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

POST IDR STATE SURVEY REPORT

NAME OF FACILITY: Complete Care at Silver Lake LLC

DATE SURVEY COMPLETED: January 23, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found to not be in substantial compliance with 42 CFR 483. Survey Dates: 01/20/26 to 01/23/26 Census: 114 Sample: 39 Supplemental Sample: 15		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed January 23, 2026: F558, F605, F656, F676, F677, F684, F686, F690, F812, F880 and F925.		

Provider's Signature Mary C Radcliffe Title Admin Date 4/29/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085027	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SILVER LAKE LLC	**1080 SILVER LAKE BLVD , DOVER, Delaware, 19904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality, on 01/20/26 to 01/23/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		01/23/2026
F0000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found to not be in substantial compliance with 42 CFR 483. Survey Dates: 01/20/26 to 01/23/26 Survey Census: 114 Sample Size: 39 Supplemental Residents: 15 No deficiencies were issued related to Intakes DE223204, DE223205, DE223206, DE2581491, DE2648287, DE2656381, DE2685706, DE2708343, DE2708379, DE2708399, DE2708415, DE2708419, DE2708428, DE2176966, DE2716970, DE2581545, DE2626016, DE2648109, DE2708365, DE2708371, DE2708384, and DE2708423 Deficiencies were issued related to Intake DE223203.	F0000		03/11/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F0812	F812 Food Procurement, Store/prepare/serve-sanitary Upon identification of the concern, the chicken salad sandwiches were removed from service and temperatures corrected to below 41 degrees prior to serving. Current residents have the potential to be affected by the deficient practice.	03/11/2026

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

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

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F0812 SS = F	Continued from page 1 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, document review, and policy review, the facility failed to ensure chicken salad sandwiches were served at the proper temperature. This deficient practice had the potential to affect 112 out of 114 residents. Findings included: During the second kitchen observation and interview on 01/22/26 from 11:54 AM to 12:15 PM, the following were made with the Dietary District Manager (DDM): A steam table pan was observed on the counter at the left end of the steam table. The steam table pan contained approximately 20 chicken salad sandwiches, stacked one on top of one another. At 12:05 PM the chicken salad sandwiches were being served on the tray line for room trays. A review of the temperature log for the lunch meal revealed the chicken salad sandwiches were within a safe temperature range. At 12:15 PM, the District Dietary Manager (DDM) obtained the temperature of the chicken salad on the chicken salad sandwich. The temperature was 54 degrees Fahrenheit (F). The DDM instructed that the DM stop service. The DDM stated there was another tray of chicken salad sandwiches in the refrigerator. The DDM removed the tray of sandwiches from the refrigerator. The DDM obtained the temperature of the chicken salad sandwiches, and the temperature was 57 degrees F. The DDM told the DM that they would need to stop serving chicken salad sandwiches until he was able to get them to the proper temperature. Review of the "Sandwich, Chicken Salad (dice) – 1	F0812	Continued from page 1 Root Cause: A gap in understanding by dietary staff of cold food holding procedures prior to food service. Administrator/designee will provide re-education to current dietary staff related to proper cooling and holding temperatures for cold food, with a focus on the importance of verifying temperatures before serving cold food to residents. Education regarding proper cooling and cold holding temperatures, including required temperature ranges and procedures for verifying and documenting temperatures prior to food service, is included in new dietary staff orientation and reinforced through ongoing continuing education and posted throughout the kitchen.. This education emphasizes resident safety, food quality, regulatory compliance, the proper cooling and holding of temperatures and temperature testing prior to serving food to the residents. Administrator/designee will audit cold food temperatures prior to food service to ensure that cold food temperatures are below 41 degrees when served. Audits will occur daily x 3 days or until 100% compliance is achieved then 3 times a week for 3 weeks or until 100% compliance is achieved then weekly for 3 weeks or until 100% compliance is achieved then monthly for 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.	03/11/2026

