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

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

STATE SURVEY REPORT

NAME OF FACILITY: Complete Care at Hillside LLC **DATE SURVEY COMPLETED:** January 30, 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 Annual, Complaint and Emergency preparedness survey was conducted at this facility from January 21, 2026, to January 30, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day was (ninety-five) 95. The sample totaled (twenty-nine) 29 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement was not met as evidenced by: Cross Refer to the CMS 2567 – L survey completed January 30, 2026: F550, F551, F552, F578, F584, F585, F628, F641, F658, F677, F685, F690, F700, F756, F757, F759, F825, F842, F868, F880, F909 and F921.	Cross Refer to the plan of corrections for CMS 2567 – L survey completed January 30, 2026: F550, F551, F552, F578, F584, F585, F628, F641, F658, F677, F685, F690, F700, F756, F757, F759, F825, F842, F868, F880, F909 and F921.	3/16/2026

Provider's Signature [signature] Title Administrator Date 2/23/26

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3201.3.0 **3201.3.7**	**General Requirements** **The nursing facility shall comply with 42 CFR 483.10, 483.12, 483.13, 483.15 and/or 483.16 Delaware Code 1121 regarding the rights of residents. Those rights shall be made available in writing to residents, guardians, representatives or next of kin.**		
Title 16 Chapter 11 Subchapter II 1121 Resident Rights	**To promote the interests and well-being of the residents in long-term care facilities, all facilities must treat residents in accordance with the following resident's rights: ...** **(8) At the bedside of each resident, the facility shall place and maintain in good order the name, address, and telephone number of the physician responsible for the residents care.** This requirement was not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to have posted the responsible physician's contact information in the resident's rooms as required by State regulation. 1/22/26 3:01 PM – An observation of various rooms revealed there was no evidence of any sign or notice with the responsible physician's name, address or telephone number. The facility failed to have a notice at each resident's bedside with the responsible physician's name, address and telephone number. 1/29/26 4:00 PM During an interview, E1 (NHA) confirmed that the facility did not have the physician/provider's contact information posted in each room.	**Title 16 Chapter 11: Subchapter 1121 Resident Rights** 1. Facility staff placed the required physician contact information at the bedside of every resident in the facility on 1/31/26. Placement was verified by the Administrator (NHA) and Director of Nursing (DON) through direct observation rounds. All identified residents are now in compliance with State regulation. 2. Because this practice was facility-wide, 100% of resident rooms were audited to ensure physician contact information was properly posted at bedside. Any room found without proper posting during the initial audit was corrected immediately at the time of discovery. 3. The root cause of the deficient practice was that there was a need for re-education for proper signage within resident rooms and the reinforcement of designated staff member(s) responsible for maintaining the procedure for bedside	3/16/2026

Provider's Signature _____ Title Administrator Date 2/23/26

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	1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	physician contact information. The administrator provided re-education to the admissions director on 2/20/26 on the Delaware Code Title 16 Chapter 11, Subchapter II, rights of residents, 1121 Resident Rights - At the bedside of each resident, the facility shall place and maintain in good order the name, address, and telephone number of the physician responsible for the resident's care. 4. The administrator or designee will audit a minimum of 10 resident bedsides at random to ensure the proper physician information is posted. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

Provider's Signature _____ Title Administrator Date 2/23/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/30/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments An unannounced Emergency Preparedness survey was conducted at this facility from January 21, 2026 through January 30, 2026. The facility census was ninety-five (95) on the first day of the survey. In accordance with 42 CFR 483.73, an emergency preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		03/16/2026
F0000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility from January 21, 2026 through January 30, 2026. The deficiencies contained in this report are based on interview, observations, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was ninety-five (95). The sample size was twenty-nine (29). Abbreviations and Definitions: Advance Directive - A written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor; AIMS assessment - Abnormal involuntary movements, a 12-item clinician-rated scale to assess severity of dyskinesias in patients taking neuroleptic medications; BIMS - Basic Inventory of Mental status, a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cognition deficit, 8-12 reflects moderate cognition deficit and 13-15 score is reflective of normal cognition; BP - Blood Pressure;	F0000		03/16/2026

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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F0000	Continued from page 1 bpm - Beats per minute; Cancer - Disease characterized by rapid growth of cells in the body; Chronic Kidney Disease - Condition characterized by gradual loss of kidney function over time CNA - Certified nursing assistant; Dementia - A severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking and disorientation; DON - Director of Nursing; EMR - Electronic medical record; Face Sheet - The facility's informational, demographic document about each resident; Heart failure - Heart unable to pump enough blood to meet the body's needs; HR - Heart rate; Hypertension - High blood pressure; leading cause of stroke; HIPAA - Health Insurance Portability and Accountability, legislation to protect health data; IVSS - Intravenous soluset, a medication route; LPN - Licensed practical nurse; MAR - Medication administration record; MD - Medical doctor; MDS - Minimum Data Set; a federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; mg - Milligrams; ml - Milliliters; Orthostatic hypotension - A drop in blood pressure when standing up from a sitting or lying position; OT - Occupational therapy;	F0000		

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F0000	Continued from page 2 PCP - Primary care provider; Permeable - Able to be penetrated or passed through, especially by liquid or gas; PHQ9 assessment - A tool to monitor depression severity; PPE - Personal protective equipment; pt - Patient; PT - Physical therapy; RN - Registered nurse; RSV - Respiratory syncytial virus; RUE - Right upper extremity; SBP - Systolic blood pressure; STS - Sit to stand; VRE - Vancomycin-resistant enterococci;	F0000		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.	F0550	F550 Resident Rights/Exercise of Rights Resident R103 was discharged before follow-up could be completed. Once the concern was identified E16 was immediately educated by the Director of Nursing on maintaining resident dignity and respect, including knocking before entering resident's rooms, fully waking residents prior to providing care, explaining the care that is going to be provided and obtaining consent before starting incontinent or personal care. Current residents requiring assistance with incontinence and personal care have the potential to be affected by the deficient practice. The Director of Nursing will audit residents who require assistance with incontinent and personal care and conduct random observations to ensure staff are knocking prior to entering, waking residents up, and obtaining consent prior to providing care any issues during this review were addressed immediately. Root cause: Was identified as a lapse in staff awareness regarding maintaining resident dignity and obtaining consent before providing personal care, along with missed follow-up education after the incident.	03/16/2026

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F0550 SS = D	Continued from page 3 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R103) out of three residents reviewed for dignity, the facility failed to ensure that R103 was treated with dignity when staff did not wake the resident or obtain resident's permission before attempting to provide incontinence care. Findings include. Review of R103's clinical record revealed: 8/19/25 - R103 was admitted to the facility with diagnoses including orthostatic hypotension and heart failure. 8/25/25 - R103's admission MDS documented a BIMS score of 15, indicating an intact cognition. 8/26/25 - A facility incident report documented, "[R103] reported that four days ago [8/22/25] a male aide came into his room and assaulted him by pulling down his underwear. [R103] then said it wasn't his underwear but it was his pants. [R103] unclear [sic] with this allegation and stated that he has been foggy since admitted from [hospital], "medications have taken over his mind." [sic] The CNA who cared for [R103] that day was [E16, CNA]...". 8/26/25 - A follow up facility incident report documented, "...[R103] said he was woken up by [E16] was [sic] trying to pull my underwear down to get them off...[R103] denied being touched inappropriately. [R103] said he didn't want [E16] to take care of him	F0550	Continued from page 3 Direct care orientation was reviewed/revised and updated as indicated: Direct care staff orientation includes resident rights related to dignity, privacy, and respectful care with a focus on waking residents before providing personal care and explaining what will be provided and obtaining consent prior to starting care. NPE/designee will provide re-education to current nursing staff on resident rights related to dignity, privacy, and respectful care with a focus on waking residents before providing personal care and explaining what will be provided and obtaining consent prior to starting care. Nursing leadership will be re-educated by the regional clinical resource on the expectation to provide timely staff counseling and education after any incident even if the resident involved has been discharged. The Director of Nursing/designee will conduct random observations on 20% of the resident population who require assistance for personal care across all shifts to ensure staff are knocking prior entering resident's rooms, waking residents appropriately before providing care, explaining the care that is being provided and obtaining consent before initiating personal care. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	

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F0550 SS = D	Continued from page 4 again. [R103] did not want the police called and wasn't fearful...". 8/29/25 - A facility incident report documented, "Statement from [E16]...[E16] adamantly denied this allegation, stating that he did take care of [R103] but did not pull down his underwear or assault him...". 9/15/25 1:47 PM - Correspondence submitted by E2 (DON) to the State Agency documented, "...[E16] was educated as to [sic] customer service explaining why you have entered the room and if you want check the patients for incontinence to let them know that...". 1/29/26 1:45 PM - During an interview, R103 stated, "...I was asleep and felt tugging at my hip. [E16] said that I had to take my underwear off. [E16] did not touch me sexually or anything but he didn't announce himself and he didn't knock on the door...". 1/29/26 2:11 PM - During an interview, E2 stated, "No follow up training was given to [E16] after the incident. [E16] only works every other weekend. When [E16] returned the resident was already discharged from the facility." 1/30/26 2:30 PM - Findings were reviewed with E1, E2, E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0550		
F0551 SS = D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law.	F0551	F 551 Rights Exercised by Representative Once the concern was identified F1 (R17's daughter) was notified by nursing leadership and consent was obtained for R17 psychotropic medications and documented in the medical record. Residents with cognitive impairment who received psychotropic medications have the potential to be affected by the deficient practice. The director of nursing/designee conducted an audit on 2/6/26 of residents currently receiving psychotropic medications to ensure designated representatives were notified when appropriate, and consent documentation was present in the medical record. Root Cause: Identified as a gap in the process for verifying a resident's cognitive status and decision-making ability when psychotropic medications are initiated or adjusted, which resulted in the designated representative not being notified and	03/16/2026

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F0551 SS = D	Continued from page 5 §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R17) out of one resident reviewed for dementia care, the facility failed to ensure that R17's designated representative (F1) was informed and able to participate in R17's care with regard to her psychotropic medications. Findings include:	F0551	Continued from page 5 consent not being obtained. NPE/designee will provide re-education to current licensed nursing staff on verifying cognitive status and obtaining informed consent prior to initiation or adjustment of psychotropic medications and ensuring the consent is in the medical record. Nursing orientation was reviewed/revised as indicated: Nursing orientation includes education on verifying cognitive status and obtaining informed consent prior to initiation or adjustment of psychotropic medications and ensuring the consent is in the medical record. A chart audit process is in place to verify cognitive status and obtaining informed consent prior to initiation or adjustment of psychotropic medications and ensuring the consent is in the medical record. The Director of Nursing/designee will audit residents who have newly initiated or adjusted psychotropic medications to ensure cognitive status has been verified, resident representatives are notified when appropriate, and informed consent is obtained and in the medical record. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	

