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: Delaware Hospital for the Chronically Ill **DATE SURVEY COMPLETED:** January 9, 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. An unannounced Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware at this facility from January 4, 2026, through January 9, 2026. The deficiencies contained in this report are based on observations, interviews, and review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was (seventy-four) 74. The investigative sample totaled (twenty-eight) 28 residents.		02/23/2026
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 January 9, 2026: F641, F656, F689, F695, F700, F755, F803, F880 and F883.	**3201.1.2** Cross Refer to the CMS 2567-L survey completed January 9, 2026: F641, F656, F689, F695, F700, F755, F803, F880 and F883.	

Provider's Signature Geraldine Stewart Title Hospital Director Date 2/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	**100 SUNNYSIDE ROAD , SMYRNA, Delaware, 19977**

(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
F0880 SS = D	Continued from page 30 Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff wore appropriate Personal Protective Equipment (PPE), specifically disposable gowns, and gloves, during the administration of medication through a percutaneous endoscopic gastrostomy (PEG) tube for one (Resident (R)27) of 10 residents who had PEG tubes. This deficient practice resulted in a risk of contamination and the potential spread of infection to the patient and other residents. Findings include: Review of R27's "Admission Record" located under the "Profile" tab of the Electronic Medical Record (EMR), revealed R27 was admitted on 07/06/18 with a diagnosis of gastrostomy status. Review of R27's "Minimum Data Set (MDS)" located under the "MDS" tab of the EMR, with an "Assessment Reference Date (ARD)" of 12/19/25 revealed R27 received nutrition through feeding tube. During an observation on 01/08/26 at 9:20 AM, Licensed Practical Nurse (LPN)1 administered medication to R27 through her PEG tube, and LPN1 did not wear PPE. There was no signage located on R27's door that indicated the resident was on Enhanced Barrier Precautions (EBP). During an interview on 01/08/26 at 9:20 AM, LPN1 revealed she thought the use of PPE was only for providing treatments to the resident such as cleaning the PEG tube area. LPN1 confirmed she should have worn PPE during the PEG tube medication administration. During an interview on 01/09/26 at 12:29 PM, with the Infection Preventionist (IP)2 and the Director of Nursing (DON), IP2 confirmed staff are to wear PPE during medication administration with a PEG tube resident. DON confirmed staff were trained to wear PPE and recently had a skills fair that addressed wearing PPE with residents who had PEG tubes. Review of the facility policy titled, "Enhanced Barrier Precautions and Isolation Procedures (Contact Precautions)" dated 12/31/25 revealed "Policy/ Position Statement:" ... "The facility shall utilize Standard Precautions, Enhanced Barrier Precautions (EBP), and Transmission Based Precautions, (e.g., Contact Precautions) as clinically indicated to prevent, identify, contain, and control infectious disease, including multi-drug-resistant organisms (MDROs). Precautions will be implemented using the least	F0880		

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F0880 SS = D	Continued from page 31 restrictive approach necessary to protect residents, staff, visitors, and others, while maintaining residents' rights, dignity, psychosocial well-being, and quality of life..."	F0880		
F0883 SS = E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;	F0883	F883 The facility failed to offer five (5) of eight (8) residents reviewed for pneumonia vaccinations and/or their representatives, the opportunity for the residents to be vaccinated in accordance with nationally recognized standards. The Director of Nursing (DON) and other designated staff reviewed the medical records, pharmacy records, and DelVax immunization records of all residents identified by the survey for pneumococcal vaccination status. Residents found not to be up to date were assessed for eligibility and contraindications of the pneumococcal vaccination. The residents or legal representatives were educated regarding the pneumococcal vaccine and consents or declinations were obtained. Vaccines were offered and administered accordingly. The medical record was updated to reflect the administration of the Prevnar 20 to accurately reflect each resident's vaccination status as of 01/29/2026. Residents who declined the vaccine had refusal documented per facility policy. All residents have the potential to be affected by this deficient practice. The DON and other designated staff conducted a facility-wide audit of all residents to verify pneumococcal vaccination status. This included review of the electronic medical record, paper medical records, and DelVax. Residents found not to be up to date with the pneumonia vaccine were assessed for eligibility and contraindications. The residents or legal representatives were educated regarding the pneumococcal vaccine and consents or declinations were obtained. Vaccines were offered and administered accordingly. The medical record was updated to reflect the administration of the Prevnar 20 to accurately reflect each resident's vaccination status. Residents who declined the vaccine had refusal documented per facility policy. The root cause of this deficient practice is staff's failure to follow the facility's policy on verifying the resident pneumococcal vaccination status on	02/23/2026

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F0883 SS = E	Continued from page 32 (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer five of eight residents (Residents (R) 20, R21, R22, R11, and R57) reviewed for flu/pneumonia vaccinations and/or their representatives, the opportunity for the residents to be vaccinated in accordance with nationally recognized standards of 28 sample residents. This practice had the potential to increase the risk for this resident to contract pneumonia. In addition, the facility policy did not reflect current CDC recommendations. Findings include: 1. Review of R20's electronic medical record (EMR) titled "Admission Record" located under the profile tab indicated the facility admitted the resident on 01/24/25. The resident was over the age of 55 at the time of his admission. Review of R20's EMR titled "Immunization" located under the "Immun (Immunization)" tab failed to indicate that the resident received a pneumococcal vaccine. There was no evidence in the clinical record that the resident and/or his representative were given the opportunity to receive the PCV20 or the PCV21. 2. Review of R21's EMR titled "Admission Record" located under the "Profile" tab indicated the facility admitted the resident on 02/21/24. The resident was over the age of 65 at the time of his admission. Review of R21's EMR titled "Immunization" located under the "Immun" tab failed to indicate that the resident	F0883	Continued from page 32 admission or routinely after admission. The facility revised its policy regarding pneumonia vaccinations requiring assessment for pneumonia vaccination on admission, readmission, and annually. The Medical Director and Infection Preventionist will verify pneumococcal vaccination status on admission and routinely thereafter. Medical providers, pharmacy, and nursing staff were educated by the Trainer Educator II or designee on the facility's revised policy, Protocols for Vaccinations, which includes vaccine schedules and eligibility for the vaccine, documentation of administration, and refusals and contraindications by February 14, 2026. The Infection Preventionist or designee will conduct monthly audits of pneumococcal vaccination documentation and vaccination status of 30 percent of residents who are reviewed by the Interdisciplinary Team (IDT) the prior month using Pneumococcal Vaccine Audit Tool (Attachment #1). The audit will be completed until 100% compliance is achieved for four (4) consecutive months. Then, the audit will be completed every other month until 100% compliance is achieved for two (2) consecutive audits. Then, the facility will conclude that we have successfully addressed this deficient practice and achieved compliance. Audit results will be reviewed during Quality Assurance and Performance Improvement (QAPI) meetings. Any identified issues will result in immediate corrective action and additional staff education as needed.	

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F0883 SS = E	Continued from page 33 received a pneumococcal vaccine. There was no evidence in the clinical record that the resident and/or his representative were given the opportunity to receive the PCV20 or the PCV21. 3. Review of R22's EMR titled "Admission Record" located under the "Profile" tab indicated the facility admitted the resident on 09/21/16. The resident was 55 years of age at the time of her admission. Review of R22's EMR titled "Immunization" located under the "Immun" tab indicated the resident received (Pneumovax23) PPSV23 on 12/26/16. There was no evidence in the clinical record that the resident and/or her representative were given the opportunity to receive the PCV20 or the PCV21. 4. Review of R11's EMR titled "Admission Record" located under the "Profile" tab indicated the facility admitted the resident on 12/30/08. The resident turned 55 years of age during his stay at the facility. Review of R11's EMR titled "Immunization" located under the "Immun" tab indicated the resident received the PPSV23 on 03/13/15. There was no evidence in the clinical record that the resident and/or her representative were given the opportunity to receive the PCV20 or the PCV21. 5. Review of R57's EMR titled "Admission Record" located under the "Profile" tab indicated the facility admitted the resident on 04/16/08. The resident turned 65 years of age during his stay. Review of R57's EMR titled "Immunization" located in the "Immun" tab indicated the resident received the PPSV23 on 09/10/15. There was no evidence in the clinical record that the resident and/or his representative were given the opportunity to receive the PCV20 or the PCV21. Review of a document provided by the facility and referred to as a pharmacy report indicated that in 2023 four residents received the PCV20 vaccination. In 2024, two residents were identified who received the PCV20 vaccination. Finally, in 2025 two residents were identified who received the PCV20 vaccination. During an interview on 01/06/2026 at 11:49 AM, the Pharmacist stated the facility ordered the PCV20 in 2025 and would need to run a report which identified how often the PCV20 was ordered. During an interview on 01/06/26 at 1:02 PM, the	F0883		

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F0883 SS = E	Continued from page 34 Director of Nursing (DON), who was also the facility's Infection Preventionist (IP)1, confirmed the facility failed to offer the PCV20 vaccine to the following residents: R20, R21, R22, R11, and R57. During an interview on 01/07/2026 at 1:56 PM, the Medical Director stated there had been no communication regarding the pneumococcal vaccines for the residents for at least six months. The Medical Director stated that he has not updated the facility's policy on the current CDC recommendations. Review of the CDC website titled "PneumoRecs VaxAdvisor App (Application) for Vaccine Providers" dated 01/15/25 indicated ". . . Administer PCV15, PCV20, or PCV21 for all adults 50 years or older. . .Who have never received any pneumococcal conjugate vaccine. . .Whose previous vaccination history is unknown. . . Based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both. . .PCV13 (but not PCV15, PCV20, or PCV21) at any age and . . . PPSV23 at or after the age of 65 years old. . ." Review of a facility policy titled "Protocols for Influenza and Pneumococcal Vaccinations" dated 02/08/23 indicated ". . . It shall be the policy for the Long-Term Care Sector of the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD)to have a standardized procedure/protocol for administering vaccinations. . . Pneumococcal Conjugate Vaccine (PCV13} is recommended for all adults 65 years or older. . .Pneumococcal Polysaccharide Vaccine (PPSV23) is recommended for all adults 65 years or older. . ."	F0883		

