No ... Level I Outcome: No Level II (PASARR) required- no SMI (serious mental illness)/ ID (intellectual disability)". 12/22/22 - R62's PASRR stated "Review Date 12/22/2022 ... Does the individual have a diagnosis of dementia/neurocognitive disorder? Yes. Are the deficits due to dementia/neurocognitive disorder so severe that the individual cannot live in the community because of those deficits? No ... Level I Outcome: No Level II (PASRR) required- no SMI/ ID". 6/7/23 - Vascular dementia was added to R62's medical diagnoses. 1/10/23 - Delusional disorder was added to R62's medical diagnoses. 12/11/23 2:06 PM - During an interview, E22 (social worker) stated,' ... the process for obtaining a PASSAR, typically a PASSAR comes with resident when they come from the hospital (ideally). If not, social work gets it out of the	F 644	an accurate representation of what is going on clinically with the resident, have the potential to be affected by this same deficient practice. Auditing of all residents will be conducted to ensure that any new mental health diagnosis entered beyond the most recently secured PASRR results in a new PASRR being entered into AssessmentPro Maximus portal. C. Root cause analysis is that the Social worker was not notified by the MDS coordinator or nursing that a new mental health diagnosis was given by the physician, so therefore an updated PASARR request was not submitted. MDS coordinator or Nursing leadership did not convey that there was an added mental health diagnoses to the social worker so that an updated PASARR could be done. NHA or designee will in-service Social Services on how and when to resubmit a status change review. Social Services will be given Delaware PASARR Help Desk information at Maximus for questions about the referral process. Staff educator/designee will in-service the IDT to ensure that residents with new mental status diagnosis are discussed in morning clinical meeting for social service to review for possible status change submission. D. DON/Designee will review and conduct daily audits of new orders to determine if there are any new mental health diagnoses that need to be followed up with the Social Worker so that an updated PASARR is submitted. Audits	

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F 644	Continued From page 18 PASSAR app (application). If a new diagnosis occurs while in the facility, social worker gets notified by nursing or MDS coordinator of new order, diagnosis or medication." 12/12/23 - An email communication with P1 (State PASARR Authority) stated, "his [R62] level I outcome from the resident review/significant change in status on 12/22/22 was that there was no PASARR disability present because of the following reason: There is no evidence of a PASARR condition of an intellectual/developmental disability or a serious behavioral health condition. He did not have a PASRR outcome of dementia being primary and progressed. Since this is a new diagnosis of delusional disorder and his dementia has not been determined through PASRR to be primary and progressed in my opinion, a resident review/significant change in status should have been submitted to at least evaluate individual (sic)." 12/14/23 12:30 PM - During an interview, E22 (social worker) confirmed that based on the email from P1 (State PASARR authority), R62 should have had a new PASARR evaluation when the new diagnosis of delusional disorder occurred in January 2023. 2. Review of R65's clinical record revealed: 9/2/21 - A Level 1 PASARR was completed for R65. 8/17/23 - R65's record was updated for diagnosis of anxiety disorder and adjustment disorder with depressed mood. 12/13/23 10:40 AM - A joint interview with E1	F 644	will be conducted: 1) daily until 100% success is achieved over 10 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	

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F 644	Continued From page 19 (NHA) and E4 (SW) confirmed that an updated PASARR evaluation was not completed for R65. The facility failed to ensure that a referral for a PASARR screening was completed following the new diagnosis of anxiety disorder and adjustment disorder with depressed mood. Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON) on 12/15/23 at 3:00 PM.	F 644		
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	F 656		1/23/24

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F 656	Continued From page 20 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R47 and R68) out of five residents reviewed for unnecessary medication review, the facility failed to develop care plans to address the use of antidepressant medication for R47 and R68 and use of anticoagulant medications for R47. Additionally, for one (R68) out of three residents reviewed for respiratory care the facility failed to ensure R68's care plan for respiratory distress included the residents use of a BiPAP machine. Findings include: 2. Review of R68's clinical record revealed; 7/13/23 - R68 was admitted to the facility with multiple diagnoses including chronic obstructive pulmonary disease.	F 656	A. R47 and R68 continue to reside at the facility. Comprehensive care plans were updated by the ADON to reflect use of an antidepressant and anticoagulant medications for R47. Additionally Care Plan was revised to account for the use of antidepressant medication and use of bipap machine for R68. The deficiency has since been corrected. The ADON or designee will be responsible for corrective action. B. Residents with orders for antidepressants and anticoagulant medications as well as residents needing bipap have the potential to be affected by this deficient practice. The DON or designee will audit current residents with	