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F0551 SS = D	Continued from page 6 10/15/18 – R17 was admitted to the facility with diagnoses including but not limited to, dementia and schizoaffective disorder. 10/18/18 – R17's admission MDS (Minimum Data Set) documented R17's BIMS (Basic Inventory of Mental Status) score as 12, which reflected mild cognitive impairment. 1/8/26 - R17's quarterly MDS documented that R17 was unable to complete the BIMS interview and documented R17's cognitive skills for daily decision making as severely impaired. 1/23/26 11:10 AM – A review of R17's face sheet revealed F1 (R17's daughter) as R17's emergency contact, care conference person and authorized HIPAA contact. 1/27/26 10:01 AM - A review of R17's EMR revealed that the COVID-1 Vaccine, influenza vaccine and pneumococcal vaccine consent forms that were dated 9/23/25 were signed by F1 (R17's daughter). In comparison, R17's Psychotherapeutic Medication Informed Consent form dated 3/28/25 was signed by R17, who was documented at the time to have a severe cognitive impairment. The facility failed to ensure that R17's designated representative was informed and consented to care provided to R17 with regard to her psychotropic medications. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0551		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or	F0552	F552 Right to be informed/Make treatment decisions Resident R55 had a short-term order for Spironolactone in November 2025. At the time of the review, the medication had already been completed and there was no clear documentation confirming family representative notification. R55 discharged from the facility on 1/23/26 prior to completion of corrective action; therefore, no further corrective action could be implemented for the identified resident. Current residents with newly added medication or medication changes have the potential to be affected by the deficient practice. Director of Nursing conducted an audit on 2/6/26 to identify any residents with new medications or medication changes within the last 7	03/16/2026

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F0552 SS = D	Continued from page 7 professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R55) out of one resident reviewed for notification of changes, the facility failed to provide evidence of notification of R55's family representative when R55 was prescribed a new medication, Spironolactone 25mg Daily for three days on 11/28/25. Findings include: 11/22/25 – R55 was admitted to the facility. 11/28/25 – R55's admission MDS (minimum data set) revealed a BIMS (basic inventory of mental status) score of 3, which was reflective of severe cognitive impairment. 1/21/26 6:58 PM – During a telephone interview, F3 (R55's medical foster person/ emergency contact) stated that they had never been called about any care changes since he [R55] has been in the facility. 11/28/25 – E22 (contracted NP) ordered in R55's EMR, "Spironolactone (a diuretic) oral tablet 25 mg (milligrams) – give one tablet by mouth one time a day for edema RUE (right upper extremity) for 3 days." 1/27/26 2:15 PM – A review of R55's EMR progress notes from 11/28/25 through 12/3/25 lacked any documentation of any healthcare providers notifying R55's family representative of the addition of the new medication, spironolactone. The facility lacked evidence of notification of a change to R55's medical care. 1/29/26 1:50 PM – During an interview, E13 (RN/IP) stated, "We don't have any documentation that the staff called the foster family with the new medication order for Spironolactone… We also do not have any POA (power of attorney)/guardianship paperwork on file for [R55]." 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0552	Continued from page 7 days to ensure appropriate family representative was notified, and the notification was documented in the medical record. Any identified concerns were addressed immediately. Root Cause: Was identified as inconsistent follow through with notifying families or representatives when medication changes occur, along with gaps in documentation of those notifications. NPE/designee will provide re-education to current nursing staff on the expectations to notify the resident and involved family members of new medication or medication changes when appropriate, and to clearly document that conversation in the medical record. Admissions director will also be educated by NPE/designee to ensure the medical record is current with the preferred contacts at admission. Nursing orientation was updated to include education on the expectations to notify the resident and involved family members of new medication or medication changes when appropriate, and to clearly document that conversation in the medical record. If preferred contacts are not available at the time of admission, the social services director will review preferred contacts with the resident to obtain the preferred contact information within 24 hours of admission. Director of Nursing/designee will review residents with new medication orders or medication changes to ensure family representatives have been notified, and that notification is documented in the medical record. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/30/2026

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F0552 ~~F0578~~ SS = D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R14) out of five residents reviewed for Advance Directives, the facility failed to ensure a copy of R14's advance directives was in the resident's	F0552 F0578	F578 Request/refuse/discontinue/treatment/formulate advanced directives Upon identification of the concern, a copy of R14's advanced directive was obtained and placed in the medical record to ensure it is accessible. Current residents with advanced directives have the potential to be affected by the deficient practice. Social Services conducted an audit on 2/23/26 to identify those residents with advanced directives to ensure a copy of the advanced directive is in the medical record. No concerns were identified. Root Cause: Identified as inconsistent follow through in making sure copies of advanced directives are obtained and placed in the medical record. NPE/designee will provide re-education to Nursing leadership (DON, unit managers, and supervisors), and social services on the importance of obtaining, documenting, and maintaining advanced directive information, so it is easily accessible. A system change includes the following: After an initial attempt to reach the family regarding advanced directives, we will make repeated attempts, and the social services department will escalate this to the administrator if no answer is received. At that point a certified letter will be sent to the responsible party. Social Services Director/designee will audit new admissions and any current residents with changes to advanced directives to ensure a copy of the advance directive is in the medical record audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	03/16/2026

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F0578 SS = D	Continued from page 9 medical record. Findings include: Review of R14's clinical record revealed: 12/5/25 - R14 was admitted to the facility with diagnoses including hypertension and chronic kidney disease. 12/8/25 - E17 (Social Work Assistant) documented in R14's clinical record, "...Healthcare Agent/Proxy: Daughter...Confirmed Full Code...Patient reports had [sic] a copy of AD [Advance Directives] at home. SW [social worker] encouraged [R14] to have her daughter bring in to put copy on chart...". 1/27/26 1:48 PM - During an interview, E17 stated, "I can't find R14's Advance Directives right now". 1/28/26 2:00 PM - During an interview, E7 stated, "I contacted R14's daughter. She sent copy of R14's Advance Directives.". 1/29/26 9:00 AM - Finding was reviewed with E1 (NHA). 1/30/26 2:30 PM - Findings were reviewed with E1, E2 (DON), E13 Nurse Educator/IP), E20 (ADON), and E21 (Corporate Educator).	F0578		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F0584	F 584 Safe/clean/comfortable/homelike environment Upon notification, the concerns during the survey were addressed immediately. Shower rooms were cleaned and decluttered to ensure handwashing sinks were accessible. Soiled carpet areas were cleaned and scheduled for ongoing deep cleaning as needed. Maintenance repaired or scheduled repair of cracked tiles, leaking shower heads, and wall discoloration. The damaged shower bed cushion was removed from service and replaced to ensure equipment remains cleanable and in good repair. A new cushion was received on 2/12/26. Current residents have the potential to be affected by this deficient practice. The maintenance director completed a facility wide audit on 1/28/26 to identify similar concerns to reduce clutter and unnecessary equipment in the shower rooms. Any additional findings were addressed immediately. Root Cause: identified as inconsistent	03/16/2026

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F0584 SS = E	Continued from page 10 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for three (second floor, third floor and fourth floor) of three shower rooms, the facility failed to ensure that adequate housekeeping and maintenance services were provided to maintain a clean, sanitary, and home-like environment. Additionally, the hallway carpet on all the units, and the floors of multiple residents' rooms were visibly soiled. Lastly, the facility also failed to ensure that resident care equipment was maintained in good repair and sanitary condition. Findings included: 1. 1/21/26 11:11 AM – During a tour of the second floor, the shower room was observed with cracked tiles, standing water on the floor, discolored walls and water dripping from the shower head. The handwashing sink was inaccessible due to multiple equipment including wheelchairs and mechanical lifts in the room. An area between the wall and the window was observed with a large amount black debris. During an interview, E13 (CNA) stated, "A heater used to be there. But it was removed a while ago." The Surveyor asked E13 about access to the handwashing sink. E13 stated, "We are not able to get to the sink because there is too much stuff in the way."	F0584	Continued from page 10 monitoring/rounding between maintenance and housekeeping which resulted in delayed identification of environmental concerns and equipment needing repair. The Administrator will provide re-education to current housekeeping staff, current nursing staff, environmental service, and current maintenance on the importance of maintaining a clean, sanitary and homelike environment with a focus on keeping handwashing sinks accessible and shower rooms free of clutter, prompt reporting of maintenance or sanitation concerns, and ensuring resident care equipment remains clean, intact and in good repair as well as the importance of routine environmental rounds and clearer reporting expectations to support timely follow up. In addition to education, the facility has implemented a process to prevent reoccurrence. Staff will report all environmental concerns and needed repairs immediately to the Maintenance Director/designee by entering a maintenance request through the facility's work order system. The maintenance Director will track all work orders through completion to ensure timely follow-up and resolution. Routine environmental rounds of the shower room, handwashing sinks, carpets, floor tiles, walls, and resident care equipment will be conducted weekly by the maintenance and housekeeping directors with oversight by the administrator and the director of nursing. Findings will be documented on an environmental audit tool and maintained for review at the monthly QAPI meetings. The maintenance director and housekeeping director/designee will conduct environmental audits of the shower rooms, hand washing sinks, carpets, floor tiles, shower heads, walls for discoloration, shower heads and shower bed cushions to ensure the environment remains clean, sanitary, in good repair, and free of clutter and that any concerns are identified and corrected promptly. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 3 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	

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F0584 SS = E	Continued from page 11 1/21/26 11:30 AM – During a tour of the third and fourth floor shower rooms, the floors were also observed with broken tiles, dripping shower heads and discolored walls. The handwashing sinks were also inaccessible because of the wheelchairs, and other equipment present. During an interview, the Surveyor asked E6 (CNA) about access to the handwashing sink. E6 stated, "It's not easy to wash hands in there because of all of the stuff in the way." 1/21/26 12:00 PM - During a tour of all three units, hallway carpet and multiple residents' rooms were observed with visibly soiled areas. During an interview, C4 (ESD) stated, "There was no schedule for carpet cleaning. We are getting schedules to deep clean the rooms and carpeted areas." 1/22/26 1:30 PM - During a tour of the three units, the hallway carpet and resident rooms continued to be visibly soiled. 1/22/26 1:45 PM - During a tour of the shower rooms on all three units, the rooms continued to be observed with clutter. 1/23/26 3:00 PM - During a tour of the three units, the hallway carpet and resident rooms continued to be visibly soiled. 1/23/26 3:15 PM - During a tour of the shower rooms on all three units, the rooms continued to be observed with clutter. 1/23/26 3:15 PM - Findings were confirmed with E1, E2, and E13. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference. 2. 1/27/26 10:42 AM - A plastic cushion, with five to six surface openings exposing the underlying permeable foam, was observed laying on a shower bed located in the fourth floor shower room. 1/28/26 1:33 PM - During an interview, E27 stated, "That cushion has been like that for a while.". 1/29/26 9:15 AM - During an interview, E13 (Nurse Educator/IP) confirmed the openings on the shower bed cushion. The surveyor asked E13 how the shower bed cushion can be disinfected if the plastic is torn and	F0584		