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E0000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 01/04/26 through 01/09/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		02/06/2026
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 and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. The facility's Administrator was notified on 01/07/26 at 6:40 PM that Immediate Jeopardy existed related to the failure to assess and monitor three residents (R5, R6, and R71) who smoked. The Immediate Jeopardy began on 01/07/26 at 6:40 PM when the three residents were identified with upper extremity impairments. The facility failed to supervise these three residents while they smoked. Residents with impaired upper extremity impairments may have difficulty handling cigarettes, which would increase the likelihood of burns and death of the residents and/or others. On 01/08/26 at 3:01PM, the facility provided an acceptable Immediate Jeopardy Removal Plan. The survey team verified the implementation of the facility's IJ Removal Plan on 01/09/26 at 11:30 AM and notified the Director of Nursing that the Immediate Jeopardy had been removed. After the removal of the Immediate Jeopardy the deficiency remained at a scope and severity (S/S) of an "E," potential harm. Survey Dates: 01/04/26 to 01/09/26 Survey Census: 74 Sample Size: 28 Supplemental Residents: 3	F0000		02/06/2026
F0641 SS=D	Accuracy of Assessments	F0641	F641	02/23/2026

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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F0641 SS = D	Continued from page 1 CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, review of the Centers for Disease Control and Prevention (CDC) guidelines, and review of the Resident Assessment Instrument (RAI) Manual, the facility failed to ensure three of eight residents (Resident (R) 22, R57, and R11) out of 28 sampled residents had an accurate "Minimum Data Set (MDS)" assessment. Failure to code the "MDS" correctly could potentially lead to inaccurate federal reimbursements and inaccurate assessment and care planning of the residents. (Cross Reference F883)	F0641	Continued from page 1 The facility failed to have an accurate MDS assessment for three out of eight residents. The Director of Nursing (DON) and Infection Preventionist reviewed the medical records, pharmacy records, and DelVax immunization records of all residents identified by the survey as inaccurately coded for pneumococcal vaccination status for three out of eight residents. Residents found not to be up to date for pneumococcal were assessed for eligibility and contraindications. The residents or legal representatives were educated regarding the pneumococcal vaccine, and consents or declinations were obtained. Vaccines were offered and administered accordingly. The MDS and medical records were corrected to accurately reflect each resident's vaccination status as of 01/28/2026. Residents who declined the vaccine had refusal documented per facility policy. All residents have the potential to be affected by this deficient practice. The DON and Infection Preventionist conducted a facility-wide audit of all residents to verify pneumococcal vaccination status. Multiple sources (medical records, pharmacy records, and DelVax immunization records) were used to confirm vaccine history. The vaccination status was compared to the MDS coding, any discrepancies identified were corrected promptly, and appropriate clinical action was taken. The root cause of this deficient practice is there was not a process to verify the resident pneumococcal vaccination status prior to the completion of the MDS. The facility revised its immunization review process to require verification of pneumococcal vaccination status prior to MDS completion. Multiple sources (medical records, pharmacy records, and DelVax immunization records) will be used to confirm vaccine history. In addition, the facility has began to submit vaccination records into DelVax. Medical providers, pharmacy, nursing, and MDS staff	

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F0641 SS = D	Continued from page 2 Findings include: 1. Review of R22's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab, revealed the facility admitted the resident on 09/21/16. Review of R22's EMR titled quarterly "MDS" located under the "MDS" tab with an Assessment Reference Date (ARD) of 12/12/25 indicated the staff could not determine the resident's "Brief Interview for Mental Status (BIMS)" score. The assessment revealed that the resident was up to date on her pneumococcal vaccine. Review of R22's EMR titled "Immunizations" located under the "Immun (Immunization)" tab indicated the resident received the PPSV23 on 12/26/19. There was no evidence that the resident or her representative was offered the PCV13 prior to the age of 55 or the PCV20 or the PCV21 after the age of 55. 2. Review of R57's EMR titled "Admission Record" located under the "Profile" tab revealed the facility admitted the resident on 01/31/18. Review of R57's EMR titled "Immunization" located under the "Immun" tab indicated the resident received the PPSV23 on 09/15/15. There was no evidence that the resident or his representative was offered the PCV13 during his stay at the facility. There was no evidence that the resident or his representative was offered the PCV20 or the PCV21 during his stay when the resident turned 65 years of age. Review of R57's EMR titled quarterly "MDS" located under the "MDS" with an ARD of 10/31/25 indicated the resident had a "BIMS" score of 12 out of 15 which revealed the resident was moderately cognitively impaired. The assessment revealed that the section that identifies if the resident was offered a pneumococcal vaccine or was up to date with the pneumococcal vaccine was blank. 3. Review of R11's EMR titled "Admission Record" located under the "Profile" revealed the facility admitted the resident on 12/30/08. Review of R11's EMR titled "Immunization" located under the "Immun" tab indicated the resident received the PPSV23 on 03/03/15. There was no evidence that the resident or his representative was offered the PCV13 during his stay at the facility. There was no evidence	F0641	Continued from page 2 were re-educated by the Trainer Educator II or designee on the facility's Protocols for Influenza and Pneumococcal Vaccinations policy by February 14, 2026. This includes accurate documentation and MDS coding of pneumococcal vaccines, and proper documentation of refusals and contraindications. The facility will utilize the PneumoRecs VaxAdvisor App for Vaccine Providers. MDS coordinators will co-ordinate with medical providers to verify accuracy before MDS submission. Medical providers will review immunization documentation for accuracy for new admission, quarterly reviews, and annual history and physicals. The Infection Preventionist or designee will conduct weekly audits of pneumococcal vaccination documentation and MDS coding of 30 percent of residents who are reviewed by the Interdisciplinary Team (IDT) the prior week using Pneumococcal Vaccine Audit Tool (Attachment #1). The audit will be completed until 100% compliance is achieved for four (4) consecutive weeks. Then, the audit will be completed monthly until 100% compliance is achieved for three (3) consecutive months. Then, the facility will conclude that we have successfully addressed this deficient practice and achieved compliance. Audit results will be reviewed during Quality Assurance and Performance Improvement (QAPI) meetings. Any identified issues will result in immediate corrective action and additional staff education as needed.	

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F0641 SS = D	Continued from page 3 that the resident or his representative was offered the PCV20 or the PCV21 during his stay when the resident turned 55 years of age. Review of 11's EMR titled quarterly "MDS" located under the "MDS" tab with an ARD of 12/05/25 indicated the resident had a "BIMS" score of nine out of 15 which revealed the resident was moderately cognitively impaired. The assessment revealed that the resident was up to date on his pneumococcal vaccine. During an interview conducted on 01/08/25 at 10:35 AM, the MDS Coordinator (MDSC)1 and MDSC2 were present. MDSC1 stated that she looked into each residents' clinical record to retrieve the information from the EMR. MDSC1 stated that she relied on the accuracy of the clinical record for the status of the pneumococcal vaccine status. MDSC1 stated it was easy to locate accurate information for the influenza vaccine for the residents since that information was in the residents' "Medication Administration Records." MDSC1 stated she was not familiar with the CDC recommendations for the pneumococcal vaccine. Review of the Resident Assessment Instrument (RAI) manual, dated 10/2024 and located at Minimum Data Set (MDS) 3.0 RAI Manual | CMS, revealed Pneumococcus is one of the leading causes of community-acquired infections in the United States, with the highest disease burden among the elderly. Adults 65 years of age and older and those with chronic medical conditions are at increased risk for invasive pneumococcal disease and have higher case-fatality rates. Pneumococcal vaccines can help reduce the risk of invasive pneumococcal disease and pneumonia." Review of the CDC website: https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, dated 10/26/24 indicated ". . . Based on shared clinical decision- making, adults 65 years or older have the option to get PCV20 [20-valent pneumococcal conjugate vaccine] or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both . . .PCV13 (but not PCV15, PCV20, or PCV21) at any age and . . . PPSV23 at or after the age of 65 years old. . ."	F0641		
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F0656	F656 The facility failed to address the use of psychotropic medications in four of five residents reviewed for care plans, out of a survey sample size of 28.	02/23/2026

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F0656 SS = E	Continued from page 4 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care 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 observation, record review, review of facility policy, and staff interviews, the facility failed to	F0656	Continued from page 4 All residents identified during the survey who are currently prescribed psychotropic medications and lacked care plans with measurable goals have been immediately reviewed by the Interdisciplinary Team (IDT). Individualized care plans have been revised to include: the specific psychotropic medication(s) prescribed; the diagnosed condition or target symptoms being treated; measurable, time-limited goals; non-pharmacological interventions and alternatives; monitoring parameters for effectiveness and adverse effects; and gradual dose reduction (GDR) considerations, when clinically appropriate. Revised care plans were implemented upon completion, and nursing staff were educated on the updated interventions. The facility conducted a comprehensive audit of all residents currently prescribed psychotropic medications, including antipsychotics, antidepressants, anxiolytics, hypnotics, and mood stabilizers. Any resident found to have incomplete or non-compliant care plans will have their care plan updated by the IDT. The root cause of this deficient practice is that the facility has not documented medications including psychotropic medications in the resident's care plan in the past. Upon admission and readmission, the Psychotropic Medication Advisory Committee (PMAC) will review all residents who receive psychotropic medications. The PMAC meets every week, and they will discuss all recommendations (i.e. medication changes) with the nursing staff/clinical IDT team to ensure care plans reflect current clinical status and treatment goals. Charge Nurses, Unit Managers, and MDS Coordinators who are responsible for developing and maintaining care plans will be re-educated on the appropriate monitoring and documentation for residents receiving psychotropic medications, including the development of individualized care plans listing the medications, measurable goals, use of non-pharmacological interventions, and GDR principles by February 14, 2026. The Trainer Educators II or designee will provide in-service training.	