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F 656	Continued From page 21 7/13/23 - A care plan for potential for respiratory distress was created for R68 related to history of COPD that addressed the residents use of oxygen. 7/14/23 - An order was written for R68 to receive a BiPAP machine at bedtime. 7/19/23 - An admission MDS assessment documented R68 as having an active diagnosis of depression and receiving antidepressant medication and receiving BiPAP machine. Review of R68's care plans lacked evidence of the development of a care plan that addressed the use of a BiPAP machine. During an interview on 12/14/23 at 10:50 AM E2 (DON) confirmed that R68's respiratory care plan did reflect the residents use of a BiPAP machine. Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON) on 12/15/23 at 3:00 PM.	F 656	orders for antidepressant and anticoagulant medications as well as bipap to ensure their respective care plan are updated. C. The root cause analysis indicates that the facility failed to review Physician orders to complete care plans for medications and treatments for R47 and R68 including antidepressant anticoagulant medications as well as use of bipap machines. Facility educator or designee will in-service licensed nursing staff on developing and updating a comprehensive care plan to account for orders of antidepressant and anticoagulant medications as well as use of bipap machine. Care plans will be updated and new orders will be reviewed in clinical meeting. D. The ADON or designee will audit resident orders for antidepressant and anticoagulant medications as well as use of bipap: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	
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-	F 657		1/23/24

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F 657	Continued From page 22 (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it has been determined that for one (R50) out of three residents reviewed for care plans, the facility failed to review and revise the care plan to reflect an identified need. Findings include: Review of R50's clinical record revealed: 9/24/21 - R50 was admitted to the facility with a diagnosis of stroke, left side weakness and cancer of left eye lid. 12/17/21 - Review of R50's care plan for ADL's	F 657	A. R50 continues to reside at the facility. ADON has updated the Care Plan to reflect behavior for nail grooming and toenail care refusal. There is no opportunity to correct the deficiency. B. Residents residing in the facility that refuse ADL care have the potential to be affected by this same deficient practice. An audit of ADL care will be performed to capture any trends of refusals to ensure that Care Plans reflect such. C. The root cause analysis indicated that the facility had a care plan for ADL	

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F 657	Continued From page 23 revised 11/9/23 documented... 1. "Non-adherent with care refusing prescribed medication, treatment orders and labs ... 2. Educate resident about the importance of compliance with treatment plan and medication regimen and labs ... 3. Report refusals to nurse." 12/4/22 - Review of facility provided documentation titled, "Podiatry Progress Note" revealed, R50 had refused treatment for painful mycotic toenails. 9/19/23 - Further review of facility provided documentation titled, "Physician Communication Record" revealed R50's toenails needed to be clipped. Further review of the physician communication record had revealed R50 had not consented to toenail care. 10/27/23 - Review of R50's quarterly MDS assessment documented... "R50 required substantial/maximal assistance with personal hygiene and one staff assist with more than half the effort." 12/6/23 10:45 AM - A random observation revealed R50's right hand fingernails were dirty with dark encrusted debris underneath all five fingernails. In addition, R50's fingernails on the left hand are thickened and very long. Further observations revealed that R50's toenails on the right and left foot were thick and long. 12/7/23 1:06 PM - During an interview and observation E10 (LPN) confirmed that R50 needed nail and toenail care. In addition, E10 revealed R50 had a history of refusing nail and toenail care.	F 657	refusals, but did not specifically include finger/toenail care. Unit Manager or designee will audit current resident care plans to ensure that residents that refuse nail care have a care plan to reflect such behavior. Facility educator and/or designee will in-service licensed nurses will update ADL Care Plans with nail grooming and toenail care refusals after conferring with attending aides. D. Reviews and Revisions of care plans will be completed as needed. When there are any nail grooming and toenail care refusals, they will be documented in progress notes and reviewed in morning clinical meeting to ensure care plan for refusal is in place. Unit Managers or designee will audit current resident care plans: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved to ensure nail care refusals are reflected on Care Plan. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	

