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: Excelcare at Newark LLC

DATE SURVEY COMPLETED: April 1, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found to not be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/29/26 to 04/01/26 Survey Census: 80 Sample Size: 42 Supplemental Residents: 7	Cross Refer to the CMS 2567-L survey completed April 1, 2026: F578, F609, F610, F657, F689, F761 and F812.	05/12/2026
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 April 1, 2026: F578, F609, F610, F657, F689, F761 and F812.		

Provider's Signature Rhonda DeLuca Title Administrator Date 4/22/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085025	A. BUILDING B. WING	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCELCARE AT NEWARK LLC	4949 OGLETOWN-STANTON ROAD , NEWARK, Delaware, 19713

(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
E0000	Initial Comments A Recertification Emergency Preparedness survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found to be in substantial compliance with 42 CFR 483.73. Survey Dates: 03/29/26 to 04/01/26 Survey Census: 80 Sample Size: 42 Supplemental Residents: 7	E0000		05/13/2026
F0000	INITIAL COMMENTS A Recertification and Complaint Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found to not be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 03/29/26 to 04/01/26 Survey Census: 80 Sample Size: 42 Supplemental Residents: 7	F0000		04/14/2026
F0812 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	F0812	1. After staff became aware, staff obtained and put on hair restraints in replacement of actual beard restraint, due to beard nets not in the facility 2. To ensure residents are protected, staff with facial hair will continue to wear beard restraints, when beard restraints are not available, staff will wear a	05/12/2026

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 reverse for further 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.

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

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F0812 SS = F	Continued from page 1 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure the kitchen was maintained in a sanitary manner, putting 78 residents who received meals from the kitchen (2 residents received nutrition via feeding tubes) out of 80 total residents at potential risk for unsanitary meal services. Findings include: 1. During an observation and interview on 03/29/26 from 9:25 AM through 10:28 AM, with the Dietary Manager (DM) revealed two Dietary Aides (DA) 1 and DA2 were observed not wearing beard/hair restraints while engaged in food preparation and dishwashing activities. The DM confirmed the two DAs were not wearing beard/hair restraints. 2. During an observation and interview with the DM on 03/31/26 from 8:55 AM through 11:36 AM, during the meal serving line revealed, DA1 and DA3 were not wearing beard/hair restraints. The DM stated beard/hair restraints should be worn at all times. The DM stated the facility was out of beard/hair restraints.	F0812	Continued from page 1 hair net. 3 RCA determined staff not following facility's protocol for operating the kitchen sanitation policy. Staff believed wearing a surgical mask would be sufficient. Also, the Food Service Director had ordered beard restraints, the FDS was notified by the supplier that the beard restraints were on back order. The staff should have replaced beard restraint with a hair net. A sign has been placed on the beard restraint dispenser to instruct staff, if a beard restraint is not available, a hair net is to be warn until beard restraint is available, it will also remind staff that a beard restraint is to be warn at all times. Staff Developer/designee to re-educate kitchen staff on facility's protocol for operating the kitchen, in a sanitary manor, to include wearing beard restraint. When beard restraints are not available, staff can replace them with a hair net until a beard restraint is available. 4. FSD/designee will conduct kitchen inspections to monitor facility's sanitation protocol, comprehensive sanitation audits, and to include the wearing of a beard restraint. Audits will be conducted daily for four weeks, followed by weekly audits for four weeks and monthly audits for two months. Audit results will be reported to the monthly QAPI committee until 100% compliance is achieved and maintained for three months. with immediate corrective action as indicated.	05/12/2026
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F0761	1. During survey, when nursing staff were made aware, the Medication Carts were locked.	05/12/2026