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F0656 SS = E	Continued from page 5 develop a person-centered comprehensive plan of care with measurable goals and plans for four of five residents (Resident (R) 2, R5, R1, and R24) reviewed for care plans, out of a survey sample of 28. The failure to develop a care plan increased the risk for care to be incomplete and/or inconsistent related to the residents taking psychotropic medications. Findings include: 1. Review of R2's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the facility admitted the resident on 09/23/25. Review of R2's EMR titled physician "Orders" located under the "Orders" tab dated 09/29/25, indicated the resident was ordered an intramuscular injection one time per month for his diagnosis of schizophrenia. Review of R2's EMR titled admission "Minimum Data Set (MDS)" located under the "MDS" tab with an Assessment Reference Date (ARD) of 09/29/25 indicated the resident had a "Brief Interview of Mental Status (BIMS)" score of 0 out of 15, which revealed the resident was severely cognitively impaired. The resident was on an antipsychotic medication on a routine basis. Under the "Care Area Assessment (CAA)", the resident triggered the use of psychotropic medications and directed the staff to develop a care plan. Review of R2's EMR titled "Care Plan" located under the "Care Plan" tab failed to contain evidence that the resident was care planned for the use of the aripiprazole. 2. Review of R5's EMR titled "Admission Record" located under the "Profile" tab indicated the facility admitted the resident on 06/13/02. Review of R5's EMR titled physician "Orders" located under the "Orders" tab dated 07/17/23, indicated the resident was to be administered an oral medication for the treatment of bi-polar disorders. Review of R5's EMR titled physician "Orders" located under the "Orders" tab dated 07/17/23 indicated the resident was to be administered an oral medication for major depressive disorder. Review of R5's EMR titled annual "MDS" located under the "MDS" tab with an ARD of 09/12/25 indicated the resident had a "BIMS" score of 15 out of 15 which revealed the resident was cognitively intact. The	F0656	Continued from page 5 The DON or designee will conduct weekly audits of care plans of 30 percent of residents receiving psychotropic medication(s) who are reviewed by the Interdisciplinary Team (IDT) the prior week to ensure the development or maintenance of individualized care plans listing the medications, measurable goals, use of non-pharmacological interventions, and GDR principles using Psychotropic Medication Care Plan Audit Tool (Attachment #2). The audit will be completed until 100% compliance is achieved for four (4) consecutive weeks. Then, the audit will be completed monthly until 100% compliance is achieved for three (3) consecutive months. Then, the facility will conclude that we have successfully addressed this deficient practice and achieved compliance. Audit results will be reviewed during Quality Assurance and Performance Improvement (QAPI) meetings. Any identified issues will result in immediate corrective action and additional staff education as needed.	

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F0656 SS = E	Continued from page 6 resident was on an antipsychotic medication on a routine basis. Under the "CAA", the resident triggered for the use of psychotropic medications and directed the staff to develop a care plan. Review of R5's EMR titled "Care Plan" located under the "Care Plan" tab failed to contain evidence that the resident was care planned for the use of quetiapine fumarate or the use of escitalopram. 3.Review of R1's "Admission Record" located under the "Profile" tab of the EMR, revealed R1 was admitted on 02/24/09 with a diagnosis that included major depressive disorder. Review of R1's "Order Summary Report" located under the "Orders" tab of the EMR revealed a physicians order for an oral medication for a diagnosis of major depressive disorder. Review of R1's annual MDS located under the "MDS" tab in the EMR with an ARD of 09/26/25, a BIMS score of 10 out 15 which indicates he was moderately intact. The "MDS" indicated that R1 takes antipsychotic medication. Review of R1's CAA located under the "MDS" tab in the EMR dated 12/19/25, revealed the resident was administered antipsychotic medication for seven days prior to the assessment. Review of R1's "Care Plan" located under the "Care Plan" tab of the EMR dated 12/29/25 did not address the resident's use of the antipsychotic medication. Review of R1's "Medication Administration Record (MAR)" located under the "Orders" tab of the EMR dated January 2026 revealed the resident had been administered the medication twice daily. 4. Review of R24's annual MDS with an ARD date of 05/09/25 and located in the "MDS" tab of the EMR, revealed R24 was admitted on 04/09/20. The resident had a BIMS score of 15 out of 15 indicating R24's cognition was intact. The resident received an antipsychotic medication and had a diagnosis of schizophrenia. The CAA Summary revealed "Psychotropic Drug Use triggered for care planning." Review of R24's "orders," located in the EMR under the "Order" tab revealed the resident was ordered oral medications for her diagnoses of schizoaffective	F0656		

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F0656 SS = E	Continued from page 7 disorder and depression related to the schizoaffective disorder. Review of R24's "care plan," revised 11/04/25, located in the EMR under the "Care Plan" tab revealed Neurobehavioral Health but there was no care plan for antipsychotic medications. During an interview conducted on 01/08/2026 at 10:35 AM MDS Coordinator (MDSC) 1 and MDSC2 were present. MDSC1 stated the MDSCs complete the CAA and then decide on whether or not they develop a care plan or not. MDSC1 stated the EMR for the development of the care plan does not have the capacity to specifically address the use of psychotropic medications. MDSC1 stated the care plans were individualized for each resident's needs. MDSC1 stated if there was an associated black box warning with the medication the care plan does not have the ability to add this information for a resident. During an interview conducted on 01/09/25 at 12:29 PM, the Director of Nursing (DON) stated the care plans for residents were individualized for their specific needs and the information about the use of psychotropic medications were in the residents' consents. Review of the "MDS 3.0 Resident Assessment Instrument (RAI) Manual," dated 10/24 indicated ". . .The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA (Care Area Assessment) process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based "trigger" conditions that signal the need for additional assessment and review of the triggered care area. Detailed information regarding each care area and the CAA process, including definitions and triggers. . . After completing the MDS and CAA portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes in order to identify problems, causes, contributing factors, and risk factors related to the problems. Subsequently, the IDT (Interdisciplinary Team) must evaluate the information gained to develop a care plan that addresses those findings in the context of the resident's goals, preferences, strengths, problems, and needs. . ."	F0656		
F0689 SS = SQC-K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	F689 The facility failed to ensure residents who smoked were safe and not at risk for harm. The following actions	02/23/2026

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F0689 SS = SQC-K	Continued from page 8 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 document review, interviews, observations, and facility policy review, the facility failed to ensure that four of 10 residents (Residents (R) 5, R4, R71, and R6) reviewed for unsupervised smoking, smoked safely. In addition, all residents refused to don (put on) a smoking apron for protection and would hold onto their cigarettes and/or lighters instead of nursing staff securing the smoking paraphernalia safely. In addition, R34 was identified as a resident who smoked and had a lighter in her room. R34 used an oxygen concentrator, while in her room and while her lighter was kept in her room. This placed all residents who smoke of an increased opportunity for burns. The facility's Administrator and Director of Nursing (DON) were notified on 01/07/26 at 6:40 PM that Immediate Jeopardy existed related to the failure to assess and monitor three residents R5, R71, and R6 who smoked. The Immediate Jeopardy began on 01/07/26 at 6:40 PM when the three residents were identified with upper extremity impairments.. In addition, the facility failed to supervise these three residents while they smoked. The facility provided an Immediate Jeopardy Removal Plan that was accepted on 01/08/26 at 3:01 PM. The survey team validated implementation of the removal plan through observations, interviews, and review of training records. Immediate Jeopardy was removed on 01/09/26 at 11:30 AM. After removal of the Immediate Jeopardy, the deficiency remained at a "E" scope and potential for more than minimal harm. Findings include: 1. Review of R5's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab indicated the facility admitted the resident on 06/13/02 with a diagnosis of quadriplegia. Review of R5's EMR titled "Care Plan" located under the "Care Plan" tab dated 11/07/23 indicated the resident	F0689	Continued from page 8 were taken immediately and completed 01/08/2026 to correct the immediate jeopardy deficiency for all residents who smoke: Replaced the tops of the safety fire resistant outdoor ashtrays in both smoking areas and placed a safety fire resistant outdoor ashtray in the Stadium Drive smoking area. Removed all coffee cans in the smoking areas. Placed a fire extinguisher in the stadium drive smoking area. Purchased fire blankets that are stored with the fire extinguishers in both smoking areas. Completed an updated Smoking Safety Evaluation for each resident who smokes. Based on the assessment results, it was determined that seven (7) residents needed supervised smoking. The nursing supervisors assigned staff to supervise these residents. Residents that require supervision will have scheduled smoking times and be encouraged to wear smoking aprons. Residents are not permitted to carry lighters or cigarettes; these items are kept in a secure location in the nursing station. Each identified resident, including residents with oxygen orders, received a Smoking Safety Evaluation, and care plans were updated as indicated to ensure appropriate supervision and interventions were in place. Smoking policy was updated, and all direct care staff were trained on the updated policy. The Trainer Educator II and nurse supervisors were responsible for the training. Residents who smoke were educated on safety awareness when smoking. Until all of these measures were in place, all residents who smoke were supervised. "Oxygen In Use-No Smoking" signage was placed on resident bedroom doors for residents who use oxygen. Any residents identified as using oxygen and smoking were educated on safety awareness and not to smoke while using oxygen.	