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F 657	Continued From page 24 12/7/23 1:24 PM - During an interview E9 (ADON) confirmed R50 had refused to be seen for foot care. The facility failed to update R50's care plan to include refusals of nail grooming and toenail care. Findings were reviewed during the Exit Conference wih E1 (NHA) and E2 (DON) on 12/15/23 at 3:00 PM.	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R46) out of two residents reviewed for hospitalizations, the facility failed to follow the resident's physician's order for monitoring R46's lithium level. This caused a mental status change with a resultant hospital admission with a high serum lithium level of 2.43 resulting in harm to R46. Findings include: 5/25/22 - R46 admitted to the facility with diagnoses including but not limited to stroke with left-sided weakness, post-traumatic stress disorder (PTSD) and bipolar disorder.	F 684	A. R46 continues to reside at the facility. There is no opportunity to correct the deficiency. DON or designee will be responsible for corrective action to ensure lab draws are verifiably completed. B. Resident requiring serum lithium levels have the potential to be affected by this deficient practice. All residents with lab orders for serum lithium levels will be reviewed at morning Clinical meeting and ensuring that any missed opportunities are addressed by end of business day. C. Root cause analysis indicates the lab technician failed to comply with	1/23/24

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F 684	Continued From page 25 7/11/23 - E2 (DON) entered a verbal order from E17 (MD) for lithium 300 mg by mouth every 12 hours for bipolar disorder with a serum lithium level to be drawn on 7/17/23. E17 also ordered lab (laboratory) work (CBC -complete blood count and CMP- complete metabolic profile) on 7/12/23 and 7/17/23. 7/12/23 10:48 AM - R46's lab work included a serum lithium level of < 0.3 along with the results of his CBC and CMP. The facility was unable to provide evidence/results of lab work including a serum lithium level that was drawn on 7/17/23. 7/17/23 - E17's (MD) progress note documented, "... HPI (history of present illness)... I started pt (patient) on lithium and olanzapine due to aggression and behaviorial disturbances...Plan: 1.Bipolar 1 disorder -...check lithium, BMP (basic metabolic panel) in 3 months (October)...". There was no mention in the note of a current lithium level. R46 was seen and evaluated by E3 (PA) on 7/19/23, 7/20/23 and 7/21/23. These notes documented, "Patient was started on lithium and olanzapine recently" and "Patient had recent medication change for bipolar and now is on lithium." However, there was no mention in any of the three notes of R46's current serum lithium level. 7/24/23 10:44 AM - E17's progress note documented, "...Pt aggressive behavior is controlled on current regimen of lithium and olanzapine. Last Lithium level is unremarkable...Plan: 1. Bipolar 1 disorder -...	F 684	Physicians order and that the reconciliation process did not capture the missed lab draw subsequently resulting in the Physician not being informed. The Facility Educator and/or designee will in-service licensed nurses regarding the importance of having lab draws completed as ordered. In servicing to include: use of new lab worksheets that will be documented on when lab is scheduled to be drawn; lab sheets will be printed from the lab portal to ensure that they both match; lab technician was previously in-service on this new process; ADON or designee will compare daily lab ordered with labs drawn for completeness and accuracy. D. Nursing Administration will conduct review of lab orders at morning meeting and at end of day wrap-up to confirm draws have verifiably been completed: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	