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F0584 SS = E	Continued from page 12 has openings. E13 stated, "I will have it removed." 1/30/26 9:00 AM - Finding was reviewed with E1 (NHA).	F0584		
F0585 SS = E	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F0585	F585 Grievances Upon identifying the concern, grievance information was updated and made readily accessible to residents and families. This included providing the grievance officer's name and contact information, expected timeframes for review and response, and the right to request a written decision. Grievance forms were relocated to an area accessible to residents including those in wheelchairs, and a process put into place to allow grievances to be submitted anonymously. Current residents and families have the potential to be affected by the deficient practice. Administrator/designee reviewed current grievance materials, accessibility of forms, and information posted throughout the facility to ensure residents and families can easily access the information to submit a concern. Root Cause: identified as an oversight in making grievance information and forms consistently accessible and clearly communicated to residents and families. Regional Operations VP will provide re-education to the Administrator on grievance procedures including as it relates to resident rights to file a grievance, providing required information, ensuring forms remain accessible to all residents including those in wheelchairs. The Administrator/designee will conduct audits to ensure grievance information is posted, forms are accessible to all residents and anonymous submission options remain available. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	03/16/2026

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F0585 SS = E	Continued from page 13 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interview, it was determined that the facility failed to notify residents or family representatives of the name and contact information for	F0585		

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F0585 SS = E	Continued from page 14 the Grievance Officer, the time frame that a grievance should be reviewed and addressed and the right to obtain a written decision regarding the grievance. The facility also did not have available the Grievance form (as stated in their policy) and a mechanism to submit the grievance anonymously. Findings include: 1/23/26 12:59 PM – During a tour of all three floors where residents reside, this surveyor was unable to locate postings notifying who the Grievance Officer was for the facility and their contact information. There was a sign on each floor with the name of the Compliance and Ethics Officer for the facility. 1/23/26 1:28 PM – During an interview, E18 (nursing clerical assistant) stated, "The grievance form is here (pointing to a sign holder, which contained several blank copies of the grievance form). They [residents/family members] can ask for a copy and after they fill it out, they give it to social work." Of note, the grievance forms were located on a counter at chest level height (approximately 48 inches from the ground). There was no identified place for a resident or family member to submit a grievance form, which would allow the resident/family member the opportunity to make a grievance anonymously. 1/23/26 1:35 PM – A review of page 27 of the admission packet given to each new resident that revealed a paragraph explaining the facility's grievance process noted, "... 24. Grievance procedure. (a) Reporting complaints. If the resident and/or resident representative believe that the resident is being mistreated in any way or the resident's rights have been or are being violated by staff or another resident, the resident and/or resident representative shall make his/her complaint known to the facility's Grievance officer. This notice requirement is not intended to preclude the resident or resident representative from filing a complaint with any appropriate governmental regulatory agency at any time. (b) Facility's obligations. The facility will review and investigate the complaint and provide a response to the resident and/or resident representative." Of note, this grievance process explanation did not include the name of the grievance officer and their contact information as required by regulation. Nor did it include the time frame that grievances would be addressed or provide notification of the resident and/or resident representative's right to obtain a written decision regarding the grievance.	F0585		

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F0585 SS = E	Continued from page 15 1/23/26 1:44 PM – During an interview, E1 (NHA) stated, "I am the Grievance Officer. No, the facility does not have a box or place that a resident could submit a grievance anonymously… I see your point that the (grievance) forms that are on the nursing station are not at wheel-chair level and do not have any labeling that identify what the form is (on the sign slant back holder)." 1/28/26 11:35 AM – During an interview, F2 (R118's daughter) stated, "I did not even know there was a grievance process. How do I get the form?" 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON, E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0585		
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.	F0628		03/16/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0628 SS = A	Continued from page 16 §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written	F0628		

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F0628 SS = A	Continued from page 17 notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the	F0628		

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F0628 SS = A	Continued from page 18 State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to	F0628		

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F0628 SS = A	Continued from page 19 authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R102) out of four residents reviewed for hospitalization, the facility failed to notify the Ombudsman on the May 2025 report of R102's transfer to the hospital. Findings include: 5/16/25 – R102 was admitted to the facility. 5/17/25 – R102 was transferred to [hospital] after a fall. 1/27/26 10:45 AM – A review of the facility's May 2025 Transfer Log provided no evidence that the Ombudsman Office was notified of R102's transfer to the hospital. 1/27/26 1:24 PM – During an interview, E2 (DON) confirmed that R102's name was not on the May 2025 Transfer Log. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0628		
F0641 SS = E	Accuracy of Assessments 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	F0641	F641 Accuracy of assessments Upon identification of the concern, the MDS assessments for R8, R11, R18, R32, and R59 were reviewed and corrected to accurately reflect the current siderail use. R8's wound documentation was also reviewed to ensure the MDS accurately reflects the wound status consistent with the clinical documentation. Current residents with side rails in use and residents with wounds have the potential to be affected by the deficient practice. The director of nursing/designee will conduct an audit to ensure the clinical assessments, documentation and the residents actual status match to ensure the MDS is coded correctly any discrepancies were corrected immediately.	03/16/2026

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F0641 SS = E	Continued from page 20 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 observation, interview, and record review for accuracy of assessments, it was determined for five (R8, R11, R18, R32, and R59) out of 29 residents reviewed, the facility failed to ensure that the MDS accurately reflected their use of side rails, and wound status. Findings included: 1. R8's clinical record revealed: 1/6/12 – R8 was admitted to the facility with diagnosis including, but not limited to, hemiplegia and hemiparesis affecting both the left and right-side extremities. 3/6/25 – R8's side rails evaluation documented, "No side rails to be used." 8/28/25 to 9/2/25 - R8's wound care clinical record documented a stage 3 pressure ulcer on the right buttock. 9/9/25 to 10/28/25 - R8's wound care clinical record documented an unstageable pressure ulcer on the right buttock. 10/30/25 – R8's quarterly MDS documented an inability to participate in a cognitive assessment, was completely dependent on staff for bed mobility, had a stage 3 pressure ulcer and side rails were not used. 1/21/26 10:30 AM – R8 was observed lying in bed, 2 half side rails were in the raised position.	F0641	Continued from page 20 Root Cause: was identified as the MDS was being coded based on what the siderail assessment recommends and not what the resident is using along with confusion related to accurate wound staging for MDS coding. Director of Nursing/designee will provide re-education to the current MDS staff related to ensuring the MDS coding accurately reflects the resident's current status and clinical documentation not just what the assessment recommends. The DON/designee will audit newly completed MDS assessments to ensure the MDS accurately reflects the resident's actual usage of siderails, and current wound status based on clinical documentation. Any discrepancies will be corrected immediately. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	

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F0641 SS = E	Continued from page 21 1/21/26 12:30 PM - R8 was observed lying in bed, 2 half side rails were in the raised position. 1/22/26 10:30 AM – R8 was observed lying in bed, 2 half side rails were in the raised position. 1/28/26 10:00 AM – During an interview E6 and E7 (CNAs) stated that R8 was completely dependent on staff for bed mobility and was unable to use the side rails. 1/29/26 11:00 – A review of R8's ADLs documentation revealed, "1/4 side rails to be used as enabler." This order was signed off every shift by the aides. 1/29/29 12:30 PM - During an interview, the Surveyor asked E5 (RNAC) why R8's pressure ulcer was documented as a stage 3 when the wound care records documented that it was unstageable, and why the MDS documented that side rails were not used when they were on the bed in the raised position and were signed off every shift by the staff. E5 stated, "The wound can be back staged if it improved. The side rails are not considered a restraint because the resident does not move by himself." 2. R11's clinical record revealed: 1/15/18 – R11 was admitted to the facility with diagnoses including, but not limited to, congestive heart failure and spinal stenosis. 12/30/25 – R11's side rails assessment included bilateral quarter side rails. 1/1/26 – R11's annual MDS assessment documented a BIMS score of 14, indicating a completely intact cognitive status, and side rails were not used. 1/22/26 11:45 AM – R11 was observed lying in bed with the bilateral side rails in the raised position. 1/23/26 9:24 AM - R11 was observed lying in bed with the bilateral side rails in the raised position. 1/27/26 10:44 AM – R11 was observed lying in bed with the bilateral side rails in the raised position. 1/28/26 10:00 AM – During an interview E6 and E7 (CNAs) stated, "[R11] would help with bed mobility once in a while, but we do most of the work when we change him." 3. R18's clinical record revealed:	F0641		

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F0641 SS = E	Continued from page 22 10/6/23 – R18 was admitted to the facility with diagnoses including, but not limited to, dementia. 1/6/26 – R18's quarterly MDS documented an inability to participate in a cognitive assessment. The MDS also documented that R18 required substantial assistance for rolling from side to side in bed, and side rails were not used. 1/22/26 10:00 AM – R18 was observed lying in bed with bilateral side rails in the raised position. 1/22/26 11:30 AM – R18 was observed lying in bed with bilateral side rails in the raised position. 1/27/26 9:47 AM – R18 was observed lying in bed with bilateral side rails in the raised position. 1/27/26 10:30 AM – During an interview, E12 (CNA) stated, "The staff have to help [R18] with everything except eating." 4. R32's clinical record revealed: 12/4/25 – R32 was admitted to the facility with diagnoses including, but not limited to, left sided paralysis after a stroke. 12/5/25 – R32's care plan documented, "1/4 rails up as per Dr's [doctor]order for safety during care provision, to assist with bed mobility…" 12/7/25 – R32's side rails documented, "Enabler required to assist with bed mobility…" 12/15/25 – R32's admission MDS documented a BIMS score of 13, indicating a fully cognitive status, required substantial to maximum assistance with bed mobility, and side rails were not used. 5. R59's clinical revealed: 10/9/23 – R59 was admitted to the facility with diagnoses including, but not limited to, both lower extremities paralysis and right shoulder and upper arm amputation. 7/14/25 – R59's quarterly nursing assessment documented, "Both [right and left] half side rails." 1/15/26 – R59's quarterly MDS documented a BIMS score of 15, indicating a completely intact cognitive status, dependent on staff for bed mobility and no side rails were used.	F0641		