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F0689 SS = SQC-K	Continued from page 9 voiced that it was important for him to be independent to do things on my own and to practice safe smoking habits. The care plan identified that the resident was paralyzed and required assistance, at times, for retrieving and/or lighting his cigarettes. The interventions for R5's care plan revealed that the nurses were to provide the resident with his cigarettes upon his request and preferred to keep his lighter with him. Also, the care plan indicated the resident preferred to smoke at his leisure and he declined to don a smoking apron. Review of R5's EMR titled "Smoking Safety Assessments" located under the "Assmts (Assessments)" tab dated 11/26/24 indicated that the resident had total or limited range of motion in hands or arms. Review of R5's EMR titled quarterly "Minimum Data Set (MDS)" located under the "MDS" tab with an Assessment Reference Date (ARD) of 12/05/25 indicated the resident had a "Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed the resident was cognitively intact. The resident was identified with bi-lateral impairment of both upper extremities. Review of R5's EMR titled "Smoking Safety Assessment" located under the "Assmts" tab dated 01/06/26 indicated that the resident had total or limited range of motion in hands and arms. During an interview on 01/07/2026 at 8:42 AM, Certified Nurse Aide (CNA) 2 confirmed R5 kept his cigarettes and lighter with him. During an interview on 01/07/2026 at 8:43 AM, Office Associate (OA)1, who worked on the same unit where R5 lived, stated the resident kept his own cigarettes and lighter with him. OA1 stated the staff will take R5 to the front smoking area and will then leave the resident so he can smoke on his own. During an interview on 01/07/2026 at 8:47 AM, Registered Nurse (RN) 8 stated that R5 kept his cigarettes and lighter with him. During an interview on 01/07/2026 at 9:03 AM, Licensed Practical Nurse (LPN) 5 confirmed R5 kept his cigarettes on him but not the lighter.	F0689	Continued from page 9 Staff were educated on the greater risk of smoking while using supplemental oxygen and no resident should smoke while using oxygen. The facility completed an audit of all residents who smoke including those with oxygen orders. Each identified resident received a Smoking Safety Evaluation, and care plans were updated as indicated to ensure appropriate supervision and interventions were in place. Staff and residents were educated on the greater risk of smoking while using supplemental oxygen and no residents should smoke while using oxygen. "Oxygen In Use-No Smoking" signage was placed on all residents' bedroom doors for residents who use oxygen. Additionally, "Oxygen Use Not Permitted in Smoking Area" signage was placed in both designated smoking areas. The root cause of this deficient practice is that the facility encourages person centered approaches to living; however, the facility did not have safety devices in place – fire extinguishers, smoking blankets, and safety fire resistant ashtrays. Each identified resident, including residents with oxygen orders, received a Smoking Safety Evaluation, and care plans were updated as indicated to ensure appropriate supervision and interventions were in place. Staff and residents were educated on the greater risk of smoking while using supplemental oxygen and that no residents should smoke while using oxygen. "Oxygen In Use-No Smoking" signage was placed on resident bedroom doors for residents who smoke and use oxygen. The Smoking Safety Evaluation has been revised to take a more comprehensive approach to include cognitive status, physical ability, fire safety awareness, residents' use of oxygen, and need for supervision. All residents who smoke will be reassessed. All residents who smoke will have a Smoking Safety Evaluation completed and/or updated on readmission, quarterly, annually, with any change in condition, and after any smoking-related incident. Smoking times were assigned to both smoking areas for residents who require supervision. Residents are not permitted to carry lighters or cigarettes; these items are kept in a secure location in the nursing station. All residents who smoke will be offered smoking cessation opportunities.	

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F0689 SS = SQC-K	Continued from page 10 During an interview on 01/07/2026 at 10:14 AM with RN6, who was the current nurse supervisor on the same unit where R5 lived, confirmed the staff would take R5 out to the front smoking area and allow the resident to smoke on his own. During an interview on 01/07/2026 at 11:10 AM with CNA5, who was the receptionist for the front lobby, confirmed R5 does smoke on his own., but she keeps an eye on him. During an interview on 01/07/2026 at 11:35 AM, the Activity Aide (AA)1 confirmed that R5 liked to keep his cigarettes and lighter with him. AA1 stated the resident wore a cross-body bag and that was where the resident kept his cigarettes and lighter. AA1 stated at times he would bring the resident out to the front smoking area but that the receptionist kept an eye on the resident from inside the building. During an observation on 01/07/26 at 11:41 AM, the front smoking area had multiple areas to sit. There were two black plastic buckets which contained sand and cigarette butts. There was a large metal ashtray next to one of the columns. Upon entrance back into the lobby from the front smoking area were two desks. One desk was positioned next to the large window which faced the smoking area. The second desk was closer to the main hallway entrance. During an observation at 12:23 PM, staff brought R5 to the outside front smoking area. The resident was positioned next to the large metal ashtray, and he faced the window which faced the front lobby. The resident retrieved a packet of cigarettes and pulled one cigarette with his right hand. The resident placed the cigarette in his mouth and then retrieved his lighter and lit his cigarette. These items were retrieved from the resident's green cross body bag. The resident's fingers on his right hand were severely contracted but he had slight movement in his arm to move the cigarette to and from his mouth. CNA5 was present during this observation and was reading a magazine. CNA5 pointed to a fire extinguisher which was hanging on a wall directly in front of CNA5 and stated she was not aware of a smoking blanket in case of a fire. The observation ended at 12:30 PM. 2.Review of R6's "Admission Record" located under the "Profile" tab in the EMR revealed the resident was	F0689	Continued from page 10 The nursing supervisors or designee will monitor to ensure residents requiring supervision are supervised during smoking times every day for two (2) weeks using the Smoking Supervision Audit Tool (Attachment #3). The Safety Manager or designee will ensure all safety devices are in place – fire extinguishers, smoking blankets, and safety fire resistant ashtrays are available at designated locations every day for two (2) weeks using the Smoking Safety Devices Audit Tool (Attachment #4). For both attachments #3 & #4, once 100% compliance is achieved every day for two (2) consecutive weeks, then monitoring will be decreased to one (1) per week for one (1) month. Once 100% compliance is achieved for four (4) consecutive weeks, then monitoring will be decreased to one (1) per month for three (3) months. Once 100% compliance is achieved for three (3) consecutive months, then the facility will conclude that we have successfully addressed this deficient practice and achieved compliance. Audit results will be reviewed by the Quality Assurance and Performance Improvement (QAPI) Committee, and corrective actions will be implemented as needed.	

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F0689 SS = SQC-K	Continued from page 11 admitted on 02/25/09 with a diagnosis of tobacco use, cataract, and vascular Dementia. Review of R6's Annual "MDS" located under the "MDS" tab in the EMR with an ARD of 01/24/26 revealed R6had a BIMS score of 15 out of 15 indicating cognitive intact. Review of R6's "Care plan" located under the "Care Plan" tab in the EMR with a revision date of 01/05/26 revealed the resident had the "potential to harm himself while smoking, declines to use a smoking apron, and has burned holes in his clothes and gloves, and to report changes in mood and demeanor that may cause him harm." Review of R6's "Smoking Safety Evaluation" located under the "Assessment" tab in the EMR, dated 01/24/25 revealed R6 utilizes tobacco; has poor vision or blindness; balance problems while sitting or standing; drops ashes on self; unable to light a cigarette safely; unable to hold a cigarette safely; unable to extinguish a cigarette; unable to use ashtray to extinguish a cigarette. During an interview on 01/05/26 at 11:28 AM, R6 confirmed he was a smoker, held his own cigarettes and lighter and that he smoked in the smoking section. During an observation on 01/07/26 at 11:01 AM, R6 came out of his room and confirmed he had his cigarettes. R6's cigarettes were observed in a cup holder on the side of his wheelchair in a green plastic holder. During an observation on 01/07/26 at 11:03 AM, LPN2 wheeled resident out to the smoking area. The resident did not have an apron on and was not offered one. The staff member went back into building and left the resident outside the 500 unit in the smoking area. The resident had his own cigarettes and lighter, and he lit his own cigarette. During an observation on 01/07/26 at 11:03 AM, no fire extinguisher or fire blanket was present on the 500-unit smoking area. No fire safe ash trays were present, just large metal cans.	F0689		