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F 684	Continued From page 26 check lithium, BMP in 3 months (October)...". The note did not document the date or result of R46's last lithium level. Despite R46 being evaluated by two different providers on five different dates between 7/17/23 and 7/24/23, neither provider inquired or documented about R46's ordered 7/17/23 serum lithium level that had not been obtained nor was a dated serum lithium level result included in any of the five notes. 7/24/23 - R46's Monthly Medication Review (MRR) documented the resident's record was "reviewed but did not require any recommendations". 7/26/23 - R46 was admitted to the hospital for change in mental status and found to have a supra-therapeutic (a level higher than what is considered optimal for the desired therapeutic effect) lithium level of 2.43. The laboratory normal serum (blood) lithium level was 0.6 to 1.2 mmol (millimoles) /L (liter). Documentation from the Emergency department, "given the significantly elevated lithium level, [R46] will be given lactated Ringer's (intravenous fuids) bolus and patient will require hospitalization for further observation especially of his mental status and vital signs." 7/26/23 3:00 PM - In R46's Emergency Medicine notes from the hospital, C4 (Emergency room DO) documented," ... Notified by the lab the patient (R46) with critically elevated lithium level at 2.43. Per our (hospital) lab standards, upper limit of normal is 1.2 mEq (milliequivalent)/ L (liter). Confirmed with staff at [facility] that the patient began to (sic) the medication 15 days ago ...There is no reported interval history of volume	F 684		

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F 684	Continued From page 27 losses from vomiting or diarrhea. Given the significantly elevated lithium level, will be given lactated Ringer's bolus and patient will require hospitalization for further observation especially of his mental status and vital signs ..." 7/26/23 7:18 PM - In R46's hospital History & Physical (H&P), C5 (Internal Medicine MD) documented, " ... Treatment Plan and Disposition: Altered mental status- likely secondary to supra-therapeutic dosage of lithium. As per papers from [facility], patient placed on lithium 2 weeks ago for his bipolar order (sic) with a dosage of 300 mg every 12 hours ...". 8/2/23 - Per psychiatry recommendation, his lithium was resumed on 8/2/23 at a lower dosage (150 mg twice daily) once his lithium level was within normal range. 8/3/23 -R46 was discharged back to the facility. R46 was hospitalized for eight days to monitor of his lithium level. 12/12/23 1:31 PM - During an interview, E2 stated that when a doctor gives a verbal order, the nurse confirms the order in Point Click Care (PCC) and then for lab work, the nurse enters the order in the [laboratory] website. "When the doctor types the order in PCC, the order is listed as pending until the nurse confirms the order." E2 then furnished copies of the lab requisitions for the 7/12/23 and 7/17/23 lab draws from the [laboratory] website. When asked why the labs from 7/17/23 were not drawn, E2 replied, " ...well, you know you are dealing with someone who refuses care a lot."	F 684		

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F 684	Continued From page 28 When asked what should happen if a resident refuses, E2 stated, ..." The labs would be rescheduled." When asked if there should be a note documenting the refusal, E2 replied,"yes". The facility was not able to furnish any evidence that the provider was notified that R46 did not have his lab work (lithium level) drawn on 7/17/23. 12/12/23 1:18 PM - During a telephone interview, C1 ([laboratory] account manager) stated, "I can see the requisition and there was a req for lab work on 7/17/23. I cannot see that the req was put in the binder. There is no way for me to tell if the req was printed and placed in the binder under the correct date. Our techs are told to come to the building and take the reqs (requisitions) in the binder for that day and draw those labs. I looked in both in the computer and the phone app to see if there is any documentation of refusal, I am not seeing any. Labs were drawn on 712/23 at 11:12 AM. On the 7/17/23 lab order, it says COMPLETE in our system." C1 stated that he thinks the ordered labs for 7/17/23 were completed on 7/12/23. C1 asked, "Is there a chance that that all 3 reqs were placed in the binder under 7/12? Yes, but I cannot say that definitely. All I can concretely say is that labs were drawn on 7/12 and no labs were drawn on 7/17." 12/12/23 1:44 PM - During a follow up interview, E2 confirmed that there should be a note documenting R46's refusal (if he refused to have labs drawn) and that the provider was notified. E2 also stated, "Normally, they (the lab) put in their app (application) that the resident refused but that is not listed in his record for that day.	F 684		