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F0761 SS = E	Continued from page 2 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility policy review, the facility failed to ensure medications were stored in a secure manner to prevent unauthorized access when two of five medication carts were left unattended and unlocked. This deficient practice had the potential to affect all residents, staff, and visitors placing them at risk for unauthorized access to medications. Findings include: 1. During an observation on 04/01/26 at 4:53 AM revealed the medication cart was unlocked on the West Hall in front of room W102. Licensed Practical Nurse (LPN)4 was in the room with privacy curtain pulled. The medication cart was not visible from the room. There was one staff member Certified Nursing Assistant (CNA)4 down hall delivering linen to another room. At 4:59 AM LPN4 returned to the medication cart and secured it. She confirmed medication cart was left unlocked and could not be visualized from the resident's room. 2. During an observation on 04/01/26 at 5:56 AM revealed the medication cart at the nurses station was unlocked. The Assistant Director of Nursing (ADON) walked past the unlocked medication cart	F0761	Continued from page 2 2. To ensure residents do not have access to the Medication carts, they will remain locked or turned away to face the wall when staff are away from the cart. 3 RCA determined staff were not following "Storage of Medication "policy, by not locking the carts or turning the carts to face the wall when not in use. Staff Developer/designee to re-educate nursing staff on facility's protocol for locking medication carts when not in use, via the "Storage of Medication "policy. The staff developer will educate upon orientation and during annually competencies. 4. Unit Manager/Supervisor/designee will conduct audits to monitor locked carts Audits will be conducted daily for four weeks, followed by weekly audits for four weeks and monthly audits for two months. Audit results will be reported to the monthly QAPI committee until 100% compliance is achieved and maintained for three months. with immediate corrective action as indicated. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is achieved for three consecutive months.	05/12/2026

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F0761 SS = E	Continued from page 3 twice. At 6:00 AM the ADON went down the East Hall leaving no one at the nurses' station and the medication cart remained unlocked. At 6:05 AM the ADON returned to the nurses station locked the medication cart. During an interview on 04/01/26 at 6:05 AM with ADON revealed the medication cart at nurses station was shared by both nurses on the West and East Halls. She revealed it was an expectation that all medication and treatment carts when not in use must be kept locked. Review of the facility's policy titled "Storage of Medication" revised November 2020 revealed that compartments containing drugs and biologicals are locked when not in use. Unlocked carts should not be left unattended.	F0761		05/12/2026
F0578 SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or	F0578	1. R19 and R11 have been provided with written information regarding advanced directives. 2. Any residents that are currently in the facility and future admissions to the facility have the potential to be affected. All residents who remain in the facility will have their medical record reviewed to ensure they have evidence of written information regarding advanced directives in the medical record. Any deficiencies identified through the lookback were corrected and documented as applicable. Advanced Directives Acknowledgement Form was implemented to record written information provided to resident/family. 3 The RCA determined the staff were not aware of the Advanced Directive policy on written notification at the time of admission to residents/families. The staff developer/designee will educate the Social	05/12/2026

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F0578 SS = D	Continued from page 4 articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure residents received written information regarding advanced directives and the right to accept or refuse medical and surgical treatments for two residents of two residents (Resident (R) 19 and R11) reviewed for advanced directives out of a total sample of 42. This failure places the residents at risk of not understanding their rights and options regarding care. Findings include: 1. Review of R19's "Admission Record," located under the "Profile" tab in the electronic medical record (EMR), revealed R19 admitted on 06/01/22 with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side and , major depressive disorder. Review of R19's quarterly "Minimum Data Set (MDS)," with an assessment reference date (ARD) of 02/20/26 and located under the "MDS" tab of the EMR, revealed R19 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating she was cognitively intact. Review of R19's EMR revealed no evidence to indicate R19 received written information regarding advanced directives. 2. Review of R11's "Admission Record," located under the "Profile" tab of the EMR, revealed R11 re-admitted to the facility on 06/22/25 with diagnoses including heart failure, stage three chronic kidney disease, malignant neoplasm of upper lobe, left bronchus, and pain. Review of R11's quarterly "MDS," with an ARD of	F0578	Continued from page 4 Workers and Admission staff on the Advance Directive Policy and newly created from. Going forward, any additional staff hired in Social Services and/or admissions will be educated during orientation. 4 The NHA/designee will audit all new admissions to ensure that all residents/families have documented notification of advanced directive and that the completed Advanced Directive Acknowledgement Form is in the medical record. Audits will be conducted daily for four weeks, followed by weekly audits for four weeks and monthly audits for two months. Audit results will be reported to the monthly QAPI committee until 100% compliance is achieved and maintained for three months. with immediate corrective action as indicated.	05/12/2026