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F0689 SS = SQC-K	Continued from page 12 During an interview on 01/07/26 at 11:14 AM, R6 confirmed staff do not come outside to supervise him when he smokes. During an observation on 01/07/26 at 11:24 AM, R6 put his cigarette butt on the ground and went into building. During an interview with on 01/07/26 at 11:27 AM, LPN2 revealed she did not supervise the resident during smoke break because he did not require supervision. She also stated the resident was permitted to have his smoking materials. 3.Review of R71's "Admission Record" located under the "Profile" tab in the EMR revealed the resident was admitted on 05/01/23 with a diagnosis of epilepsy, hereditary and idiopathic neuropathy, neurosyphilis, hemiplegia and hemiparesis affecting non-dominate side, traumatic subarachnoid hemorrhage. Review of the "Smoking Safety Evaluation" located under the "Assessments" tab located in the EMR dated 03/07/25, revealed R6 utilizes tobacco; had balance problems while sitting or standing; total or limited ROM in arms or hands. Review of R71's quarterly "MDS" located under the "MDS" tab in the EMR with an ARD of 11/07/25, revealed R71 had impairment of upper extremity on one side. R71 had a BIMS score of 15 out of 15 indicating cognitively intact. Review of "Care plan" located under the "Care Plan' tab in the EMR with a revision date of 11/07/25 revealed the resident had the "Potential to have skin injuries because he smokes cigarettes and declines to wear a smoking apron." The care plan also revealed for aides to report any injury, changes, or abnormalities to the nurse. During an observation on 01/07/26 at 8:43 AM, R71 wheeled himself down the 500-unit hallway with a cigarette in his mouth and lighter in his right hand. The resident did not have on smoking apron. Activity Director (AD) offered him smoking apron and resident refused. R71 and AD went out in smoking area, with	F0689		

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F0689 SS = SQC-K	Continued from page 13 staff assisting resident outside. R71 smoking a cigarette without a smoking apron. During an observation on 01/07/2026 at 8:45 AM, the AD left the smoking area where R71 was smoking, went to the farthest side of the facility van approximately 50 feet away from smoking area. During an observation on 01/07/26 at 8:47 AM, the AD went back into the facility and left R71 outside smoking alone. During an observation on 01/07/26 at 8:48 AM, no fire extinguisher or fire blanket was present on the 500-unit smoking area. No fire safe ash trays present just large metal cans. During an observation on 01/07/26 at 8:49 AM, R71 wheeled himself back into the facility and to his room. No staff accompanied him. R71 confirmed he kept his cigarettes and lighter. There were metal non fireproof cans for cigarette butts and R71 placed his cigarette butt in one of the cans. During an interview on 01/07/26 at 12:12 PM, the AD revealed that R71 did not require supervision during smoking and had a right to decline to wear the smoking apron. AD also revealed R71 was permitted to keep his cigarettes and lighter in his possession. 4.Review of R4's "Smoking Safety Evaluation" located under the "Assessments" tab in the EMR dated 12/05/25 revealed R4 utilizes tobacco; has balance problems while sitting or standing; burns skin, clothing, furniture or other; drops ashes on self; does not follow the facility's policy on location and time of smoking; unable to extinguish a cigarette safely; unable to use ashtray to extinguish a cigarette. Review of R4's annual MDS located under the "MDS" tab in the EMR with an ARD of 12/05/25 revealed the resident had impairment of upper extremity on one side. R4 had a BIMS score of 13 out of 15 indicating cognitively intact. Review of R4's "Care Plan" located under the "Care	F0689		

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F0689 SS = SQC-K	Continued from page 14 Plan" tab of the EMR dated 12/16/25 revealed R4 had the "Potential to injure himself when because he had a stroke, smoke cigarettes, and has seizure disorder, declines to wear a smoking apron and drops ashes on clothing." The care plan revealed that R4 often "Declines to wear a smoking apron, is to keep cigarettes at the nurse's station, does not always follow the smoking schedule and needs reminders to smoke in the designated smoking area, and sometimes needs assistance by one person to push him to the smoking area." During an observation on 01/05/26 at 11:03 AM, R4 was in his room sitting in a wheelchair with a pack of cigarettes in a red plastic holder and a cigarette on the outside of the pack. The resident confirmed he had a lighter that was located under a white washcloth on the arm rest of the wheelchair. During an interview on 01/07/26 at 12:12 PM, the AD stated residents are permitted to have their cigarettes and lighter in their possession as long as they are care planned and that R4 and R6 are care planned to keep them. She revealed staff are only present during smoke break if the resident is care planned for supervision. The AD revealed she was not familiar with the results of the residents smoking assessments. The AD confirmed there were no fire extinguisher or smoking blanket near the 500-unit smoking area. During an observation on 01/08/26 at 11:15 AM, R4 was sitting outside of the 500 unit in the smoking area smoking a cigarette. There was no staff present for supervision. R4 confirmed he kept his cigarettes and lighter. 5. Review of R34's quarterly MDS with an ARD date of 12/10/25 and located in the "MDS" tab of the EMR, revealed R34 was admitted on 03/04/04. The resident had a BIMS score of 14 out of 15 indicating R34's cognition was intact. The MDS also indicated that the resident received oxygen therapy, and had diagnoses of chronic obstructive pulmonary disease, unspecified, personal history of nicotine dependence, and Wernicke's encephalopathy. Review of R34's "care plan," revised 09/08/25, located in the EMR under the "Care Plan" tab revealed "Safety: Smoking, I need: to practice safe smoking habits by following my smoking schedule and smoke in authorized areas." An intervention included "I need my aides to	F0689		

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F0689 SS = SQC-K	Continued from page 15 assure proper storage of my smoking materials. (Cigarettes and lighter. I keep them at the nurse's station and also have some cigarettes kept in my room and can have whenever I want to go outside to smoke. I need everyone to report changes in my abilities to my nurse..." Review of R34's "Smoking Safety Evaluation," dated 12/02/25, located in the EMR under the "Assessment" tab revealed R34 utilized tobacco and "Note: Supervision will be required for all Residents during designated smoking times. This evaluation will be utilized for the Resident's smoking care plan on admission and as indicated." The evaluation determined that R34 was able to light a cigarette safely, was able to hold a cigarette safely, was able to extinguish a cigarette safely, and was able to use ashtray to extinguish a cigarette. During an interview on 01/07/26 at 9:03 AM, Certified Nurse Aide (CNA)4 stated, "Yes, R34 smokes" and CNA4 then picked up the sign-out sheet on a clip board at the nurse station with R34's signature when she went outside to smoke. CNA4 stated R34's cigarettes are kept in a drawer at the nurse station but R34 keeps her lighter. On 01/07/26 at 9:05 AM, R34 was in her bed with covers over her head and unwilling to talk. The oxygen concentrator was observed at R34's bedside. During an interview on 01/07/26 at 10:23 AM, Unit manager RN4 stated R34 was a smoker and occasionally needed assistance with wheeling in her wheelchair. RN4 stated R34 signed herself out to smoke and refused to wear a smoking apron. RN4 stated staff always supervised her and could be seen through the window and there are outside cameras. RN4 stated R34's cigarettes were kept at the nurse station and R34 kept her lighter as R34 had a private room. On 01/07/26 at 12:25 PM, R34 was sitting in a wheelchair at the lunch table in the dining room feeding herself with no difficulty. R34 confirmed she kept her lighter, but the pack of cigarettes are returned to the nurse station. R34 had oxygen in use via nasal cannula and an oxygen concentrator plugged into the wall. During an interview on 01/08/26 at 3:37 PM, RN2 was	F0689		

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F0689 SS = SQC-K	Continued from page 16 asked if a resident used oxygen in their room should they keep a cigarette lighter in their room. RN stated, "No." During an interview on 01/08/26 at 4:07 PM, CNA8 and CNA9 stated R34 was a smoker. They stated the residents' cigarettes and lighter are stored in the nursing station. The CNAs stated R34 had her own lighter, but it was not okay to have a lighter in her room because she used oxygen in her room. During an interview on 01/08/26 at 6:10 PM, CNA10 stated the facility's new policy was that R34 had to be supervised. CNA10 stated cigarettes were kept at the nurse station. CNA10 then opened a drawer in the nurse station and a pack of cigarettes with R34's name was in the drawer but there was no lighter observed. During an interview on 01/09/26 at 9:23 AM, RN9 stated R34, should not keep a cigarette lighter in her room since she uses oxygen. During an interview on 01/07/26 at 1:33 PM, the Administrator, DON , the Medical Director, Quality Assurance, Social Services Chief Administrator, and RN 4, who was responsible for the development of resident care plans, were in attendance. The Administrator stated all residents who smoked were supervised. RN4 stated R5 was a resident who lived in the facility for a long time and if he needed assistance with smoking, he would request this from the staff to help him. The Administrator confirmed there were no smoking blankets for the front smoking area or the smoking area in the back of the facility. The Administrator also stated the residents from the 500 unit who utilized the back smoking area did not require supervision. During an interview on 01/09/26 at 9:00, the Maintenance Director stated the necks to the ash tray bottoms were located behind the facility and verified that they were not attached to the safety ash trays in the front and back smoking areas. Review of the facility's policy titled, "Smoking Policy" dated 05/31/24, noted "Procedures/ Responsibilities: "..."In the case of residents who are excluded/ grandfathered by this policy, they will be monitored and assessed as needed for unsafe smoking behaviors. Notwithstanding this policy, other residents	F0689		