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F 684	Continued From page 29 12/12/23 3:15 PM - E2 provided a copy of the [laboratory] log which documented that the 7/17/23 labs were ordered and documented as "complete" without being drawn. "So the error was on the lab personnel." 12/13/23 10:42 AM - During an interview, C2 (Phlebotomist) who was in R46's room drawing labs, "If a resident refuses lab draws, we document it in out app (Lab Gen) and the nurse has to sign her name on the app." C2 stated that the surveyor could get a copy of that day's reporting from the [laboratory] office. 12/13/23 12:33 PM - During an interview, E3 (Physician Assistant) stated, "We (the providers) order standing set labs (for drug monitoring) once a resident is stable on the medication. I like three lab levels that are in normal range to say they are stable on the medication. For a patient that we just started on a med, we order the lab level and then respond to that level ... if the level is low, we increase the medicine and get a new level in 6 to 8 weeks." 12/14/23 11:44 AM - During a telephone interview, C3 (PharmD) confirmed that she did perform R46's MRR on 7/24/23. When questioned about medications that require serum level monitoring, C3 stated, "Yes, I usually try to recommend interval monitoring (lab levels) on drugs that require monitoring. I would write it on my monthly recommendation." 12/14/23 12:27 PM- During a telephone interview, E17 (MD) confirmed that he ordered the lithium 300 mg PO every 12 hours with lab levels on 7/12 and 7/17. E17 stated that the only way he tracks	F 684		

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F 684	Continued From page 30 lab results is from seeing them posted in PCC. "The facility has a way to communicate with the lab that we do not have access to." With regard to monitoring, E17 stated, "we try to order levels when we initiate the drugs but a lot can change in this population- they refuse the med, get sick have kidney failure so we order the levels at times that we feel are appropriate. We try to get levels once or twice a year. The pharmacist is good about reminding us in their monthly recommendations." 12/15/23 3 PM - Findings were reviewed with E1 (NHA), E2 (DON), E23 (Corporate risk manager) and E24 (Corporate Director of Clinical Reimbursement) at the exit conference.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for one (R27) out of three residents reviewed for pressure ulcers, the	F 686	A. R27 continues to reside at the facility. There is no opportunity to correct the deficiency. Unit Manager or designee will	1/23/24

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F 686	Continued From page 31 facility failed to ensure a resident received care, consistent with professional standards of practice, to prevent pressure ulcers. Findings included: Review of R27's clnical record revealed: 5/26/22 - R27 was admitted to the facility with diagnoses including non-Alzheimer's dementia arthritis, severe protein calorie malnutrition, and diabetes. 5/30/23 - The annual MDS (Minimum Data Set) assessment indicated for bed mobility extensive assist. The MDS documented a stage four pressure ulcer that was present upon admission to the facility. The BIMS (Brief Interview for Mental Status) score was 15 indicating "sufficient judgement, planning, organization, self-control, and the persistence needed to manage the normal demands of the environment." 10/3/23 - R27's care plan documented that R27 admitted with a sacral wound and risk for further breakdown noted related to: immobility and incontinence. Interventions included turned and repositioned every two hours. (Date initiate 6/7/22). The care plan also documented [R27] was non-adherent with care as evidenced by: refusing to be repositioned in bed. (Date initiated 6/1/23). Interventions included: encourage compliance with repositioning schedule (Date initiated 6/1/23); explain benefit of repositioning (Date initiated 6/1/23); report refusals to nurse (Date initiated 6/1/23); and return at later time and offer shower again. (Date initiated 6/1/23). The care plan also included a focus of R27 being at risk for skin breakdown related to decreased mobility, history of wounds, incontinence. (Date	F 686	be responsible for corrective action. B. Residents dependent on bed mobility and incontinence care have the potential to be affected by this deficient practice. DON or designee will audit current residents' with orders to turn and reposition every 2 hours to ensure all staff are aware of who needs to be turned and repositioned to prevent potential for recurrent skin breakdown has verifiably been completed. C. Root cause analysis indicates resident frequently refuses for positon change which she is care planned for. Aide taking care of resident did not turn or reposition her for more than 2 hours. Aide did not communicate to licensed staff that the resident refused turn and repositioning so that it could be appropriately documented. Facility Educator and/or designee will in-service licensed nurses regarding the importance of turning and repositioning residents as ordered to prevent potential for skin breakdown. Additionally, educator will in-service the nursing staff on the importance of communication between aide and licensed staff when it pertains to resident refusal. In the event of any refusals, aide will inform licensed staff so that documentation within the progress note can then be entered. D. Nursing Administration and licensed nurses will conduct random timed audits to confirm turning and repositioning are verifiably completed for the residents who are dependent for bed mobility and incontinence care: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success	