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F0578 SS = D	Continued from page 5 01/29/26 and located under the "MDS" tab of the EMR, revealed R11 had a "BIMS" score of 12 out of 15, which indicated moderately impaired cognition. Review of R11's EMR revealed no evidence to indicate R11 received written information regarding advanced directives. During an interview on 10/30/26 at 10:35 AM, the Social Service Director (SSD) stated she did not have any written information that she provided to residents regarding the distinct types of advanced directives. There was no signature page to indicate a verbal explanation was provided or to indicate the residents understand they have the right to accept or refuse medical and surgical treatments. During an interview on 04/01/26 1:45 PM, the Admissions Director (AD) stated there was only one page in the admission packet that asked if a resident had an advanced directive or if they would like to formulate one. She stated she did not have any written information defining the types of advanced directives to provide residents with upon admission. During an interview on 04/01/2026 at 1:50 PM, the Administrator stated she was not aware of the regulatory guidance to provide written information regarding advanced directives and the right to accept and or refuse medical and surgical treatment to residents. She was not aware that her policy indicated this would be done. Review of the facility policy titled, "Advanced Directives," revised November 2025 revealed, ". . . The resident has the right to formulate and advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. . .Providing the Resident with Written Information Concerning Advance Directives: . . . (2) Written information is provided in a manner easily understood by the resident or representative. . ."	F0578		05/12/2026
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations	F0609	1. Resident R11 is no longer in the facility Once identified as an allegation of abuse, the State Survey Agency was notified prior to survey	05/12/2026

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F0609 SS = D	Continued from page 6 involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of facility policy, the facility failed to report an allegation of sexual abuse to the State Survey Agency (SSA) within the required two hour timeframe for one resident (Resident (R)110) out of 11 residents reviewed for abuse out of a total sample of 42 residents. This failure had the potential to delay a timely investigation and the implementation of appropriate protective measures, placing resident safety at risk and increasing the potential for further abuse. Findings include: Review of R110's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted on 09/10/25 with diagnoses of cognitive communication deficit, and mild cognitive impairment. R110 discharged from the facility on 09/25/25. Review of R110's 5-day Entry "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/17/25 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R110 was cognitively intact. Review of the "Grievance/Concern Form" dated 09/18/25 and provided by the facility revealed	F0609	Continued from page 6 2. Any Resident with Reported Grievance/concern forms have the potential to be affected. Review of all grievance/concern forms completed over the past 30 days will be reviewed to determine if any allegations need to be reported to the State Survey Agency. Reports and investigations will be conducted according to regulation. 3. The RCA determined that the staff conducting the investigation failed to recognize the Resident's statement as an allegation of verbal abuse. The grievance form did not indicate an allegation of sexual abuse, the grievance from the son indicated a verbal statement from the staff member that was viewed as customer service vs verbal abuse. Add to the grievance policy, the grievance form, it will be noted to hand deliver directly to the Administrator, in the absence of the administrator, deliver directly to the highest ranking in the facility, i.e. DON, ADON, Supervisor, to review within 2 hours for the potential for abuse. The staff developer/designee will re-educate staff across all departments on abuse policies, including reporting allegations. Staff will be instructed when receiving a grievance with an allegation or potential allegation of abuse to be given directly to the administrator, in the absence of the administrator; grievances will be given directly to the next highest ranking in administration, DON, ADON, Staff Developer, etc. 4. The NHA/designee will audit within two hours of notice to the Administrator/DON, all reported events that could be interpreted as abuse and taken to determine if an allegation needs to be reported to the State Survey Agency. Additionally, all grievances will be reviewed daily, for	05/12/2026