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F0641 SS = E	Continued from page 23 1/21/26 1:34 PM – R59 was observed lying in bed with bilateral side rails in the raised position 1/22/26 10:00 AM – R59 was observed lying in bed with bilateral side rails in the raised position 1/27/26 11:00 AM – R59 was observed lying in bed with bilateral side rails in the raised position. 1/27/26 11:30 AM – During an interview, the Surveyor asked R59 about the use of the side rails. R59 stated, "I can't use that rail (pointing to the left side rail) because my right arm has been amputated." During an interview, E6 stated, "[R59] can't use the left side rail because his right arm is amputated." 1/29/26 2:30 PM – During an interview, the Surveyor asked E5 about R11, R18, R32 and R59's use of side rails and the MDS documentation that they were not being used. E5 stated, "According to the MDS definition, the side rails are not considered restraints." 1/29/26 1:30 PM – Findings were confirmed with E1 and E2. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0641		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for three (R55, R98 and R105) reviewed for care plans, the facility failed to provide care that meets the professional standards of care. For R55 and R105, an LPN completed R55's and R105's admission assessments in violation of the State Board of Nursing Scope of Practice. For R98, there was no evidence of an RN providing discharge education. Additionally, for R105, there was no evidence that an RN completed post fall assessments and documentation.	F0658	F658 Services Provided to Meet Professional Standards Residents R55, R98 and R105 have all been discharged prior to completion of corrective action; therefore, no further corrective action could be implemented for the identified residents. Residents requiring admission assessments, post-fall assessments and discharge education have the potential to be affected by the deficient practice. The director of nursing or designee audited admissions, discharges and post fall assessments from the last 7 days on 2/23/26 to ensure the initial assessments and any education were completed and documented by an RN. Root Cause: Identified as a lack of understanding of the LPN nurse practice act and the requirement for an RN to provide education and complete initial assessments. NPE/designee will provide	03/16/2026

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F0658 SS = D	Continued from page 24 Delaware State Board of Nursing – RN, LPN and NA/UAP Duties 2024... Admission Assessments * - RN... * = Once a care plan is established, the LPN may do assessments... Post Fall Assessment & Documentation ^ - RN...^ = RN must do initial fall assessment; LPN can do subsequent assessments. Discharge Process (RN must do initial teaching) **... ** = LPN can reinforce discharge teaching/plan. RN must do all initial assessments. Review of R55's clinical record revealed: 11/22/25 – R55 was admitted to the facility. 11/22/25 – E15 (LPN) completed the "Nursing Admission/ Readmission/Annual/Sig Change Assessment" in R55's EMR (electronic medical record). 11/22/25 – E15 completed R55's Lift/Transfer/Reposition evaluation, AIMS assessment, PHQ9 evaluation and bedrail evaluation in R55's EMR. An LPN, not an RN as required by the Delaware State regulation for Board of Nursing Scope of Practice, completed the admission process for R55. 2. Review of R98's clinical record revealed: 11/11/25 – R98 was admitted to the facility. 11/19/25 – R98 was discharged from the facility. 1/26/26 10:32 AM – A review of R98's Discharge Plan Documentation revealed E17 (Social Work Assistant) and E18 (nursing clerical assistant) documented all aspects of R98's discharge to home plan. The facility lacked evidence of any licensed personnel reviewing R98's Discharge Plan documentation. 1/27/26 9:57 AM – A review of R98's EMR progress notes revealed no evidence that an RN provided discharge education prior to R98's discharge. E19 (Social worker) documented in R98's EMR progress notes, "Pt (patient) is discharging per choice. He was informed that he can and should stay and he declined. He was educated on the risks of not completing rehab." 1/28/26 2:10 PM – During an interview, E18 stated, "I sign at the bottom of the discharge plan because I am the one printing it out. The nurses should write a note about the discharge and the education given. The	F0658	Continued from page 24 re-education to current licensed nursing staff on the state scope of practice requirements including that RNs must complete initial assessments, discharge education when required, and post-fall initial assessments. System change: In addition to education, the RN will do admission assessments, post-fall assessments, and discharge education as required, and the completion of these items will be reviewed/verified each morning by clinical leadership in clinical meetings. The Director of Nursing/designee will audit new admissions, discharges, and post fall assessments to ensure an RN has completed the initial assessments for admissions, post falls and provided the discharge education. The audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved, then monthly x 2 months until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	

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F0658 SS = D	Continued from page 25 resident/family gets a copy, we (the facility) keep a signed copy that goes in the paper chart and I mail a copy to the PCP (primary care provider). The facility lacked evidence that an RN provided R98 any discharge education. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON, E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference. 3. Review of R105's clinical record revealed: 6/27/25 - R105 was admitted to the facility with diagnoses including breast cancer and dementia. 6/27/25 7:15 PM - E24 (LPN) completed a Nursing Admission/Readmission/Annual/Significant Change Assessment form in R105's EMR. 6/27/25 7:15 PM - E24 entered a System Note in R105's clinical record documenting that an admission nursing assessment was completed. 7/8/25 10:45 AM - A facility fall incident report documented, "...[R105] found lying on her side in front of her wheelchair...Immediate Action Taken:..Neurocheck in effect. Assessment done. Lump noted on left side of [R105's] head...Person Preparing Report: [E23, LPN]...". 7/8/25 - A facility document titled, "Neurological Evaluation Flow Sheet" noted that E23 completed an initial neurological assessment for R105 at 10:45 AM. 1/29/26 11:32 AM - During an interview, E21 (Corporate Educator) stated, "The nurse who is assigned to the resident will do the post fall assessment and any other assessment prompted by entering a change in condition note [in the EMR]." 1/29/26 12:00 PM - Review of a facility staffing document dated 7/8/25 noted that E23 was assigned to R105 at the time the fall occurred. 1/29/26 12:15 PM - During an interview, E23 stated, "I don't remember the resident but if I was assigned to a resident that fell and hit their head, I would do a full body assessment and the neuro checks for the shift.". 1/29/26 1:00 PM - Review of R105's EMR lacked evidence that an RN completed R105's admission assessment or	F0658		

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F0658 SS = D	Continued from page 26 post fall assessment. 1/30/26 9:00 AM - Finding was reviewed with E1 (NHA). 1/30/26 2:30 PM - Findings were reviewed with E1, E2 (DON), E13 (Nurse Educator/IP) and E21.	F0658		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R99) out of two residents reviewed for activities of daily living, the facility failed to ensure the dependent resident received his scheduled bathing/showers. Findings include: Review of R99's clinical record revealed: 8/19/25 - R99 was admitted to the facility. 8/19/25 – R99 was care planned for ADL self-care performance deficit related to a stroke. An intervention was that R99 was totally dependent on staff to provide bath/shower. 8/21/25 – R99 was care planned that it was "… important that he has the opportunity to engage in daily routines that are meaningful and relative to his preferences." An intervention for R99 was "...very important for [R99's name] to choose how he [was] bathed. He prefers a shower or bed bath." Review of R99's Documentation Survey Reports from 8/19/25 through 9/4/25 revealed that he was scheduled to be showered or bathed every Wednesday and Saturday evening shift and as needed. Out of five scheduled shower/bathing opportunities documented, R99 received bathing two times and refused bathing one time. Review of R99's progress notes lacked evidence of the reason for no bathing provided on 8/30/25 and 9/3/25.	F0677	F677 ADL Care Provided for Dependent Residents Resident R99 was discharged from the facility on 9/4/2025 and is no longer residing in the facility. Therefore, no further corrective action could be implemented for the identified resident. Current residents who are dependent or require assistance for care have the potential to be affected by the deficient practice. DON/designee conducted an audit on 2/23/26 of current residents who are dependent or require assistance for care with who refused showers over the last 7 days to ensure nursing staff was notified of that refusal and follow up was documented. Root Cause: Identified as a breakdown in the process of managing refusals and proper documentation for the refusal of showers. This hinders proper communication between nursing assistants and licensed nursing staff. Nursing assistants did not consistently document and communicate the refusals to the licensed nurse. The licensed nurses did not consistently verify the refusal, assess the residents, encourage care, and document the follow up in the medical record when refusals occurred. In addition, the process of ensuring scheduled showers are completed was not properly tracked. NPE/designee will provide re-education to current licensed nurses and nursing assistants on the refusal of showers process including immediate notification to the licensed nurse upon refusal of showers, the importance of reapproaching residents at a later time to ask if they want a shower, and the importance of documenting in the medical record the nurse assessment and encouragement to allow care. The UDA and POC will be reviewed daily in clinical meeting and documentation will be reviewed for accuracy and completion. Employees who are identified to not properly document missed showers/refusals (whether the resident refused or it was for another reason) will be disciplined accordingly. Additionally, if a resident does not receive a scheduled shower for reasons other than refusal, the assigned nursing assistant will	03/16/2026

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

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F0677 SS = D	Continued from page 27 1/30/26 11:50 AM - E13 (NE/IP) confirmed the finding. 1/30/26 2:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E13 (NE/IP), E20 (ADON) and E21 (CE).	F0677	Continued from page 27 notify the licensed nurse immediately. The licensed nurse will ensure the shower is rescheduled and completed within the appropriate timeframe and will document the reason the shower was missed, and follow-up actions taken will be documented in the medical record. Shower completion will be verified by the charge nurse prior to the end of the shift to ensure residents receive scheduled hygiene services as care planned. Ongoing monitoring of missed showers, including non-refusal occurrences, will be reviewed by the Director of Nursing/designee through routine ADL audits and the QAPI process to ensure sustained compliance. DON/designee will audit ADL shower documentation to identify residents who refused showers, as well as those residents who did not receive a shower for reasons other than refusal and verify nurse notification, assessment, and documented follow up when a dependent resident refuses a shower to ensure residents receive the necessary services to maintain good personal hygiene. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	
F0685 SS = D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.	F0685	F685 Treatment/devices to maintain hearing and vision Resident R1's audiology recommendation was reviewed by the DON and the DON reached out to the audiology vendor on 1/28/2026 and the appropriate follow up was initiated to assist with obtaining hearing aids for R1. Residents who have been evaluated by the audiologist or who have documented hearing concerns requiring audiology services are at risk for being affected by the deficient practice. The Social Services Director contacted the Audiology vendor, Hearsay, to obtain a list of residents with audiology consultations or hearing-related recommendations for the past several visits. Current residents with audiology consultations or hearing-related recommendations were reviewed to ensure	03/16/2026