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F 686	Continued From page 32 initiated 1/5/23; revision date 3/6/23). The goal was [R27's] wounds would show no signs of worsening. (Date initiated 1/5/23; revision date 9/29/23). Interventions included turning and repositioning, assess skin and monitor pressure points every two hours. Report any changes to nurse. (Date initiated 11/3/23). 11/29/23 - The quarterly MDS for R27 showed substantial/maximal assist for rolling left to right. The BIMS score was 14 indicating "sufficient judgement, planning, organization, self-control, and the persistence needed to manage the normal demands of the environment." 12/12/23 - From 10:36 AM to 1:15 PM, R27 was continuously observed lying on the back with a pillow under each side of the upper body. When R27 was asked if turning had been done today R27 replied, "No", because of just awakening. 12/13/23 - R27's skin evaluation from 12/13/23 documented no current skin issues. An observation of R27's sacral area on 12/13/23 revealed no open areas and barrier ointment was being applied to the sacrum. 12/14/23 at 12:24 PM - R27 was observed lying on the right side. 12/14/23 at 2:50 PM - R27 was observed lying on the right side. The finding was confirmed with E25 (RN, ADON). The facility failed to ensure R27 was turned and repositioned every 2 hours which increased the potential for recurrent skin breakdown. 12/15/23 at 3:00 PM - Findings were reviewed	F 686	is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	

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F 686	Continued From page 33 during the Exit Conference with E1 (NHA), E2 (DON), E23 (Corporate Risk Manager) and E24 (Corporate Director Clinical Reimbursement).	F 686		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined for one (R37) out of one resident reviewed for range of motion (ROM) the facility failed to ensure the resident received the ordered foot brace to prevent a decline in range of motion. Findings include: The facility policy on resident mobility and range of motion last updated July 2017 indicated, "Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility...".	F 688	A. R37 continues to reside at the facility. There is no opportunity to correct the deficiency. ADON or designee will be responsible for corrective action. B. Residents with brace orders have the potential to be affected by this deficient practice. ADON or designee will audit current residents' with brace orders have devices applied as ordered to prevent a decline in range of motion and if resident refuses, such instances will be documented in the Electronic Medical	1/23/24

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F 688	Continued From page 34 Review of R37's clinical record revealed: 3/18/22 - R37 was admitted to the facility with multiple diagnoses including weakness and paralysis affecting the left side. 10/20/23 - A therapy order was written by E8(RD) for R37 to wear left foot brace at night on after evening care, off after morning care for foot drop as tolerated. 10/20/23 - A care plan for alteration in mobility requiring restorative nursing program related to decreased strength upper and lower extremities was updated to include the intervention for R37 to wear left foot brace at night on after evening care off after morning care. October 20 - 31 2023 - Review of CNA documentation revealed 5/11 evenings that R37's left foot brace was not applied and not refused. November 2023 - Review of CNA documentation revealed 20/30 evenings that R37's left foot brace was not applied and not refused. During an interview on 12/14/23 at 3:23 PM E45 (CNA) an evening CNA who has been assigned to R37 more than once confirmed that she does not apply R37's leg brace. E45 stated, "She wears a brace during the day time, I haven't seen a brace for at night". During an interview on 12/14/23 at 3:27 PM E8 (RD) explained, "At night she wears it so that the top of the foot more comfortable and it keeps in a neutral position".	F 688	Record. C. Root cause analysis indicates nursing staff did not consistently offer donning and doffing of left foot brace or document refusals properly. Licensed nurse did not verify that brace was in place Facility Educator and/or designee will in-service licensed nurses regarding the importance of applying braces to prevent a decline in range of motion. Facility educator will also in-service nursing staff on proper documentation in POC. D. Nursing Administration and licensed nurses will conduct audits to confirm braces ordered are being verifiably being applied to prevent potential for skin breakdown: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	

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	085012	A. BUILDING _____ B. WING _____	C 12/15/2023