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F0812 SS = F	Continued from page 2 Sandwich" recipe revealed the chicken salad consisted of "Diced, cooked chicken; mayonnaise; and pepper." During an interview on 01/22/26 at 12:42 PM, the Administrator stated all food should be served at the right temperature to avoid any residents getting sick. Review of the facility's policy titled "Food: Preparation" revised 02/2025 revealed, "...All foods will be held at appropriate temperatures, less than 4l degrees F for cold food holding..."	F0812		03/11/2026
F0925 SS = F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the facility failed to ensure the kitchen area was free from fruit flies. The facility failed to keep the kitchen clean and ensure bait boxes remained under the three compartments sink to deter pests as recommended by their pest control provider. This created the potential for the harborage of insects and vermin which had the potential to affect 114 out of 114 residents. Findings included: 1. During the initial kitchen observation and interview on 01/20/26 from 9:30 AM to 9:54 AM, the following observations were made with the Dietary Manager (DM): a. The smaller three compartment sink in the corner of the kitchen, near the hand-washing sink, had approximately 15-20 fruit flies near the floor on the right side of the sink. On the floor, there were three bait boxes on the right side of the sink and two bait boxes on the left side. There was a one-ounce plastic, empty coffee creamer container on the floor on the right side of the sink and black debris. The Dietary Manager (DM) stated the area needed to be cleaned and confirmed they had a problem with fruit flies currently and in the past. He stated pest control came weekly and sprayed the area. 2. During the second kitchen observation and interview on 01/22/26 from 11:54 AM to 12:15 PM, the following observations were made with the	F0925	F925 Maintains Effective Pest Control Program Upon identification of the concern, pest control was notified and requested to come out to the facility prior to their regular scheduled service date. The affected area was thoroughly cleaned, including removing the black debris from the floor drain and standing water was eliminated. Residents and staff have the potential to be affected by the deficient practice. Root Cause: Debris and standing water were present in the floor drain which has the potential to breed fruit flies, Although, pest control services were in place, the frequency of visits and chemicals being used were not effective at eliminating of the fruit flies. The center contacted pest control to request more frequent visits from once weekly to twice weekly. The pest control company changed the chemicals previously used to an alternate pesticide specifically for fruit fly elimination. Pest control service reports are reviewed by the Administrator to ensure treatments are completed as scheduled. Administrator/designee will provide education to current dietary staff on pest prevention practices which includes maintaining clean and dry sink and drain areas and promptly removing any visible debris and reporting pest activity immediately to maintenance. The center purchased a shop vac to remove any standing water from the drain nightly to prevent standing water resulting in breeding of fruit flies. The Administrator will be responsible for overseeing the pest control program and any required interventions. The Dietary manager/dietary designee will report increased sighting or the need for increased services to the Administrator and/or Director of Maintenance. The Dietary Manager/dietary	03/11/2026

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F0925 SS = F	Continued from page 3 Dietary District Manager (DDM): a. The smaller three compartment sink in the corner of the kitchen had approximately 50-75 fruit flies near the floor at each end of the sink. There was one bait box on the floor on the left side of the sink. No other bait boxes were observed. The Dietary District Manager (DDM) stated pest control would treat fruit flies weekly. The DDM stated the area should be clean and food and debris should be removed. The DDM stated the Dietary Manager (DM) added cleaning the area to his weekly cleaning schedule and confirmed it had not been on the schedule until Monday. During an interview on 01/22/26 at 12:42 PM, the Maintenance Director (MD) stated pest control come to the facility weekly, and he encouraged the kitchen to ensure bait boxes are in place. The MD stated they could contact pest control in between weekly visits if they saw an increase in bugs. The MD stated they did not contact pest control this week and they were waiting for the weekly Thursday treatment which occurred on Thursdays. Review of the facility's policy titled, "Pest Control Program" dated 03/22/26 revealed, "It is the policy of this facility to maintain an effective pest control program that eradicates and contains common household pests and rodents."	F0925	Continued from page 3 designee will be responsible for verifying and ensuring the cleanli ness of the kitchen is documented. The Dietary Aide assigned to dish machine area will be responsible for using the shop vac when needed. The maintenance director/designee will conduct audits to ensure there is no standing water or debris in the sinks or the drains, proper sanitation, and to monitor any noted continued fruit flies. These audits will occur daily at the end of food service and in the am prior to food service x 1 week or until 100% compliance is achieved then 3 times per week x 1 week 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.	03/11/2026
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review and policy review, the facility failed to ensure a call light was within reach for one resident (Resident (R) 1) out of 39 sampled residents reviewed for call lights. This failure had the potential to create a situation where the resident would need help and could not reach the call light, causing the resident's needs to go unmet. Findings Include: Review of 1's "Face Sheet" located under the "Profile" tab of the electronic medical record (EMR),	F0558	F558 Reasonable Accommodations Needs/Preferences Resident R1's breath activated call light was immediately placed within reach of the resident and staff verified R1's ability to independently activate the call system Current residents who rely on adaptive call light systems or who cannot access a standard call bell independently have the potential to be affected by the deficient practice. DON performed an initial audit to identify those residents with adaptive call light systems or who cannot access a standard call bell independently on 2/10/2026. No further residents were identified as being unable to access or active their call light system. Root Cause: Staff did not validate that the breath activated call bell was within reach prior to leaving the room. NPE/designee will provide re-education to current facility staff to ensure call	03/11/2026