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F0609 SS = D	Continued from page 7 R110's son called to report that "sometime this week a male aide come into his mom's room in the middle of the night stating he needed to check if she was wet. Patient refused. A little later aide came back again and she refused"... (missing second page). Review of the facilities "Investigation Report" dated 09/22/25 and provided by the facility indicated R110's assigned Certified Nursing Assistant (CNA)13 made an inappropriate verbal remark directed toward R110. Further review of the investigation report revealed that the CNA stated, "you don't know what you are missing." Review of the "Incident Tracking Form" provided by the facility dated 09/22/25 at 8:21 PM revealed the following "A police officer arrived at the facility and informed staff that they had received a complaint from a resident's family alleging that the resident may have been spoken to in a manner that was uncomfortable for her. Per the resident, the male staff who was assigned to her care said "You don't know what you are missing" when she refused incontinent care..." During an interview on 03/30/26 at 4:03 PM, the Admissions Director (AD) stated that she had received a telephone call from R110's son on 09/18/25 who stated a male staff member entered his mother's room to provide incontinent care for R110 who refused and then the male retuned again and the male aide made a comment which made R110 feel uncomfortable with the comment. Further interview with the AD she stated that immediately after concluding the telephone conversation with R110's son she informed the Director of Nursing (DON) of the R110's son's concern. The AD also stated that the facilities protocol is to immediately notify the Administrator and the DON of all grievance and abuse concerns. During an interview on 03/30/26 at 4:26 PM with the DON stated that she did not remember receiving the Grievance/Concern form related to R110's son's concerns. The DON further stated that she learned about the alleged abuse was on 09/22/25 when a Police Officer went to the facility after receiving an allegation of abuse at the facility. The DON further stated that she initiated the investigation on 09/22/25. The DON stated that the SSA should have been notified on 09/18/25 after immediately following the R110's son's grievance concerns. During an interview on 03/30/26 at 4:30 PM with the Administrator/Abuse Coordinator revealed she was	F0609	Continued from page 7 4 weeks at stand-up to determine if there are trends requiring further education. After 4 weeks, a weekly audit will be conducted. Then monthly until 100% compliance for 3 months. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is achieved for three consecutive months.	05/12/2026

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F0609 SS = D	Continued from page 8 not aware of R110's sons grievance concerns as she was out on leave. The Administrator confirmed that alleged violations involving abuse should have been reported to the State SSA within two hours after the allegation was made. During a second interview with the DON on 03/31/26 at 8:52 AM the DON confirmed that the SSA was notified of the abuse allegation on 09/22/25 four days after the R110's grievance allegation. The DON further stated that it is the facility's policy to report alleged violations involving abuse to be reported to the SSA within two hours after the allegation was made. CNA13 was unable to be interviewed as he was on vacation during the survey. Review of the facility's policy titled, "Abuse/Neglect-Exploitation Mistreatment and Misappropriation of Property Prevention," dated 06/15/25, revealed it was the policy of the facility that each resident be free from verbal, sexual, physical, and mental abuse, and mistreatment. The policy indicated that alleged violations involving abuse were to be reported to the State Survey Agency within two hours after the allegation was made.	F0609		05/12/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by:	F0610	1. Resident R110 is no longer in the facility Once identified as an allegation of abuse, the State Survey Agency was notified prior to survey 2. All residents who have a report event have the potential to be affected. The facility will review alleged abuses cases investigated over the past 30 days for thoroughness. The facility will obtain statements as indicated. 3. The RCA was determined to be that the facility failed to follow the facility's "Investigation Report" policy.	05/12/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0610 SS = D	Continued from page 9 Based on record review, interview, and policy review, the facility failed to conduct a thorough investigation of an abuse allegation for one resident (Resident R110) out of 11 residents reviewed for abuse out of a total sample of 42 residents. This deficient practice placed residents at risk for ongoing abuse and failed to ensure residents' safety. Findings include: Review of R110's "Face Sheet" located in the electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted on 09/10/25 with a diagnosis of cognitive communication deficit and mild cognitive impairment. The resident was discharged from the facility on 09/25/25. Review of R110's 5-day Entry "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/17/25 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated R110 was cognitively intact. Review of the "Grievance/Concern Form" dated 09/18/25 and provided by the facility revealed R110's son called to report that "sometime this week a male aide came into his mom's room in the middle of the night stating he needed to check if she was wet. Patient refused A little later the aide came back again and she refused"..., (missing second page). Review of the facilities "Investigation Report" dated 09/22/25 provided by the facility indicated R110's assigned Certified Nursing Assistant (CNA) 13 made an inappropriate verbal remark directed toward R110 after the resident refused an incontinence check/change. Further review of the investigation report revealed that the male CNA had stated, "you don't know what you are missing." Although the facility conducted resident interviews receiving care provided by the alleged male CNA, the interview process lacked specifics to the allegation. Interview questions were general in nature (e.g., whether residents had concerns or complaints or if the CNA had been inappropriate), and did not include targeted questions related to potential sexual abuse, such as inappropriate sexual remarks, unwanted touching, or sexual advances. Questions asked to the residents provided care by the alleged CNA were: 1. Have you had any concerns or complaints with your 11-7 CNA... 2. Has ... (11-7 CNA ever been inappropriate or spoken to you inappropriately? No other questions were documented.	F0610	Continued from page 9 It was determined that staff conducting the investigation failed to recognize the Resident's statement as an allegation of verbal abuse. The grievance form did not indicate an allegation of sexual abuse, the grievance from the son indicated a verbal statement for the staff member that was viewed as customer service vs verbal abuse. Add to the grievance policy, the grievance form, it will be noted to hand deliver directly to the Administrator, in the absence of the administrator, deliver directly to the highest ranking in the facility, i.e. DON, ADON, Supervisor, to review within 2 hours for the potential for abuse. The Staff Developer/designee will re-educate the staff that conduct facility investigations on the "Investigation Report" policy to include interviewing other residents and staff, as well as follow up questions to the reporter. Staff will be instructed when receiving a grievance with an allegation or potential allegation of abuse to be given directly to the administrator, for review of completion and directed questions relating to the allegation; in the absence of the administrator; grievances will be given directly to the next highest ranking in administration, DON, ADON, Staff Developer, etc. 4. The NHA/designee will conduct weekly audits on allegations to monitor for thoroughness to Include interviews from other staff and residents. Audits will be conducted daily for four weeks, followed by weekly audits for four weeks and monthly audits for two months. Audit results will be reported to the monthly QAPI committee until 100% compliance is achieved and maintained for three months. with immediate corrective action as indicated.	05/12/2026