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F 688	Continued From page 35 During an interview on 12/14/23 at 3:57 PM with R37 it was reported that the evening staff was not applying the residents brace. When asked if R37 was given an explanation why staff did not apply the brace when requested R37 stated, "They say no, that therapy should be doing it and that they shouldn't have to." R37 permitted the surveyor to visualize the brace, which was located in the second drawer of the nightstand, on the right side of drawer nearest to the window. During an interview on 12/15/23 at 10:12 AM E47 (CNA) confirmed that R47 was not wearing a brace E47 began providing morning care. During an interview on 12/15/23 at 10:19 AM E46 (LPN) a day shift nurse who has been assigned to R37 more than once confirmed that she has not had to remove R37's brace in the mornings. E46 stated that R37 "has nothing on her legs in the morning, I go in and apply her stockings". During an interview on 12/15/23 at 10:21 AM E7 (LPN) and unit manager on R37's unit reviewed R37's CNA documentation related to application of the left foot brace in the evening. E7 confirmed the brace was documented as not applied and explained that "Nurses are supposed to make sure" that R37's brace is applied in the evening. E7 confirmed she was unaware the brace was not being applied and clarified that resident refusals of the brace are documented. December 2023 - Review of CNA documentation revealed 6/14 evenings that R37's left foot brace was not applied and not refused. Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON) on	F 688		

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F 688	Continued From page 36 12/15/23 at 3:00 PM.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R3) out of three residents reviewed for falls the facility failed to ensure adequate supervision to prevent falls when R3 was transferred with one staff member instead of two during the use of a mechanical lift/Hoyer lift. Findings include: The facility policy on using a mechanical lift last updated July 2017, indicated at least two nursing assistants are needed to safely move a resident with a mechanical lift. Review of R3's clinical record revealed: R3's care plan for potential for (actual) falls related to poor safety awareness last reviewed 10/19/23, included the intervention for R3 to transfer with Hoyer lift assistance of two staff. 11/11/23 10:39 AM - A statement written by E3 (CNA) documented, "I was placing [R3] into the sling and while I start cranking up the lift I instructed her to hold on which she didn't comply	F 689	A. R3 continues to reside at the facility. There is no opportunity to correct the deficiency. ADON or designee will be responsible for corrective action to ensure there are two team members when operating a mechanical lift to safely move a resident. B. Audit was conducted to determine the residents requiring use of mechanical lift . Residents requiring the use of mechanical lift have the potential to be affected by this deficient practice. C. Root cause analysis indicates that the aide acted alone when utilizing a mechanical lift for resident transfer and disregarded facility procedure and protocol. ADON or designee will audit current residents' with orders for mechanical lift to ensure order is written to utilize two team members. Facility Educator and/or designee will in-service licensed nurses regarding the requirement of utilizing two team	1/23/24

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F 689	Continued From page 37 to leaning all the weight on her bad side as I seen her slipping down. I lowered the lift to the floor and got an aide and nurse we assessed the situation and pulled her into the bed". 11/11/23 11:43 AM - A nurses note in R3's clinical record documented, "Nurse was alerted that resident had an incident. Nurse assessed that resident was lowered to the floor. Vital [signs] taken 116/91 heart rate 79 pulse oxygen 97% on room air. Resident was assisted back into bed and denies pain at this time. Family was notified at 11:14 AM and on call service made aware at 11:26 AM. No further actions taken". During an interview on 12/15/23 at 1:49 PM E2 (DON) confirmed that E32 transferred R3 using a mechanical lift without the assistance of another staff member. During an interview on 12/19/23 at 11:45 AM E32 (CNA) confirmed that transferring R3 using a mechanical lift alone, without the assistance of a second person. Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON) on 12/15/23 at 3:00 PM.	F 689	members when using a mechanical lift to prevent a fall and safely move a resident. D. Nursing Administration and licensed nurses will conduct audits to confirm mechanical lifts are being utilized correctly with two team members present to prevent potential for a fall to a resident: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		1/23/24