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F0685 SS = D	Continued from page 28 This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R7) out of one resident reviewed for hearing services, the facility failed to assist in obtaining hearing aids as recommended by a licensed audiologist. Findings include: A review of R7's medical record revealed: 1/10/24 – An Audiology consult was completed, with recommendation made for "Hearing Aid evaluation/assistive listening device." Further recommendations included devices "with domes and ones that are rechargeable." 4/23/25 - An ENT consult was completed which recommended an Audiology evaluation. 1/21/26 2:17 PM – During an interview, R7 stated he had been "waiting a long time" to receive hearing aids that he had been told were ordered. He reported he was having "trouble hearing the TV." 1/23/26 12:47 PM -During an interview with E26 (LPN), it was confirmed that staff were not aware that hearing aids had been recommended, or that the resident had requested them. E26 reported audiology vendor "makes monthly rounds and reviews the residents" with staff. She had not seen R7 on their list. 1/27/26 12:08 PM –During an interview with E2 (DON), it was confirmed that the audiology consult dated 1/10/24 recommended "Hearing Aid evaluation/assistive listening device...'with domes and ones that are rechargeable'." 1/28/26 12:24 PM - Interview with E2 (DON), confirmed she reached out to the Audiologist. 1/28/26 3:11 PM – A note in R7's electronic health record confirmed that E19 (Social Worker) met with R7 who confirmed he wanted hearing aids. 1/29/2026 12:33 PM – Finding was reviewed with E2. 1/30/26 2:45 PM - Finding was reviewed with E1 (NHA), E2, E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0685	Continued from page 28 recommendations were acknowledged, documented, and followed up in a timely manner. No concerns were identified. Root Cause: Identified as not having an effective process in place for reviewing and tracking audiology vendor recommendations. This resulted in the recommendation for hearing aids not being consistently reviewed, documented, or followed up on. The facility will implement a process to track and review audiology vendor recommendations. The Director of Nursing will educate the current licensed nursing staff on the new process for tracking and reviewing audiology vendor recommendations to ensure recommendations are acknowledged, documented in the medical record and followed up on in a timely manner. The new facility process will include the Audiologist leaving the consultations with the Social Service Director/ designee to review and follow-up with any recommendations. Social Services Director/designee will audit audiology vendor recommendations to ensure recommendations are reviewed, documented in the medical record, and followed up in a timely manner. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 3 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	

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F0685 F0690 SS=D SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R118) out of one resident reviewed for respiratory care, the facility failed to ensure that a resident who was continent of bladder at admission, was assessed and received the assistance to maintain continence. Findings include: Cross refer F842 Facility's "Incontinence policy- ...Policy Explanation and Compliance Guidelines: 1. The facility must ensure that residents who are continent of bladder and bowel	F0685 F0690	F690 Bowel/bladder Incontinence Catheter, UTI Resident R118 was discharged from the facility on 2/11/2026 prior to completion of corrective action; therefore, no further corrective action could be implemented for the identified resident. Residents who are newly admitted and readmitted have the potential to be affected by the deficient practice. NPE/designee will conduct an initial audit of residents admitted within the past 30 days to ensure continence assessments, toileting, transfer status; bladder/voiding diaries were completed appropriately. Any identified concerns will be addressed immediately for current residents with updated resident care plans. Root Cause: Identified as a gap in the admission assessment process and follow-through with the continence evaluation, including not completing and reviewing bladder/voiding diaries timely and ensuring toileting assistance was provided when indicated. NPE/designee will provide re-education to current nursing staff on admission continence assessments, documentation requirements, toileting assistance, and maintaining continence when possible, with a focus on the admission process to ensure continence status is assessed promptly, interventions are care planned and documentation is completed according to facility policy. The new admission assessment process will include the completion and review of bladder/voiding diaries. Nursing orientation will include a review of admission continence assessments, documentation requirements, toileting assistance, maintaining continence whenever possible, and that documentation is completed according to facility policy. The facility will perform an admission chart review the following day post-admission to verify the admission assessment process was in compliance with facility and state/CMS requirements. The director of Nursing/designee will audit new admissions to ensure continence assessments, toileting plans and bladder voiding diaries are completed appropriately and plan of care initiated if appropriate. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be	03/16/2026

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F0690 SS = D	Continued from page 30 on admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain…". (date revised 3/13/23). 1/9/26 10:10 AM -C7 (discharging Hospital PT) documented in R188's PT (Physical therapy) Inpatient Treatment Note, "…Transfers- Minimal Assist (patient performs 75%), STS (sit to stand) from bed and commode…Gait- level Surface- Minimal Assist; Roll Walker- 2 wheel, 6 steps bed to commode and commode to chair…". 1/9/26 10:19 AM – C6 (discharging hospital OT) documented in R118's OT (Occupational therapy) Inpatient Treatment Note, "…Transfers – Minimal Assist (patient performs 75%); On and Off Toilet…". 1/9/26 – R118 was admitted to the facility. 1/15 26 – R118's admission MDS (Minimum Data Set) assessment documented R118's BIMS score as 15, which reflected normal cognition. R118's Functional Abilities section documented her Toilet Transfer status as 88, which signifies "not attempted due to medical condition or safety concerns." The facility failed to assess R118's toilet transfer status, which was necessary to ensure R118 received appropriate services to maintain continence. 1/28/26 10:20 AM – A review of R118's chart at the nursing station revealed the facility's 3 Day Bladder/Voiding Diary form in R118's chart that was completely blank. The CNAs documented in the Task section that R118 was incontinent several times a day and required changing. The facility failed to obtain and assess R118's voiding diary, which was an integral assessment for determining services needed to maintain continence. 1/28/26 11:01 AM – During an interview, F2 (R118's daughter) stated, "My mom is continent at home. She needs help to get to the bedside commode but is typically continent." 1/28/26 11:15 AM – During an interview, R118 stated that she has been wearing an incontinence brief during her stay at the facility and no one has offered to help toilet her. 1/29/26 4:06 PM – During an interview, E1 (NHA) confirmed that R118's Bladder/Voiding Diary form was	F0690	Continued from page 30 presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	

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F0690 SS = D	Continued from page 31 blank with no documentation on it. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0690		
F0700 SS = E	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, it was determined for five (R8, R11, R18, R32, and R59) out of five residents reviewed for the use of side rails, the facility failed to ensure that the residents were accurately assessed and reviewed for the use of side rails. Findings included: 1. R8's clinical record revealed: 1/6/12 – R8 was admitted to the facility with diagnoses including a stroke which affected both upper and lower extremities. 3/6/25 – R8's side rails evaluation documented, "No side rails to be used."	F0700	F700 Bed rails Residents R8, R11, R18, R32, and R59 had their side rail use reviewed. Assessments were completed to determine medical necessity, safety, and ability to use side rails for mobility. Physician orders were obtained when appropriate; care plans updated, and side rails were removed or adjusted when not clinically indicated. Current residents utilizing siderails have the potential to be affected by the deficient practice. Director of Nursing/designee conducted a facility wide audit on 1/27/2026 of current residents utilizing siderails to ensure accurate assessments, physicians orders, informe d consents, and appropriate documentation and care plans were in place that accurately reflect the use of side rails. Any identified concerns were addressed immediately including completion of assessments, obtaining orders if needed, and updating care plans or discontinuing siderails when not clinically appropriate. Root Cause: Identified as inconsistent completion and review of side rail assessments, documentation gaps, and lack of clear communication regarding physician orders for siderail use. NPE/designee will provide re-education to current licensed nurses on proper assessment of side rails as a potential restraint, documentation requirements, obtaining physicians orders and ensuring use is clinically appropriate and care planned according to facility policy. In addition to education, the facility follows a structured 2 step bed rail evaluation process for all new admissions and current residents. Alternatives are attempted prior to siderail use, and the rails remain in the down position during evaluation. If alternatives are unsuccessful, an interdisciplinary assessment is completed to determine clinical appropriateness. The resident is assessed for entrapment risk; risk and benefits are reviewed with the resident and/or responsible party, and informed consent is obtained prior to use. Maintenance verifies correct	03/16/2026

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F0700 SS = E	Continued from page 32 10/30/25 – R8's quarterly MDS documented an inability to participate in a cognitive assessment, complete dependence on staff for bed mobility, and side rails were not used. 1/21/26 10:30 AM – R8 was observed lying in bed, 2 half side rails were in the raised position. 1/21/26 12:30 PM - R8 was observed lying in bed, 2 half side rails were in the raised position. 1/22/26 10:30 AM – R8 was observed lying in bed, 2 half side rails were in the raised position. 1/28/26 10:00 AM – R8's clinical record documented, "Bilateral 1/4 side rails to be used as enabler." The side rails order was signed by the staff every shift. 1/28/26 9:00 AM – A review of R8's clinical record lacked evidence of a physician's order or care plan for side rails. 1/28/26 10:30 AM – During a combined interview, E6 and E7 (CNAs) stated that R8 was completely dependent on staff for bed mobility and was unable to use the side rails for bed mobility. 1/29/26 12:30 PM – During an interview, the Surveyor asked E5 (RNAC) about the use of the side rails. E5 stated, "The side rails were not considered a restraint because he [R8] does not move by himself." 2. R11's clinical record revealed: 1/15/18 – R11 was admitted to the facility with diagnoses including, congestive heart failure and spinal stenosis. 12/30/25 – R11's nursing side rail assessment included the use of bilateral quarter side rails. 1/1/26 – R11's annual MDS assessment documented a BIMS score of 14, indicating a completely intact cognitive state, dependent for toileting, dressing of the lower extremities, partial to moderate assistance for bed mobility and side rails were not used. 1/22/26 11:45 AM – R11 was observed lying in bed with bilateral side rails in the raised position. 1/23/26 9:24 AM - R11 was observed lying in bed with	F0700	Continued from page 32 installation and completes a bed system measurement device test to ensure proper fit and absence of entrapment gaps. Ongoing review of siderail use documentation and equipment safety is conducted by nursing leadership with the oversight of the Director of Nursing and Administrator through routine audits and the QAPI process to ensure compliance. Director of Nursing/designee will audit new admissions and residents with significant change in condition related to mobility to ensure accurate side rail assessments are completed; physicians orders are obtained as indicated and informed consent obtained from resident representative and documentation and care plans accurately reflect the use of siderails. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan. Audit tools will reflect the facility's side rail process outlined as above, including verification that alternatives were attempted prior to side rail use, entrapment risk assessments were completed, physicians orders were obtained as indicated, informed consent was secured, proper installation and compatibility of the bed system was verified and documentation and care plans accurately reflect siderail use. Audit findings will be tracked through the QAPI process to ensure ongoing compliance.	