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F0689 SS = SQC-K	Continued from page 17 may be excluded from this policy once they have been deemed in need of a special non-pharmacological approach to behavior modification management. Upon admission, each resident will be assessed for tobacco use and any safety concerns regarding tobacco use. The assessment for tobacco use will be utilized to determine a resident's plan of care for tobacco cessation. Individuals are responsible for ensuring that they clean up any and all tobacco product waste, such as cigarette butts, after use". Review of the NFPA (National Fire Protection Association) 99(12), Sec. 11.5.1.1.1 requires that smoking materials (e.g., matches, cigarettes, lighters, lighter fluid, and tobacco in any form) be removed from patients receiving respiratory therapy. Review of the NFPA 99(12), Sec. 11.5.3.2.1 requires that smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read No Smoking or shall be posted with the international symbol for no smoking.	F0689		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview, and facility policy review, the facility failed to ensure that one resident (R) 8 out of a survey sample of two, had a complete tracheostomy (trach) change. This has the potential for residents to have their airway compromised and potentially develop severe infection that could be life-threatening. Findings include: Review of R8's electronic medical record (EMR) titled "Admission Record" located under the "Profile" tab	F0695	F0695 The facility failed to ensure that one resident received a complete tracheostomy change in accordance with the physician's orders. The physician order was written for the Respiratory Therapist (RT) to change the tracheostomy every three months in April, July, October, and January. The tracheostomy change for this resident was not completed as ordered; however, the resident was routinely assessed and monitored on an ongoing basis for signs and symptoms of respiratory distress, infection, or complications related to the untimely tracheostomy changes. When it was brought to our attention, the physician was made aware of the late tracheostomy changes. The NHA and DON also met immediately with the RT to discuss the deficient practice. The RT received immediate re-education regarding the specific physician order for this resident. All residents with tracheostomies have the potential to be affected by this deficient practice. This facility has a total of three (3) residents with tracheostomies. One of these residents has been hospitalized for an extended period of time; therefore, two (2) residents have the potential to be affected by this deficient	02/23/2026

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F0695 SS = D	Continued from page 18 indicated the facility admitted the resident on 04/28/21, with a diagnosis of anoxic brain injury. The resident required the use of a tracheostomy (a device that was placed in the opening of the windpipe [trachea] to provide an airway for breathing). Review of R8's EMR titled physician "Orders" located under the "Orders" tab dated 07/17/23 indicated the physician or the respiratory therapist (RT) was to change the tracheostomy every three months, each April, July, October, and January. The tracheostomy change included a size six trach, with an extra-long Shiley, with a cuffed trach tube with a disposable inner cannula. Review of R8's EMR titled "TAR" located under the "Orders" tab dated 01/06/25 was blank. Review of R8's titled respiratory "Progress Notes" located under the "Prog (Progress) Notes" tab dated 01/15/25 revealed the RT completed tracheostomy care. Review of R8's EMR titled "Treatment Administration Record (TAR)" located under the "Orders" dated 04/06/25 indicated Registered Nurse (RN) 6 changed R8's tracheostomy. Review of R8's EMR titled respiratory "Progress Notes" located under the "Prog Notes" tab dated 04/15/25 revealed that the RT completed trach care only. Review of R8's EMR titled respiratory "Progress Notes" located under the "Prog Notes" tab dated 05/05/25 revealed the RT completed the resident's tracheostomy change. Review of R8's EMR titled "TAR" located under the "Orders" tab dated 07/06/25 indicated RN8 changed the resident's tracheostomy. Review of R8's EMR titled respiratory "Progress Notes" located under the "Prog Notes" tab dated 07/08/25 revealed the RT completed trach care only. Review of R8's EMR titled respiratory "Progress Notes" located under the "Prog Notes" tab dated 07/24/25 revealed the RT completed trach care only. Review of R8's EMR titled respiratory "Progress Notes" located under the "Prog Notes" tab dated 09/05/25 revealed the RT completed the resident's tracheostomy change. Review of R8's EMR titled "TAR" located under the	F0695	Continued from page 18 practice. An audit was completed to ensure the physician orders are up to date and present, tracheostomy care and change schedules are clearly documented, and care is being provided in accordance with physician orders. No additional residents were found to be out of compliance. The root cause of this deficient practice was a lack of communication with the RT following the physician orders as written. The RT was not aware of the specific details (the months listed to change the tracheostomy) in the physician's order, or that the order was in the treatment administration record (TAR). There was also miscommunication about the terminology used in our electronic medical records (EMR) system. Nursing staff are aware they are not to change the tracheostomy; however, they are expected to provide tracheostomy care (i.e. suctioning, cleaning the site, etc.). In the EMR checklist, the terminology "trach change" and "trach care" were used synonymously. Another concern that contributed to this deficient practice was the physician not being made aware of the missed tracheostomy change as the physician could have changed it. The physician orders for both residents with tracheostomies have been updated by the Medical Providers (Medical Director and Nurse Practitioners) to reflect when the tracheostomy changes are to be completed. All licensed nursing staff will be re-educated by the Trainer Educator II or designee by February 14, 2026, on following physician orders for tracheostomy changes and, if missed or delayed, the physician should be notified immediately for a tracheostomy change. The RT will report any schedule changes that would affect the scheduled physician ordered tracheostomy changes to the Director of Nursing (DON) or RN Supervisor. The DON or RN Supervisor will oversee that the tracheostomy changes are completed according to the physician orders on an ongoing basis. The RT was re-educated by the Nursing Home Administrator (NHA) and DON on the facility's Tracheostomy Care and Suctioning policy on January 8, 2026. The DON or designee will conduct weekly audits of both residents with a tracheostomy to ensure the tracheostomy care is in accordance with physician orders and nursing staff documentation reflects only tracheostomy care using the Tracheostomy Change & Care Audit Tool (Attachment #5). Once 100% compliance has	

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F0695 SS = D	Continued from page 19 "Orders" tab dated 10/06/25 was blank. There were no corresponding RT progress notes which would address when the resident's tracheostomy change was completed per physician order. Review of R8's EMR titled "Medical Professional Note [written by the RT]" located under the "Prog Notes" dated 12/24/25 revealed the RT completed the resident's tracheostomy change. Two months later the physician orders specifically indicated the resident was to have a complete tracheostomy change in October. There was no documentation in the clinical record that the physician was notified of the late tracheostomy change. During an interview on 01/06/26 at 2:20 PM, RT stated she tries to come to the facility each week and it has not happened recently due to medical issues. RT stated the last time she was in the facility was during the month 12/25 and she changed R8's tracheostomy. RT stated nursing was not to change the tracheostomy only the RT. RT stated nursing can change the Velcro ties, clean the trach site, and suction the resident's trach. RT stated she was not aware of the physician orders to change R8's tracheostomy for the specific months identified in the orders for the resident. During an interview on 01/06/26 at 3:06 PM, RT stated that a tracheostomy change was the removal of the tracheostomy and only the RT can do this. During an interview on 01/06/26 at 3:16 PM, RN 6 reviewed the entry he made on 04/06/25 documenting that he had completed R8's tracheostomy change. RN6 stated that there was an error in his documentation and only the physician or the RT could complete the tracheostomy change. During an interview on 01/07/26 at 8:47 AM, RN 8 reviewed the entry she made on 07/06/25 and stated that she never would remove a resident's inter cannula and this was the responsibility of the RT. RN8 stated the entry was a mistake. During an interview on 01/07/26 at 10:43 AM, the Director of Nursing (DON) stated her expectation was the TAR was to reflect the care for R8, but that nursing needed to ensure that the documentation was correct and that care was provided to the resident. During an interview on 01/07/26 at 1:33 PM, the Medical Director stated the clinical staff were to follow his orders and to notify him if the orders could not be	F0695	Continued from page 19 been achieved for 4 consecutive weeks, then the audits will be decreased to monthly. When 100% compliance has been achieved for 2 consecutive months, then the facility will consider that the deficient practice has been addressed, and compliance has been achieved. The DON or designee will conduct quarterly audits of both residents with a tracheostomy to ensure the tracheostomy changes are completed by the RT in accordance with physician orders and the RT documentation reflects tracheostomy changes using the Tracheostomy Change & Care Audit Tool (Attachment #5). When 100% compliance has been achieved for 4 consecutive audits, then the facility will consider that the deficient practice has been addressed, and compliance has been achieved. Audit results will be reviewed by the QAPI Committee, and corrective actions will be implemented as needed.	

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F0695 SS = D	Continued from page 20 implemented. In addition, the Medical Director stated the reason that a complete tracheostomy change was required for R8 was to maintain patency, to prevent infections, and to provide cleanliness.	F0695		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to assess the need for side rails and obtain informed consent for two (Resident (R)9 and R27) of two residents reviewed for side rails. This had the potential to place residents at risk of injury or death. Findings include: 1. Review of R9's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 12/10/25 and located in the "MDS" tab of the electronic medical record (EMR), revealed R9 was admitted on 03/13/25. R9's cognition was severely impaired, and had diagnoses of epilepsy, traumatic brain injury, and tracheostomy status.	F0700	F700 The facility failed to assess the need for bed rails and to obtain informed consent for two (2) residents. The bed rails were on the bed; however, they were not used in the upright position. Bed rails were removed immediately for the two residents identified as there was no justification for bed rails. All the residents have the potential to be affected by this deficient practice. A sweep of all residents' beds was completed. If bed rails were found on the beds that were not needed, they were removed immediately. If the resident required or requested bed rails, a Bed Rail Assessment for any safety concerns, including the risk for entrapment, was completed prior to bed rail installation. The risks and benefits of bed rails were reviewed with the resident and/or resident representative. An informed consent was obtained if applicable. A physician's order was also obtained, and a care plan initiated. Prior to installation of bed rails, the Adaptive Equipment Technician and Unit Manager/Charge Nurse ensured the beds' dimensions were appropriate for the residents' size and weight. In addition, the manufacturer's recommendations and specifications for installing and maintaining bed rails were followed by the Adaptive Equipment Technician. The root cause of this deficient practice was the facility's failure to routinely assess the need for bed rails using the Bed Rail Assessment. Bed rail assessments and reviews, which are part of the electronic medical record, will be completed upon admission, readmission, quarterly, annually, and with any change in condition, by the Unit Manager/Charge Nurse. If the resident requires or requests bed rails, a Bed Rail Assessment for any safety concerns, including the risk for entrapment, will be completed prior to bed rail installation. The risks and benefits of bed rails will be reviewed with the resident and/or resident representative. An informed consent will be obtained if applicable. A physician's order will also be obtained, and a care plan initiated. Prior to installation of bed rails, the Adaptive Equipment Technician and Unit Manager/Charge Nurse will ensure the beds' dimensions are appropriate for the residents'	02/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD , SMYRNA, Delaware, 19977