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F 695	Continued From page 38 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for two (R47, R68 and R83) out of three residents reviewed for respiratory care the facility failed to ensure respiratory care was provided as ordered when R83 was suctioned without continuous oxygen level monitoring. Additionally, the facility failed to ensure the nebulizer mask/tubing for R47 were changed, dated and placed in a zip-lock plastic bag for storage. Findings include: The facility policy for suctioning of the tracheostomy tube last updated 2023 documented, "apply pulse oximetry, asses oxygen saturation, respirations, and heart rate. Maintain pulse oximeter in position throughout the procedure". 1. Review of R83's clinical record revealed: 9/6/23 - R83 was admitted to the facility with a tracheostomy tube and multiple diagnoses including chronic respiratory failure. 9/6/23 - A physicians order was written for R83 to receive endotracheal suctioning for increased congestion with continual pulse oximeter monitoring every shift and as needed. During an observation endotracheal suctioning on 12/13/23 at 9:04 AM, E20 (LPN) was observed suctioning R83. Following removal of the suctioning device E20 then applied a pulse oximeter to R83s left index finger. When asked whether it was appropriate to monitor R83's	F 695	A. R47 and R83 continues to reside at the facility. There is no opportunity to correct the deficiency. DON or designee will be responsible for corrective action. B. Residents with tracheostomies have the potential to be affected by this deficient practice. Resident receiving PRN nebulizer treatments have the potential to be affected by this deficient practice. ADON or designee will audit current residents to identify with tracheostomy and who require tracheal suctioning have continuing oxygen monitoring performed throughout procedure. In addition, they will also audit residents to identify those with nebulizer treatment orders. C. Root cause analysis indicates that the nurse who performed tracheostomy care did not use continuous pulse oximetry monitoring throughout procedure. Mistakenly she only applied the pulse oximetry at the end of the procedure. Resident respiratory status was stable at that juncture. Resident nebulizer mask/tubing were not changed weekly secondary to it to being a PRN order. Employee thought since it was only used once it could be saved and was unaware that it could be placed into a plastic bag. Facility Educator and/or designee will in-service licensed nurses regarding the importance of continuous oxygen monitoring when performing tracheostomy care and tracheal suctioning as outlined in the procedure. Facility educator will	

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F 695	Continued From page 39 oxygen continually during the procedure, E20 stated, "I usually do it between procedures". 12/13/23 9:31 AM - E20 and the Surveyor reviewed R83's physicians orders and E20 confirmed that pulse oximeter monitoring should be continuous during suctioning. 2. R47's clinical record revealed: 4/5/23 - R47 was admitted to the facility with a diagnosis of chronic obstructive pulmonary disease and cancer of the larynx (voice box). 8/16/23 2:47 PM - A physician's order written for R47 documented... "1. Albuterol Sulfate Inhalation Nebulization Solution 2.5mg/3ml (milligrams) (milliliters) 0.083% (Albuterol Sulfate) one vial inhale orally every six hours as needed for shortness of breath and wheezing." 12/6/23 1:34 PM - A random observation revealed R47's nebulizer mask and tubing had not been stored in a zip-lock plastic bag. Additional observations identified that the mask and tubing had not been dated. Further review of R47's physician medication and treatment orders lacked an order to change and date R47's nebulizer equipment weekly. 12/6/23 1:38 PM - During an interview E10 (LPN) stated, "the night shift is supposed to change R47's nebulizer mask/tubing weekly." E10 accompanied the Surveyor to R47's room. E10 confirmed that R47's tubing had not been changed and then proceeded to change the nebulizer mask/tubing. Additionally, E10 dated the equipment and stored it in a zip-lock plastic	F 695	in-service the need to date and change nebulizer tubing and mask weekly and place them in a plastic bag regardless of PRN order. Randomly timed audits with impacted individuals will ensure conformity and successful adherence to the weekly changing of the nebulizer tubing and mask. D. Nursing Administration and licensed nurses will conduct random audits to confirm changing of nebulizer tubing and mask as well as oxygen monitoring being continuously observed during tracheostomy care and tracheal suctioning: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	

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F 695	Continued From page 40 bag. 12/8/23 2:01 PM - During an interview, E1 (NHA) said, "there is not a policy and procedure for changing a resident's respiratory mask and other related respiratory equipment. E1 stated, "[R47] should have an order entered to change the nebulizer equipment." Findings were reviewed during the Exit Conference with E1(NHA) and E2 (DON) on 12/15/23 at 3:00 PM.	F 695		