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F0700 SS = E	Continued from page 33 bilateral side rails in the raised position. 1/27/26 10:44 AM – R11 was observed lying in bed with bilateral side rails in the raised position. 1/27/26 11:00 AM – During an interview, R11stated, "I need the staff to help me move in bed." During an interview, E6 stated, "We [staff] help him to move in the bed." 1/27/26 12:00 PM – A review of R11's clinical record lacked evidence of a physician's order for the use of side rails. 3. R18's clinical record revealed: 10/6/23 – R18 was admitted to the facility with diagnoses including, dementia. 10/6/25 – R18's quarterly significant nursing assessment documented bilateral half side rails. 1/6/26 – R18's quarterly MDS documented an inability to participate in a cognitive assessment. The MDS also documented that R18 was dependent on staff for ADLs (Activities of Daily Living), required substantial assistance for rolling from side to side in bed, and did not have side rails. 1/22/26 10:00 AM – R18 was observed lying in bed with bilateral side rails in the raised position. 1/22/26 11:30 AM – R18 was observed lying in bed with bilateral side rails in the raised position. 1/27/26 9:47 AM – R18 was observed lying in bed with bilateral side rails in the raised position. 1/27/26 10:30 AM – During an interview, E12 (CNA) stated, "The staff have to help [R18] with everything except eating." 4. R32's clinical record revealed: 12/4/25 – R32 was admitted to the facility with diagnoses including, left sided paralysis after a stroke. 12/5/25 – R32's care plan documented, "1/4 rails up as per Dr's [doctor] order for safety during care provision, to assist with bed mobility…" 12/7/25 – R32's side rails assessment documented, "Enabler required to assist with bed mobility…"	F0700		

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F0700 SS = E	Continued from page 34 12/15/25 – R32's admission MDS documented a BIMS score of 13, indicating a fully cognitive status, required substantial to maximum assistance with bed mobility, and side rails were not used. 1/22/26 10:30 AM – R32 was observed lying in bed with bilateral side rails in the raised position. 1/22/26 1:30 PM – R32 was observed lying in bed with bilateral side rails in the raised position. 1/27/26 9:00 AM – R32 was observed lying in bed with bilateral side rails in the raised position. 1/27/26 10:30 AM – During an interview, R32 stated, "I need help to turn in bed." The Surveyor asked R32 if he was able to use the side rails to move himself or transfer. R32 stated, "No." 1/27/26 11:00 AM – During an interview, E12 stated, "He [R32] needs a lot of help to move in bed. Sometimes he can hold himself to the side, but we [staff] do everything." 1/27/26 11:30 AM – A review of R32's clinical record lacked evidence of a physician's order for side rails. 5. R59's clinical record revealed: 10/9/23 – R59 was admitted to the facility with diagnoses including, both lower extremities paralysis and right shoulder and upper arm amputation. 7/14/25 – R59's quarterly nursing assessment documented, "Both [right and left] half side rails." 1/15/26 – R59's quarterly MDS documented a BIMS score of 15, indicating a completely intact cognitive status, dependent on staff for bed mobility and "No side rails used." 1/21/26 1:34 PM – R59 was observed lying in bed with bilateral side rails in the raised position 1/22/26 10:00 AM – R59 was observed lying in bed with bilateral side rails in the raised position 1/27/26 11:00 AM – R59 was observed lying in bed with bilateral side rails in the raised position. 1/27/26 11:30 AM – During an interview the Surveyor asked R59 about the use of the side rails. R59 stated, "I can't use that rail (pointing to the left side rail)	F0700		

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F0700 SS = E	Continued from page 35 because my right arm has been amputated." During an interview, E6 stated, "[R59] can't use the left side rail because his right arm is amputated." The facility failed to ensure that R8, R11, R18, R32 and R59 were accurately assessed for the use of side rails. 1/29/26 10:00 AM – Findings were confirmed with E1 and E2. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0700		
F0756 SS = E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F0756	F756 Drug Regimen Review, Report Irregular Act On No specific resident was identified. The facility reviewed and revised the Medication Regimen Review policy in collaboration with corporate support to include clear timeframes and steps the pharmacist must follow when identifying any irregularities requiring urgent action on 2/17/26. The consultant pharmacist and licensed nursing leadership were notified and educated on the updated process on 1/23/26. Current residents had the potential to be affected by the deficient practice. The DON/Designee reviewed the last 30 days of pharmacy consultant reports on 2/23/26 to ensure any identified irregularities were addressed in a timely manner. Root Cause: Identified as a gap in the Medication Regimen Review Policy which did not clearly outline the required timeframes or steps for handling urgent medication irregularities by the consulting pharmacist. The policy has been revised to include expectations for pharmacist notification, timeframe for communicatio n, and follow up actions. Regional Clinical Consultant will provide education to current nursing leadership on the revised policy and the expectations for timely response and documentation. The Director of Nursing will provide education to the consulting pharmacist on the policy update and the expectations for notification. System change: The facility will implement a tracker that logs monthly pharmacist reviews. The pharmacist will call and speak to a nurse promptly whenever there is an irregularity that requires urgent action. Any irregularities requiring	03/16/2026

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F0756 SS = E	Continued from page 36 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that the facility failed to have a medication regimen review policy that included the required time frames for an urgent action irregularity. Findings include: Facility's "Medication Regimen Review ... Policy Explanation and Compliance Guidelines: ... 6. Timelines and responsibilities for Medication Regimen Review: a. The consultant pharmacist shall schedule at least one monthly visit to the facility, and shall allow for sufficient time to complete all required activities. b. The pharmacist shall communicate any recommendations and identified irregularities via written communication within 10 working days of the review. c. If the pharmacist should identify an irregularity that requires urgent action to protect a resident, the DON (Director of Nursing) or designee is informed verbally...". (date revised 2/15/2024) 1/23/26 2:15 PM – A review of the Medication Regimen Review lacked evidence of a time frame and steps that the pharmacist must take when an irregularity that requires urgent action was identified. 1/29/26 4:00 PM – During an interview, E1 (NHA) confirmed that the facility's medication regimen review policy did not delineate a process and time frame for steps that must occur when an irregularity that requires urgent attention was identified. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0756	Continued from page 36 urgent action will be reviewed during the monthly QAPI meeting to ensure timeliness requirements were met. The assistant director of nursing (ADON) or designee will be responsible for the oversight of monthly pharmacist reviews. The Director of Nursing/designee will review the monthly pharmacist consult reports to ensure any irregularities requiring urgent actions were communicated promptly, addressed timely and documented appropriately. Audits will occur monthly x 3 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F0757	F757 Drug Regimen is Free from Unnecessary Drugs R114's medication regime was reviewed by the physician and the midodrine was discontinued on 1/23/2026. The resident was monitored for therapeutic response and adverse effects following medication review.	03/16/2026

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F0757 SS = D	Continued from page 37 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R114) out of two residents reviewed for Antibiotic use, the facility failed to ensure that R114's metoprolol (beta-blocker) dose was adjusted in the presence of adverse side effects causing the initiation of a midodrine (alpha-adrenergic agonist) order. Findings include: American Heart Association categorizes "normal blood pressure in an adult as systolic (top number) less than 120 mm (millimeters)/Hg (mercury), and diastolic (bottom number) less than 80 mm/Hg, with elevated blood pressure as systolic 120-129 mm/Hg and diastolic less than 80 mm/Hg and Stage 1 hypertension being classed as systolic pressure 130-139 mm/Hg and diastolic pressure 80-89 mm/Hg. Low blood pressure is called hypotension and occurs when blood pressure is below 90/60 mm/Hg." (AHA website revised August 14, 2025). 1/15/26 – R114 was admitted to the facility with diagnoses of Atrial fibrillation, chronic kidney disease and hypertension. 1/16/26 – E4 ordered in R114's EMR, "Metoprolol Succinate ER (extended release) 50 mg - give one tablet by mouth one time a day for hypertension/Afib (atrial fibrillation)."	F0757	Continued from page 37 Current residents receiving Midodrine along with other cardiovascular medications that affect blood pressure have the potential to be affected by the deficient practice. Regional Clinical Consultant performed an audit on 1/26/2026 to identify those residents (8 residents) on midodrine along with other cardiovascular medications that affect blood pressure to ensure no other residents were affected by the deficient practice. No other residents were identified. Root cause: Identified as a lack of clinical questioning when using cardiovascular medication with opposing effects on blood pressure. NPE/designee will provide re-education to current licensed nurses on monitoring vital signs and questioning the use of opposing effect cardiovascular medications when blood pressures are stable and notifying the physician and the consulting pharmacist when concerns are identified. System change: Chart checks will be completed during the 11-7 shift to prompt/alert when medications with opposing effects on blood pressure are ordered. The Director of Nursing/designee will audit current residents receiving midodrine to ensure they are not also taking other cardiovascular medications that could cause opposing effects on the resident's blood pressure. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	

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F0757 SS = D	Continued from page 38 1/21/26 3:49 PM – During an interview, R114 stated that she was on antibiotics for septic arthritis of her left knee. R114 also stated that she "recently graduated from hemodialysis". 1/23/26 – E4 (MD) ordered in R114's EMR, "Midodrine 10 mg (milligrams) – give 1 tablet by mouth three times a day for hypotension. Hold for SBP (systolic blood pressure) greater than 140." 1/27/26 12:13 PM - During an interview, C9 (consultant pharmacist) stated, "That is not the best regimen… Giving metoprolol to lower her blood pressure and then later in the day giving midodrine to raise her blood pressure. They [providers] sometimes do that to on hemodialysis days to raise the blood pressure while they are getting their dialysis treatment… I did not know that she [R114] was off of hemodialysis. Maybe should try to give 25 mg metoprolol twice a day and see if there is no longer a need for midodrine." 1/27/26 1:24 PM – During an interview, E2 (DON) confirmed that R114 was no longer a hemodialysis patient. 1/28/26 11:30 AM – A review of R114's documented blood pressures (BP) since her admission on 1/15/26 revealed R114's BP range from 104/60 to 149/78 mm (millimeters)/Hg (mercury). Of note, at no point during this admission did R114 have a documented blood pressure that qualified as hypotensive (below 90/60 mm/Hg), which would warrant the need to raise blood pressure using medications (alpha-adrenergic agonist). 1/28/26 11:40 AM – A review of R114's January MAR (Medication Administration Record) revealed R114 received midodrine (an alpha-adrenergic agonist), which was prescribed to elevate blood pressure, everyday from 1/23/26 to 1/28/26 at 2 PM and 10 PM. Of note, R114's documented BP at the time of midodrine administration ranged from 119/74 to 136/84. 1/28/26 11:45 AM - A review of R114's documented heart rates (HR) since her admission on 1/15/26 revealed R114's HR ranged from 62 to 98 bpm (beats per minute). 1/28/26 11:55 AM -A review of R114's January 2026 MAR revealed R114 received Metoprolol (a beta-blocker), which was prescribed in the setting of Afib to control heart rate, everyday from 1/16/26 to 1/28/26 at 9 AM.	F0757		