(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
F0700 SS = D	Continued from page 21 Review of R9's "orders" located in the EMR under the "Order" tab revealed no order for side rails. Review of R9's "care plan," revised 09/08/25, located in the EMR under the "Care Plan" tab revealed "Basic Care Needs: I can't complete my cares on my own; I am totally dependent for all care. Because I have had a subdural hematoma, post-traumatic brain injury, seizures, and encephalopathy. I am nonverbal, nonambulatory and have the potential to have skin impairment and weight gain or loss. I show this by: not participating in my ADLs [activities of daily living] total dependent and not being able to tell you what I want or need and being incontinent." Interventions included "I use a wide low air loss mattress, bilateral side rails. I reposition in bed: with the help of 2 staff and use my wedge for effective turning off my back" Review of R9's "Bed Rail Assessment," dated 03/14/25, located in the EMR under the "Assessment" tab revealed "3a. Side Rail Placement: a. Side Rails/Assist Bar are indicated and serve as an enabler to promote independence." The assessment included the resident representative's signature and date but no documentation about if the risks versus benefits were explained, no risk for entrapment was assessed or if alternatives were tried before using the bed rails. On 01/05/26 at 10:38 AM, R9 was observed asleep in bed with a tracheostomy in place, the head of the bed was up, and side rails in use. R9's bed was in a low position with fall mats in place. On 01/08/26 at 9:24 AM, Certified Nurse Aide (CNA)4 was observed bringing in a shower bed into R9's room. CNA3 was standing at R9's bedside. CNA3 stated regarding the use of side rails, "To keep her in bed so she doesn't fall." CNA3 stated the resident had not fallen from the bed and could not grab or used the side rails. 2. Review of R27's quarterly "MDS" with an ARD date of 01/07/26 and located in the "MDS" tab of the EMR, revealed R27 was admitted on 07/06/18. R27's cognition was severely impaired. The resident was coded for functional limitation in range of motion in her upper and lower extremity, had a feeding tube, and had diagnoses of Alzheimer's disease, epilepsy, unspecified, and cerebral vascular accident.	F0700	Continued from page 21 size and weight. In addition, the manufacturer's recommendations and specifications for installing and maintaining bed rails will be followed by the Adaptive Equipment Technician. The Adaptive Equipment Technician will conduct quarterly maintenance checks to verify the safety of the bed rails for all residents who have bed rails. The Continuous Quality Improvement RN III and Adaptive Equipment Technician will oversee the bed rail system changes. All nursing staff and Adaptive Equipment Technician were re-educated by the Trainer Educator II or designee on the use of bed rails, the benefits and risks, and the process if residents request or require having bed rails on their beds by February 14, 2026. The Unit Managers or Charge Nurses will conduct monthly audits of 30% of all residents' beds to determine if bed rails are appropriate using the Bed Rail Audit Tool (Attachment #6). This audit will be completed weekly for four (4) weeks. If 100% compliance is achieved after four (4) consecutive weeks, then the audit will be decreased to monthly for three (3) months. If 100% compliance is achieved after three (3) consecutive months, then the audit will be decreased to quarterly for two quarters. If 100% compliance is achieved for two consecutive quarters, then this facility has successfully addressed this deficient practice and achieved compliance. Audit results will be reviewed during Quality Assurance and Performance Improvement (QAPI) meetings. Any identified issues will result in immediate corrective action.	

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F0700 SS = D	Continued from page 22 Review of R27's "order," dated 11/18/24, located in the EMR under the "Order" tab revealed "Bilateral upper side rails for safety. No directions specified." Review of R27's "care plan," revised 07/16/25, located in the EMR under the "Care Plan" tab revealed "Safety: Falls. I: have the potential to fall and injure myself. Because I: have dementia/Alzheimer's disease. In the past: I have fallen; I have fractured my right hip." An intervention included "have bilateral side rails to ensure my safety." Review of R27's "Bed Rail Assessment," dated 12/15/25, located in the EMR under the "Assessment" tab revealed "12. Reason(s) for Side Rail Use: a. Used to keep resident in bed." The assessment included the resident representative's signature and date but no documentation about if the risks versus benefits were explained, no risk for entrapment was assessed or if alternatives were tried before using the bed rails. On 01/05/26 at 10:39 AM, R27 was observed asleep in a low bed with the head of bed up, a fall mat in place, and both hands contracted with cloth rolls in place. On 01/08/26 at 9:15 AM, R27 was observed being transported back to her room from the shower room on a shower bed by CNA3 and CNA4. R27's hands were contracted and positioned on her chest. During an interview on 01/08/26 at 9:20 AM, CNA3 stated the resident had side rails "For falling." CNA 3 stated the resident could not grab or use the side rails. During an interview on 01/09/26 at 10:27 AM, Registered Nurse (RN)4 stated she or another RN completes the side rail assessments. RN4 stated she will be discontinuing the side rails for both residents (R9 and R27). RN4 stated, "The only reason they should have side rails is if the residents use them to reposition." RN4 stated the residents' responsible parties signed the assessments, but it didn't include risks versus benefits. RN4 stated when she started her employment, the side rails were already in place for both residents. RN4 stated she thought maybe at one time the residents could use them as enablers. RN4 stated R9 and R27 had not been assessed for the risk of entrapment. She also acknowledged the assessments didn't include it. RN4 stated she was not sure what alternatives were tried before the installation of the side rails. She also stated, both residents have low beds with fall	F0700		

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F0700 SS = D	Continued from page 23 mats and R9 had a wide mattress." RN4 stated she wasn't sure if they should have a physician's order for the use of side rails. RN4 stated they don't have a policy for side rails. A facility policy for side rails was requested and not provided.	F0700		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure medication was administered to one (Resident (R)35) of one resident observed for pharmacy services. This failure had the potential to	F0755	F755 The facility failed to ensure medication was administered to one resident. Once it was brought to our attention, the physician was notified and the resident was monitored for adverse effects related to improper administration of the ferrous sulfate, multi-vitamin, and cholecalciferol/vitamin D3. The nursing staff involved received immediate re-education on proper medication administration per physician orders and facility policy. All residents have the potential to be affected by this deficient practice. The facility considers this an isolated incident. Nursing staff will receive re-education on proper medication administration; proper medication timing, dosage, route, and documentation; and following physician orders as written. For any discrepancies found during medication administration, the resident will be assessed for adverse outcomes, and interventions will be implemented as needed. The root cause of this deficient practice is staff's failure to follow facility policy and procedures labeled "Medication Administration Policy". All licensed nursing staff will be in-serviced by the DON, Trainer Educator II, and/or designee by February 14, 2026, regarding proper medication administration; proper medication timing, dosage, route, and documentation; and following physician orders exactly as written. The Nursing Supervisors or designee will conduct random observation rounds focusing on medication administration. The audits will be completed for two (2) residents on each shift daily for each unit for one (1) week using the Medication Administration Audit Tool (Attachment #7). The audits will be completed until 100% compliance is achieved for seven (7) consecutive days. Then, the audit will be completed on any shift daily for each unit until 100% compliance is achieved	02/23/2026

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F0755 SS = D	Continued from page 24 compromise patient safety, efficacy of the prescribed treatment, and fulfill the legal and ethical responsibilities. Findings include: Review of R35's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 11/26/25 and located in the "MDS" tab of the electronic medical record (EMR), revealed R35 was admitted on 09/08/17, and had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 indicating R35's cognition was intact. The resident had diagnoses of vitamin deficiency, unspecified, anemia, unspecified, and vitamin D deficiency, unspecified. Review of R35's "orders," located in the EMR under the "Order" tab revealed orders for "Ferrous Sulfate Tablet 325 (65 Fe [iron]) MG [milligram] Give 1 tablet by mouth one time a day for Anemia, Give before breakfast with orange juice," start date 12/23/25; "Multiple Vitamin Oral Tablet (Multiple Vitamin) Give 1 tablet orally one time a day for Vit [vitamin] supplementation," start date 10/18/25, and "Cholecalciferol Oral Tablet 25 MCG [microgram] (1000 UT [unit]) (Cholecalciferol) Give 2 tablet by mouth one time a day for Vit D," start date-10/18/25. Review of R35's "care plan," located in the EMR under the "Care Plan" tab revealed "Basic Care Needs: I need some assistance with my ADLs [activities of daily living] because I have arthritis and physical challenges." On 01/05/26 at 9:47 AM, R35 was observed awake in bed wearing a hospital gown and three (3) pills [a small white tablet, a medium off-white tablet, and a medium black tablet] were on her chest. R35 stated she was given her medication in a cup but must have missed her mouth. R35 then picked up a small medicine cup that was on her overbed table positioned over her lap. Licensed Practical Nurse (LPN)2 was in the hallway and was asked about the three pills. LPN2 entered the room and confirmed she gave the medication to R35 in a medicine cup but didn't notice she didn't take them. LPN2 stated the pills were a multivitamin, iron, and one to reduce fat. During an interview on 01/07/26 at 10:11 AM, Registered Nurse (RN)4 stated she was the Unit Manager. RN4 explained their procedure prior and during the administering of medications to a resident. RN4 was denied there were any residents who self-administered	F0755	Continued from page 24 for seven (7) consecutive days. Then, the audit will be completed once a week on any shift for any unit until 100% compliance is achieved for four (4) consecutive weeks. Then, the facility will conclude that we have successfully addressed this deficient practice and achieved compliance.	