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F0610 SS = D	Continued from page 10 Review of Troop 2 "State Police Report" dated 09/23/25 and provided by the facility revealed "the victim reports that she may have been touched inappropriately by a staff member while he was checking her...." Review of the typed statement by the Social Services Director (SSD) dated 09/22/25 indicated that the SW had spoken with R110 and indicated that R110 explained that about 4:00 AM the week prior the aide went into her room to check her "diaper" left the room and then returned and stated, "you don't know what you missed." The typed statement indicated R110 was asked if she felt safe in the facility and the resident replied, "it was hard to answer." No other questions were documented. Review of the typed statement by the SSD dated 09/23/25 indicated the SSD had spoken with R110 and asked if R110 felt safe in the facility the resident's response was documented as "right now talking with you, yes". No further questions were documented on the written statement. Review of a typed interview dated 09/23/25 conducted with the roommate of R110 revealed the roommate was asked the following question: "Can you tell me if you heard or know of any problem with A bed and her male CNA on the 11 to 7 shift?" No other questions regarding the alleged allegations were asked to R110 or documented. In a typed statement dated 09/25/25 indicated the SSD was following up with R110 to ask how R110 was feeling and doing. The statement indicated R110 stated she was "happy as can be..." It is also documented that the SSD asked the resident felt safe in the facility and the resident replied, "I feel safe now because I am going."(sic) No further questions were documented on the written statement. During an interview on 03/30/26 at 4:03 PM with the Admissions Director (AD) stated she was not aware that the second page of the Grievance/Concern report was missing. The AD further stated that she did not have a copy of the second page of Grievance/Concern Form dated 09/18/25. The AD also stated that she did not keep a copy of the Grievance/Concern report and did not keep any documentation regarding the grievance called in by R110's son. The AD stated that she gave Grievance/Concern to the Director of Nursing (DON) immediately following the call with the resident's son.	F0610		05/12/2026