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F0757 SS = D	Continued from page 39 The facility failed to adjust R114's medication regimen to account for changes in R114's medical status. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0757		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview, it was determined that for two (R9 and R40) out of four residents observed during medication administration, the facility failed to accurately administer medications for two out of 26 opportunities, resulting in a 7.7% error rate. Findings included: 1. R9's clinical record revealed: 4/10/25 – R9 was admitted to the facility with diagnoses including, diabetes mellitus. 12/10/25 – R9's clinical record included orders to check blood sugar before meals and administer insulin per sliding scale. The morning blood sugar check and insulin administration were scheduled for 7:30 AM. 1/23/26 9:30 AM - During a review of medication administration, the Surveyor observed E11(LPN) checking R9's blood sugar and administering R9's insulin. R9's empty breakfast was on the bedside table. The Surveyor asked E11 what time R9's blood sugar was supposed to be checked and insulin administered. E11 stated, "It was supposed to be done before breakfast, but I only just got to her." The facility failed to ensure that R9's blood sugar was checked and insulin administered before her meal. 2. R40's clinical record revealed: 12/8/22- R40 was admitted to the facility with diagnoses including neuralgia and neuritis.	F0759	F759 Medication Errors Resident R9 and R40 were assessed by an RN following the identified medication errors. The physician was notified, and no adverse effects were noted because of the deficient practice. E11 was provided with immediate education and counseling from the NPE on the five rights of medication administration with a focus on proper medication administration, including correct dosing, timing, and checking blood sugars before meals. Current residents receiving medication have the potential to be affected by this deficient practice, especially residents receiving insulin or medications with specific timing or dosing requirements. Director of Nursing/designee conducted an audit on 2/22/26 to identify those residents who receive insulin or high-risk medications to ensure orders are scheduled appropriately time and medications are administered according to physician's orders. Root Cause: Identified as inconsistent medication verification practices, including failure to fully review medication orders, medication cards, and timing requirements prior to administration. Not following the 5 rights of medication administration. This contributed to insulin not being administered before meals as ordered and incorrect interpretation of a medication card resulting in an incorrect medication dose being prepared. NPE/designee will provide re-education to current licensed nurses on the 5 rights of medication administration with a focus on proper dose verification, reviewing cards against physician's orders and the importance of administering insulin according to ordered times. This education will be included in new hire orientation process The Director of Nursing/designee will conduct medication pass observations on all shifts and all units to ensure medications are administered according to physician's orders, including proper dosing and	03/16/2026

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F0759 SS = D	Continued from page 40 12/9/22 – R40's clinical order documented, "Neurontin 400 mg. Give 1 capsule at bedtime for neuropathy." This order was scheduled for 8:00 PM. 2/27/25 - R40's clinical order documented, "Neurontin 100 mg, give 2 capsules one time a day. 2 caps [capsules] equal to 200 mg." This order was scheduled for 9:00 AM. 1/23/26 9:45 AM - During a medication review, E11 was observed putting a 400 mg Neurontin capsule in R40's medication cup. The Surveyor asked R11 if that was the correct medication. E11 stated, "Yes, this is the correct medication." The Surveyor showed E11 that the medication was taken from the 400 mg medication card. E11 then proceeded to remove another 400 mg Neurontin from the same medication card and put it in R40's medication cup. The Surveyor asked E11 if that was the correct medication. E11 stated, "Yes, 2 capsules will equal 200 mg." The Surveyor intervened before the incorrect dose of 800 mg of Neurontin was administered to R40. The facility failed to ensure that R40 received the correct dose of medication per the physician's order. 1/23/26 10:00 AM – Findings were reviewed with E13. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0759	Continued from page 40 timing. Audits will include residents with orders for glucose monitoring and insulin administration. Audits will occur daily x 3 days on all shifts or until 100% compliance is achieved then weekly x 3 weeks on all shifts or until 100% compliance is achieved then monthly x 2 months on all shifts or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	
F0825 SS = D	Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) §483.65 Specialized rehabilitative services. §483.65(a) Provision of services. If specialized rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- §483.65(a)(1) Provide the required services; or	F0825	F825 Provide/Obtain Specialized Rehab Services Resident R7 therapy was re-screened to evaluate the residents' current need for skilled PT services on 2/23/2026. Current residents who have been referred to therapy for screenings have the potential to be affected by the deficient practice. The Director of Rehab/designee conducted an audit on 2/25/26 to identify those residents who have been referred to therapy for screenings for any falls/post fall assessments within the last 4 months to ensure recommended rehabilitative services were ordered, implemented, and documented. No areas of concern were identified.	03/16/2026

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F0825 SS = D	Continued from page 41 §483.65(a)(2) In accordance with §483.70(f), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R7) out of two residents reviewed for falls, the facility failed to ensure R7 received therapy services that were recommended by physical therapy on 9/8/25 after a post fall screening evaluation was completed. Findings include: Review of R7's record revealed: 8/31/25 2:30 PM – A facility incident report documented that R7 "was found lying supine in his room, next to nightstand and bed, walker by his side. Nonskid shoes on, bed in lowest position. Resident stated he was walking from the bathroom to the bed and while trying to sit on the bed, lost balance and fell…". 9/8/25 - A post fall screening evaluation was completed by physical therapy. Per the therapy note, "Pt [patient] was seen for PT [physical therapy] screen and noted to benefit from skilled PT services. MD [Medical Doctor] order will be requested for PT intervention… Recommendation: PT indicated." 1/29/26 2:30 PM - Physical Therapy notes were reviewed. The most recent PT note was dated 8/21/25, which was the date the resident was discharged from PT services. 1/30/26 10:12 AM - During an interview, E9 (DOR) provided a copy of the post fall screening evaluation, which was completed by E25 (PT) on 9/8/25. E9 confirmed that skilled services were recommended. 1/30/26 12:30 PM – During an interview, E9 (DOR) reviewed therapy notes and confirmed that R7 did not receive skilled services as recommended on 9/8/25. 1/30/26 12:40 PM – Finding was discussed with E9 and	F0825	Continued from page 41 Root Cause: Identified as a breakdown in communication and follow-up between nursing and therapy regarding physica l therapy recommendations post screening resulting in the recommendation not being communicated to the physician to obtain an order and initiation of therapy services. The facility will implement a tracking process to ensure all therapy recommendations are reviewed, orders obtained timely, and services initiated when indicated. The Director of Nursing will educate the current nursing leadership (unit managers, NPE, ADON) and therapy staff on the implemented process for tracking therapy recommendations, screenings, documentation expectations, and timely physician notification. To ensure all therapy recommendations are reviewed, orders obtained timely, and services initiated when indicated, the director of rehab (DOR) or designee will review the order review reports from the physician and nursing in the EMR daily. Any issues identified will be brought to the director of nursing for immediate correction. The DON/designee will audit residents who have newly been referred to therapy screenings to ensure recommended therapy services were ordered, and services have been initiated as recommended, and documentation is complete. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	

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F0825 SS = D	Continued from page 42 E2. 1/30/26 2:45 PM – Finding was reviewed with E1 (NHA), E2, E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0825		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse,	F0842	F842 Resident Records Resident R118 was discharged from the facility on 2/11/2026. No further corrective action can be taken for this resident. Newly admitted residents have the potential to be affected by the deficient practice. The MDS coordinator/designee will conduct an initial audit of residents admitted within the last 30 days to identify residents affected by this deficient practice to ensure their transfer status and functional abilities are documented accurately on the Minimum Data Set assessments. Any discrepancies will be corrected immediately. Root cause: Identified as a lack of consistent review of hospital and therapy documentation upon admission and assessment process which resulted in inaccurate documentation of the resident's toilet transfer status. Director of Nursing/designee will provide re-education to current MDS staff on the importance of accurate documentation, including reviewing hospital discharge paperwork and therapy recommendations when completing assessments. To avoid any gaps, the MDS coordinator/designee will review hospital discharge paperwork and therapy recommendations daily when completing assessments. The MDS coordinator/designee will audit new admissions to ensure functional status including transfer abilities is coded accurately based on hospital records, therapy assessments and nursing documentation on the most recent MDS. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	03/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085013	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/30/2026

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

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F0842 SS = D	Continued from page 43 neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review, it was determined that for one (R118) out of twenty-nine residents reviewed, the facility failed to accurately document in R118's medical records. Findings include: Cross refer F690 1/9/26 10:10 AM -C7 (discharging Hospital PT)	F0842		

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F0842 SS = D	Continued from page 44 documented in R188's PT (Physical therapy) Inpatient Treatment Note, "…Transfers- Minimal Assist (patient performs 75%), STS from bed and commode…Gait- level Surface- Minimal Assist; Roll Walker- 2 wheel, 6 steps bed to commode and commode to chair…". 1/9/26 10:19 AM – C6 (discharging hospital OT) documented in R118's OT (Occupational therapy) Inpatient Treatment Note, "…Transfers – Minimal Assist (patient performs 75%); on and Off Toilet…". 1/9/26 – R118 was admitted to the facility. 1/15 26 – R118's admission MDS (Minimum Data Set) assessment documented R118's BIMS (Basic Inventory of Mental Status) score as 15, which reflected normal cognition. R118's Functional Abilities section documented her Toilet Transfer status as 88, which signifies "not attempted due to medical condition or safety concerns." The facility failed to accurately document R118's toilet transfer status. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0842		
F0868 SS = E	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or	F0868	F868 QAA Committee Unable to correct for Q3 2025. The facility conducted a QAPI meeting on 2/24/26 with the required committee members present, and attendance documentation was completed and maintained. Current residents have the potential to be affected by the deficient practice. Root Cause: Identified as inconsistent scheduling and documentation of the monthly QAPI meeting including not ensuring all required committee members are present, and attendance records are maintained. The regional vice president of Operations will provide re-education to the Administrator on the QAPI meetings expectations including required attendees, frequency of meetings, and documentation requirements. QAPI meetings have been pre-scheduled for the last Tuesday of each month, and this has been communicated to the required QAA committee members. Any deviations in this schedule will be communicated to the QAA committee in advance via	03/16/2026

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F0868 SS = E	Continued from page 45 designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that the facility failed to have evidence of quarterly QAA committee meetings with the required members. Findings include: 1/30/26 12:30 PM – A review of the quarterly QAA committee meeting sign-in sheets revealed no evidence of a third quarter QAA meeting with the four required Committee members in attendance. There was no evidence of a July meeting. For the August 2025 meeting, the medical director was not in attendance. For the September 2025 meeting, the Infection Preventionist was not in attendance. 1/30/26 1:00 PM – During an interview, E1 (NHA) confirmed that the facility lacked evidence of a third quarter QAA committee meeting with all four required committee members in attendance. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0868	Continued from page 45 email. Verification of meeting minutes and attendance will be performed each month by the administrator. The administrator/designee will ensure QAPI meetings are scheduled monthly, and required members are notified in advance; attendance is documented, and meeting minutes are maintained. Compliance will be monitored monthly through the QAPI process x 3 months or until 100% compliance is achieved. Results of the monitoring will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection	F0880	F880 Infection Prevention & Control Unable to correct for E28. Staff member E11 and C8 were immediately re-educated by the NPE on proper hand hygiene, glove removal, and required PPE for enhanced barrier and contact	03/16/2026