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F0755 SS = D	Continued from page 25 their medications. RN4 confirmed LPN2 should have stayed with R35 to ensure she took her medications. She stated, "Yes absolutely, never leave the medication with the resident." During an interview on 01/07/26 at 4:21 PM, the Director of Nurse (DON) stated she was unaware of R35 spilling three of her medications on 01/05/26 during the morning medication pass and the nurse wasn't in the room but was in the hallway when it was discovered. DON stated there were no residents who self-administered their medications. DON stated, it was her expectation for the nurse to stay with the resident until the medications were taken. Review of the facility's policy titled "Medication Administration," dated 12/04/23 provided by the facility revealed "It shall be the policy of the Long-Term Care Section of the Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) that nursing services, in collaboration with pharmaceutical services, will administer medications in accordance with acceptable standards of practice.... d. Medications should never be left at the bedside to be taken later." The policy did not include staff ensuring the residents take the medication.	F0755		
F0803 SS = F	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups;	F0803	F0803 The facility failed to use menus with portion sizes for regular, mechanical soft, and puree diets. Upon identification of the deficient practice, the facility implemented revised menus that include clearly identified portion sizes for regular diets, mechanical soft diets, and puréed diets. Dietary staff were instructed to begin using the updated menus immediately to ensure residents received meals consistent with nutritional requirements. All residents receiving regular diets, mechanical soft diets, and puréed diets prepared by the facility have the potential to be affected by this deficient practice. The Dietary Manager (DM) will revise the menus to reflect portion size, and the Registered Dietitian (RD) will review the revised menus to confirm nutritional adequacy and compliance with residents' dietary needs. No residents experienced adverse outcomes related to the deficient practice.	02/23/2026

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F0803 SS = F	Continued from page 26 §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to utilize menus with portion sizes for regular, mechanical soft, and puree diets for two of two meals. This failure could potentially cause residents to become malnourished or experience weight loss or weight gain. Findings include: Review of the week-two menus for Spring 2025 did not include portion sizes for the regular, mechanical soft and pureed diets. Review of the individual resident's pre-selected menu sheets for lunch on 01/06/26 and 01/07/26 did not include portion sizes. Review of the facility diet type report, dated 01/09/26, provided by the facility, revealed 35 regular diets, 18 mechanical soft diets, and nine pureed diets. On 01/06/26 at 12:10 PM, the tray line on the 200 unit was observed in progress. Food Service Worker (FSW)1 read each resident's pre-selected menu and plated the food accordingly with no portion sizes to follow. FSW1 confirmed he followed the resident's pre-selected menu items. No portion sizes were listed on the food items, and no other menus were being used to determine portion sizes. The food items that were served included a cold turkey submarine sandwich, salmon square, chips, roasted potatoes, mixed vegetables, mashed potatoes with gravy, pureed mixed vegetables, and puree salmon. On 01/07/26 at 12:07 PM, the tray line on the 200 unit was observed in progress. FSW1 read each resident's pre-selected menu and plated the food accordingly with no portion sizes to follow. FSW1 confirmed he followed the resident's pre-selected menu items. No portion sizes were listed on the food items, and no other menus	F0803	Continued from page 26 The root cause of this deficient practice is that the portion sizes were not listed for residents to review and servers to have knowledge. The facility will revise its dietary services procedure to require that all facility menus include portion sizes for each food item. The menus for mechanical soft and puréed diets will now reflect appropriate portion sizes equivalent to regular diets unless otherwise specified by the RD. All dietary staff will be re-educated by the Dietary Manager, supervisors, or designee on the importance of following standardized menus with portion sizes, ensuring meals are prepared and served according to the approved menus by February 14, 2026. The RD will review and approve all future menu revisions prior to implementation. The DM, RD, or designee will conduct daily meal audits (breakfast, lunch, & dinner) of food served by staff (rotating one nursing unit per day) for one (1) week to ensure the portion sizes are being utilized during food service using the Serving Size Audit Tool (Attachment #8). Once 100% compliance has been achieved for seven (7) consecutive days, the audits will be decreased to once a week (rotating one nursing unit per week for all three meals). When 100% compliance has been achieved for four (4) consecutive weeks, then the facility will consider this deficiency addressed and compliance achieved. Audit results will be reviewed during Quality Assurance and Performance Improvement (QAPI) meetings. Any identified issues will result in immediate corrective action and additional staff education as needed.	

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F0803 SS = F	Continued from page 27 were being used to determine portion sizes. The food items included roast beef slices, stuffed pasta shells, gravy, pureed soup, pureed stuff pasta shells, pureed asparagus, mechanical soft roast beef, rice, pureed beef, pureed mix vegetables, regular mix vegetables, baked potato halves, asparagus, regular soup, mashed potatoes, French fries, and garlic bread. FSW1 was asked how he knew what serving utensils to use since the menus did not have portion sizes. FSW1 stated they have a list of portion sizes in the main kitchen they go by for proteins, mashed potatoes, etc. During an interview on 01/07/26 at 12:08 PM, the Dietary Manager (DM) confirmed the portion sizes were not included on the facility's week-two Spring 2025 menus or pre-selected menus. DM stated the dietary staff used a list of portion sizes available in the main kitchen that included general food groups and items. DM then provided the list titled "Standard Serving Sizes," the dietary staff used when determining serving utensils or amounts to serve. The list only included generalized food groups such as protein, starches, vegetables, and breakfast foods. The list did not include mechanical soft or pureed foods. During a follow up interview on 01/09/26 at 12:40 pm, the DM stated they had menus with serving sizes that could have been used. The week-two menus for Spring 2025 with portion sizes were provided. During an interview on 01/09/26 at 12:42 pm, the Registered Dietitian (RD) stated she was not aware menus without portion sizes were being utilized. The RD stated, she was aware of the requirement for menu portion sizes, "So to ensure the menus were balanced." When comparing lunch on 01/06/26 according to the week-two Spring 2025 menus with portion sizes it was revealed: The portion size for the regular roasted potatoes was 4 ounces (oz) but 3.25oz was served, and The portion size for the puree salmon was 4 oz but 3.25oz was served When comparing lunch on 01/07/26 according to the week-two Spring 2025 menus with portions sizes it was revealed: The portion size for the pureed soup was 6 oz, but 3 oz was served, The portion size for the pureed stuff pasta shells was	F0803		

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F0803 SS = F	Continued from page 28 4 oz but 3oz was served, The portion size for the pureed asparagus was 4 oz, but 3 oz was served, The portion size for the mechanical soft roast beef was 4 oz, but 3.25 oz was served, The portion size for the rice was 4 oz, but 3.25 oz was served, The portion size for the pureed roast beef was 4 oz, but 3 oz was served, The portion size for the baked potatoes was one potato, but one half was served, The portion size for the asparagus was 4 oz, but it was served with tongs, and The portion size for the regular soup was 6 oz, but 3 oz was served A policy for menus was requested and the facility stated they did not have one.	F0803		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F0880	F880 The facility failed to ensure staff wore appropriate personal protective equipment (PPE) during the administration of medication through a percutaneous endoscopic gastrostomy (PEG) tube. This deficient practice could not be corrected immediately. Once brought to our attention, on the same day, the nurse was counseled and re-educated on proper infection control practices and required PPE usage during PEG tube medication administration, hand hygiene, and standard precautions. All residents have the potential to be affected by this deficient practice. Enhanced barrier precautions signage will be placed in the residents' rooms in a visible location for all residents requiring enhanced barrier precautions (Attachment #9). All direct care staff will receive a refresher in-service by the Trainer Educator II or designee on infection prevention and control policies, including enhanced barrier precautions, hand hygiene, and standard precautions by February 14, 2026. The root cause of this deficient practice is staff's	02/23/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085035	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD , SMYRNA, Delaware, 19977

(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
F0880 SS = D	Continued from page 29 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0880	Continued from page 29 failure to follow the facility's policy and procedure on enhanced barrier precautions. Enhanced barrier precautions signage will be placed in the residents' rooms in a visible location for all residents requiring enhanced barrier precautions (Attachment #9). The Trainer Educator II or designee re-educated all direct care staff on infection prevention and control policies, including enhanced barrier precautions, hand hygiene, and standard precautions. The Nursing Supervisors or designee will conduct random observation rounds focusing on proper PPE usage during medication administration. The audits will be completed for two (2) residents on each shift daily for each unit for one (1) week using the Medication Administration Audit Tool (Attachment #7). The audits will be completed until 100% compliance is achieved for seven (7) consecutive days. Then, the audit will be completed on any shift daily for each unit until 100% compliance is achieved for seven (7) consecutive days. Then, the audit will be completed once a week on any shift for any unit until 100% compliance is achieved for four (4) consecutive weeks. Then, the facility will conclude that we have successfully addressed this deficient practice and achieved compliance. Audit results will be reviewed during Quality Assurance and Performance Improvement (QAPI) meetings. Any identified issues will result in immediate corrective action and additional staff education as needed.	