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F0610 SS = D	Continued from page 11 During an interview on 03/30/26 at 4:26 PM with the DON stated she did not remember receiving the Grievance/Concern report and did not know the second page of the Grievance/Concern dated 9/18/25 was missing. The DON further stated that she learned about the alleged abuse on 09/22/25 when a Police Officer went to the facility after receiving an allegation of abuse at the facility and initiated the investigation. During an interview on 03/30/26 at 4:30 PM with the Administrator/Abuse Coordinator the Administrator revealed she were not aware of R110's sons grievance concerns as she was out on leave. The Administrator also stated she did not know that the second page of the Grievance/Concern Form was missing and stated she would try to locate the missing page. During a follow up interview with the DON on 03/31/26 at 4:46 PM revealed that a skin assessment was completed on R110 on 09/22/25 per her instruction and there were no positive findings of abuse. The DON also stated that the male assigned CNA was re-assigned and was not to enter the resident's room. Additionally, the DON stated that other residents assigned to the male CNA had no complaints reported. The DON stated that the male CNA was interviewed and denied touching the resident inappropriately and denied making the comment "you don't know what you're missing" after R110 refused the incontinence check. The DON stated that per policy the male CNA was suspended pending the investigation. During a follow-up interview 04/01/26 at 1:30 PM with the Administrator/Abuse Coordinator the Administrator revealed she was unable to find the missing second page of the Grievance/Concern Form. CNA13 was unable to be interviewed as he was on vacation during the survey. Review of the facility's policy titled, "Abuse/Neglect -Exploitation Mistreatment and Misappropriation of Property Prevention," dated 06/16/25, revealed "...under VII. Reporting/Response: indicates "When an allegation or suspicion of one of the activities set out in the definitions herein occurs the facility shall: 2. Have evidence that all alleged violations are thoroughly investigated...."	F0610		05/12/2026

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F0657 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. (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 interviews, record reviews, and facility policy review, the facility failed to ensure care plans were revised to accurately reflect the resident's code status for two of two residents (Resident (R) 19 and R11) reviewed for care planning out of a total sample of 42. This failure had the potential to cause residents to not receive appropriate care and treatment. Findings include: 1. Review of R19's "Admission Record," located under the "Profile" tab in the electronic medical record (EMR), revealed R19 admitted on 06/01/22 with diagnoses including hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, major	F0657	1. R19 and R11 have had their care plans updated to include the correct code status 2. Al residents have the potential to be affected. All resident care plans and code status will be audited. All code status care plans will be corrected as appropriate. 3. The RCA was determined to be that the facility failed to follow the facility's "Care Plans, Comprehensive Person-Centered" policy by updating the care plan by Nursing Management or the Social Worker during care plan meeting of updated code status change, the team also failed to change the care plan when the physician changed the code status order. Residents due for quarterly/annual/ new admission/re-admission will have their care plan reviewed and updated as appropriate. The Social Worker will add a review of the code status as an additional item to document at all care plan meetings. The Staff Educator/Designee will educate the DON, ADON, Admitting Nurse, Unit Managers, Social Workers and the care plan team on updating the code status upon quarterly/annual/ new admission/re-admission 4. The DON/designee will audit care plans weekly for any resident with a quarterly/annual/ new admission/re-admission to ensure care plan has the correct code status documented in the medical records. The audits will be conducted, Weekly x 4 weeks then biweekly for 2 months and then monthly x 2 months. Results will be reviewed in monthly QAPI meeting until 100% compliance is achieved for 2 months.	05/12/2026

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F0657 SS = D	Continued from page 13 depressive disorder, chronic obstructive pulmonary disease (COPD), and pain in thoracic spine. The "Admission Record," indicated R19 was a "Full Code". Review R19's quarterly "Minimum Data Set (MDS)," with an assessment reference date (ARD) of 02/20/26 and located under the "MDS" tab of the EMR, revealed R19 had a "Brief Interview for Mental Status (BIMS)" score of 15 of 15, indicating she was cognitively intact. Review R19's Physician Orders," dated March 2026 and located under the "Orders" tab of the EMR, revealed R19 was a "Full Code." Review of the "Care Plan," initiated on 06/01/22 and located under the "Care Plan, tab of the EMR, revealed ". . . Psychosocial Well-Being: Advance Directive: DNR [do not resuscitate] . . ." 2. Review R11's "Admission Record," located under the "Profile" tab of the EMR, revealed R11 re-admitted to the facility on 06/22/25 with diagnoses including heart failure, stage three chronic kidney disease, malignant neoplasm of upper lobe, left bronchus, and pain. Review R11's quarterly "MDS," with an ARD of 01/29/26 and located under the "MDS" tab of the EMR, revealed R11 had a "BIMS" score of 12 out of 15, which indicated moderately impaired cognition. Review of R11's "Physician Orders," dated March 2026 and located under the "Orders" tab of the EMR revealed R11 was a "Full Code". Review of R11's "Care Plan," dated 06/07/23 and located under the "Care Plan" tab of the EMR, revealed ". . . Psychosocial Well-Being: Advance Directive: DNR. . ." During an interview and record review on 03/31/26 at 9:37 AM, Licensed Practical Nurse (LPN) 2 verified the care plan should not indicate R19 and R11 had a DNR status and confirmed the orders indicated the resident were a full code. LPN2 stated the nurses and unit managers usually updated the care plans. During an interview on 03/31/2026 at 11:32 AM, the Assistant Director of Nursing (ADON) confirmed the	F0657		05/12/2026