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F0880 SS = E	Continued from page 46 prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions 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	F0880	Continued from page 46 precautions. The phlebotomy company was notified of the deficient practice 1/23/26. Current residents have the potential to be affected by the deficient practice. The Infection Preventionist conducted an initial infection control observation audit on 2/23/26 to ensure staff are performing proper hand hygiene, using appropriate PPE and following transmission based and enhanced barrier precautions. Any concerns were addressed immediately. Root Cause: Identified as inconsistent adherence to infection control practices including hand hygiene and proper PPE use by facility staff and contracted personnel. The NPE will provide re-education to current nursing staff and staff of the laboratory services on hand hygiene, proper PPE use and transmission-based precautions and enhanced barrier precautions. New hire orientation includes hand hygiene, reasons for the need for PPE use, transmission-based precautions, and scenarios in which enhanced barrier precautions are required. NPE/IP/designee will conduct random infection control audits that include a sample of 20% of residents on enhanced barrier/transmission-based precautions on each unit to ensure staff are following proper hand hygiene and PPE practices. Audits will occur daily x 3 days on all shifts or until 100% compliance is achieved then weekly x 3 weeks on all shifts or until 100% compliance is achieved then monthly x 2 months on all shifts or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	

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F0880 SS = E	Continued from page 47 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview during medication administration, it was determined that for three (R9, R114, R118) out of four residents reviewed, the facility failed to maintain an infection prevention program. Findings included: 1. Observed during R9's medication administration: 1/23/26 9:30 AM – The Surveyor observed E11 (LPN) don gloves and check R9's blood sugar. Using the same gloved hands, R11 used the blood pressure machine to R9's blood pressure on both arms. R11 then used the same gloved hands to pick up the blood sugar machine, opened the door and exited the room. E11 then opened the medication cart and began to prepare medications for another resident. The Surveyor asked E11 about the lack of hand hygiene after R9's blood sugar check. E11 stated, "I forgot to wash my hands." E11 failed to remove the used gloves and perform hand hygiene after checking the blood sugar, prior to using the blood pressure machine, opening the room door and preparing medications. 1/23/26 10:00 AM – Findings were confirmed with E2 (DON and E13 (Nurse Educator/IP). 2. Review of R114's clinical record revealed: Facility's "Enhanced barrier precautions policy: It is the policy of this facility to implement enhanced	F0880		

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F0880 SS = E	Continued from page 48 barrier precautions for the prevention of transmission of multidrug- resistant organisms... Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug resistant organisms that employs targeted gown and gloves use during high contact resident care activities... Policy Explanation and Compliance Guidelines: ... 4. High-contact resident care activities include: ... g. Device care or usage: central lines...". (Date revised 2/25/25) 1/15/26 – R114 was admitted to the facility. 1/15/26 – E4 (MD) ordered in R114's EMR (electronic medical record), "Cefazolin (an antibiotic) Use 2 grams intravenously (via the veins) every 12 hours for septic arthritis left knee." 1/18/26 – E4 ordered in R114's EMR, "Resident requires enhanced barrier precautions for a diagnosis of open wounds with dressings and central line every shift." 1/21/26 11:10 AM – The surveyor observed an enhanced barrier precautions sign on R114's door. 1/27/26 8:48 AM – The surveyor observed E28 (LPN) prep and administer R114's morning dose of Cefazolin via R114's right central line. E25 wore gloves but did not don the yellow gown as required for EBP precautions. The facility failed to ensure that staff maintained enhanced barrier precautions while administering IVSS medications via an indwelling medical device. 3. Review of R118'S clinical record revealed: Facility's "Transmission-Based (Isolation) Precautions policy- It is our policy to take appropriate precautions to prevent transmission of pathogens, base don pathogens' modes of transmission... 1/9/26 – R118 was admitted to the facility. 1/14/26 - E4 ordered in R118's EMR, "Firvang (an antibiotic) 25 mg/ml – give 5 ml by mouth one time a day for c-diff (C. difficile) 1st recurrence until 2/9/2026." 1/21/26 11:15 AM – The surveyor observed a contact precautions sign on R118's door. 1/28/26 10:38 AM – The surveyor observed C8 (contracted phlebotomist) enter R118's room with only gloves on and then draw R118's blood. C8 did not wear any additional	F0880		

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F0880 SS = E	Continued from page 49 PPE besides gloves despite the contact precautions sign stating that a yellow PPE gown was also required. 1/28/26 10:50 AM – During an interview, C8 confirmed that there was a contact precautions sign on R118's door and that she did not wear any additional PPE besides gloves during the phlebotomy procedure. The facility failed to ensure that Contact precautions were maintained during R118's blood draw. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0880		
F0909 SS = E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review for safety for the use of side rails, it was determined for five (R8, R11, R18, R32 and R59) out of five residents reviewed, the facility failed to ensure that regular inspection of all bed frames, mattresses, and bed rails was conducted as part of a regular maintenance program to identify areas of possible entrapment. Findings included: 3/14/23 – A facility document entitled, "Proper Use of Bed Rails", revised 9/10/25, included, "…If bed rails are used, the facility ensures correct installation, use, and maintenance of the rails…The maintenance director or designee, is responsible for adhering to a routine maintenance and inspection schedule for all bed frames, mattresses, and bed rails." 1/23/26 12:00 PM – The Surveyor observed the following residents with side rails on their beds: 1. R8 – bilateral side rails in the raised position. 2. R11 – bilateral side rails in the raised position. 3. R18 – bilateral side rails in the raised position.	F0909	F909 Resident Bed Residents R8, R11, R18 R32, and R59 had their bed, mattresses, and side rail inspected by maintenance promptly to ensure proper fit, safe, installation, and absence of entrapment risk. The maintenance director has received education and competency training on bed safety including manufacture guidelines, CMS bed system entrapment guidance and proper inspection of bed frames, mattresses, and side rails by the regional maintenance support to ensure safe fit, installation, and identification of potential entrapment risk. This education ensures the maintenance director is knowledgeable and competent to perform ongoing inspections. Current residents with siderails or specialty bed equipment have the potential to be affected by the deficient practice. The Maintenance Director conducted a facility-wide audit on 1/29/26 of all identified resident's mattresses, beds, and side rails to ensure proper fit, installation, and documentation of inspections. Any concerns identified during the audit were addressed immediately. Root Cause: Identified as inconsistent documentation and tracing of routine bed, mattress, and side rail inspections as part of the facility's maintenance program. The Administrator/designee will provide re-education to the maintenance director on requirements for routine inspection and documentation of bed frames, mattresses, and side rails to ensure safety and reduce entrapment risk. The maintenance director has received education and competency training on bed safety including manufacture guidelines, CMS bed system	03/16/2026

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F0909 SS = E	Continued from page 50 4. R32 – bilateral side rails in the raised position. 5. R59 – bilateral side rails in the raised position. 1/27/26 12:00 PM – During an interview, the Surveyor requested the side rails inspection and maintenance logs. E1 stated, "The bed rails inspections are done routinely." E14 MD (Maintenance Director) provided a documented dated 6/2/25 and entitled, "Medical Equipment Inspection Report." The document listed the equipment in the rooms but lacked evidence that an inspection was completed to ensure that the side rails were safely adhered to the bed frames. The facility lacked evidence of documentation of the side rails inspections. 1/28/26 1:00 PM – Findings were confirmed with E1. 1/30/26 2:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E13 (Nurse Educator/IP), E20 (ADON) and E21 (Corporate Educator) at the exit conference.	F0909	Continued from page 50 entrapment guidance and proper inspection of bed frames, mattresses, and side rails by the regional maintenance support to ensure safe fit, installation, and identification of potential entrapment risk. Routine inspections of all bed frames, mattresses and side rails will be conducted at least quarterly and as needed with any equipment change or identified concern, with findings documented as part of the facility's maintenance program. Ongoing oversight of bed safety inspections will be provided by the Administrator and Director of Nursing to ensure continued compliance. The Administrator or designee will audit resident bed inspection documentation to ensure routine inspections of bed frames, mattresses and side rails are completed timely, documented appropriately, and verification of proper installation and the absence of entrapment risk. Audits will occur weekly x 3 weeks or until 100% compliance is achieved then monthly x 3 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	
F0921 SS = E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, it was determined that the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents and staff. Findings include: 1/22/26 1:55 PM – During a laundry tour with C4 (ESD), the surveyor observed water retention along the wall behind the washing machines and around the drainage area. The presence of standing water in the laundry environment creates an unsafe and unsanitary condition and increases the risk of microbial growth, equipment deterioration, and structural damage to the building. C4 confirmed the observation at the time of the tour. 1/22/26 3:38 PM – The findings were reviewed with E1 (NHA).	F0921	F921 Other Environmental Conditions The standing water observed in the laundry area was addressed immediately. The area was cleaned and dried, and maintenance evaluated the drainage issue to ensure proper function. Residents and staff have the potential to be affected by the deficient practice. The maintenance director conducted an audit of the laundry areas on 1/22/26 to ensure there were no additional drainage issues or water accumulation concerns. Any findings were addressed promptly. Root Cause: Identified as inconsistent routine monitoring of the laundry drainage area which delayed identification of the water accumulation. The Administrator/designee will provide education to current maintenance staff, current laundry staff, and current housekeeping staff on environmental safety expectations, routine monitoring and prompt reporting of concerns such as water accumulation or drainage issues. In addition to education, the facility has implemented a process to ensure ongoing monitoring of the laundry	03/16/2026

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F0921 SS = E		F0921	Continued from page 51 drainage areas. The housekeeping Director/designee will conduct routine environmental round of the laundry area to monitor for water accumulation or drainage concerns and findings will be documented on an environmental audit tool including confirmation when no water accumulation is present. Any concerns identified will be reported immediately to the Maintenance Director through the facility work order system for prompt follow-up and resolution. The maintenance Director will track repairs through completion and results of environmental monitoring will be reviewed by the administrator and director of nursing at the monthly QAPI meeting to ensure ongoing compliance. The housekeeping director/designee will complete environmental audits of the laundry areas to ensure there is no accumulation of water in the drainage areas indicating drainage issues. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved then monthly x 2 months or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, /recommendations, and sustainability of plan.	