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F0657 SS = D	Continued from page 14 care plans were not correct for R19 and R11 and did not reflect the current code status. The ADON stated the nurses and unit managers usually updated the care plans. Review of the facility policy titled, "Care Plans, Comprehensive Person-Centered," revised March 2022, revealed, ". . . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. . .11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition changes. . ."	F0657		05/12/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that one (Resident (R)8) of four residents reviewed for falls was safely transferred using a Hoyer (mechanical lift) out of a total sample of 42 residents. This failure has the potential to cause the resident to sustain an injury. Findings include: Review of R8's "Admission Record" located in the electronic medical records (EMR) under the tab titled "Profile" revealed the resident was initially admitted to the facility on 09/08/11 with diagnoses that included cerebrovascular disease with hemiplegia and hemiparesis, abnormalities of gait, and falls. Review of R8's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 02/13/26 located in the EMR under the "MDS" tab revealed the resident had a "Brief Interview for Mental Status" (BIMS) score of 12 out 15 points,	F0689	1. · R8 requires assistance from two staff members for transfers while using mechanical lift. CNA7 was immediately educated by the Staff Developer on the use of a mechanical lift with two people for assistance 2. · All residents requiring a mechanical lift for assistance from two staff members for transfers may be affected. · A facility-wide audit will be conducted by the Staff Developer to assess staff while using the mechanical lift for transfers, has two people. 3. · The RCA determined that employee CNA7 did not follow proper number of staff while using the mechanical lift, as she was unable to find another staff to assist according to the policy. A systemic change was developed to include a "buddy" system. Each C.N.A will be partnered with another C.N.A. to assist with residents requiring a two person assist.	05/12/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F0689 SS = D	Continued from page 15 which indicated the resident had moderately impaired cognition. The resident was assessed as being totally dependent on staff for activities of living (ADLs) care needs. The resident was assessed to require transfers with a Hoyer lift. Review of R8's "Care Plan" with a revision date of 10/22/24 located in the EMR under the "Care Plan" tab revealed the resident required two staff members for bed mobility and Hoyer lift transfers. During an observation 04/01/26 at 10:30 AM revealed Certified Nursing Assistant (CNA)7 used the Hoyer lift by herself to transfer R8 from the bed to a shower stretcher so the resident could be taken to the shower room. CNA7 had to reposition the lift several times to move the lift closer to the stretcher. The resident was swinging the lift sheet holding onto the lift with his good arm. During an interview on 04/01/26 at 1:57 PM with Licensed Practical Nurse (LPN)3 revealed CNA7 had already reported that she had failed to have another staff member present while transferring the resident from the bed to shower stretcher. LPN3 stated the resident was care planned to have two staff members present for bed mobility and transfer. The LPN stated she assumed another staff member was in the room assisting CNA7. During an interview on 04/01/26 at 2:00 PM CNA7 revealed she found it difficult to get someone to help as everyone was busy. CNA7 stated she knew the resident required two persons to assist; she knew what she did was wrong that why she did a self-report.	F0689	Continued from page 15 Staff Developer/Designee will educate all Nursing staff on the use of mechanical lift, to include the system change of a "buddy" system, also to include, if "buddy" is unavailable seek out Unit Manager/Supervisor. The Staff Developer includes Hoyer lift training, the use of two persons when using Hoyer lift in orientation and during annual competencies, the staff developer will now add the "buddy" system to both trainings. 4. The Staff Developer/Designee will conduct daily audits of staff using the Hoyer lift to ensure there are two persons, audits will continue until 100% compliance is achieved for three consecutive weeks. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. Finally, the facility will conduct a monthly audit until 100% compliance is maintained. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is maintained for three consecutive months.	05/12/2026