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F0558 SS = D	Continued from page 4 revealed admission date of 10/07/25 with diagnoses which included Schizophrenia and intellectual disabilities. Review of R1's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/24/25, located in the "MDS" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 which indicated the resident was cognitively intact. R1 was dependent on staff for all Activities of Daily Living (ADLs). Review of the "Care Plan" located in the EMR under the "Care Plan" tab and dated 10/08/25 revealed, "…Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance…." During an observation on 1/21/26 8:55 AM, R1 was in her bed calling out, saying "help" repeatedly. Observed at the top of her bed was a long black tube with a white end that was attached to her bed. The tube had a place at the bottom to attach to the call light. The white end was close to her mouth, and the black tube was malleable. The call light was placed above her head, approximately six inches. During an observation and interview on 01/22/26 at 3:43 PM, Registered Nurse (RN) 9 stated R1's call light was used with her breath. The call light was placed above her head, approximately six inches from her mouth. She stated that for R1 to use her call light, it needed to be in a position where she could blow into it. RN9 moved the call light closer to R1's mouth until the call light was in R1's mouth. R1 blew into the call light, and the call light turned on. During an interview and observation on 01/22/25 at 3:30 PM, Certified Nurse Aide (CNA) 10 stated R1 required total care, and her call light needed to be near her mouth for it to work. CNA 10 agreed it was not in place. During an observation and interview on 01/23/25 at 10:10, CNA 10 came out of R1's room. R1 had her call light in front of her face, approximately six inches away. R1 stated she could not use her call light. During an interview and observation on 01/23/26 at 10:19 AM, Licensed Practical Nurse (LPN) 5 stated that if R1 needed help, she would usually call out. She stated her call light was important and should be within R1's reach. LPN5 stated R1 has the type	F0558	Continued from page 4 lights are always accessible with an emphasis on those residents who cannot independently access the call bell. Unit managers/designee will conduct audits of those residents identified as not having the ability to independently access the call bell system to ensure the call bell system is withing reach and the resident is able to activate it and provide return demonstration to the auditor to verify the call light can be activated by the resident. 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.	03/11/2026

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F0558 SS = D	Continued from page 5 of call light that worked when R1blew into it. LPN5 attempted multiple times to get the call light in the correct position, while R1 continuously stated she could not use it. LPN5 finally took the call light and bent it into a fashion that worked when R1 blew into it. R1 stated she knew where her call light was and could use it. During an observation on 01/23/26 at 10:37 AM and at 10:42 AM, R1 turned on her call light; there was no one in R1's room at the time. During an interview on 01/23/26 at 10:37 AM, RN5stated that it was important that R1's call light was within reach. RN5 stated that all staff who work with R1 should know where to place R1's call light so R1 can use it when necessary. During an interview on 01/23/26 at 8:19 AM, the Director of Nursing (DON) stated that call lights should always be within residents' reach. Review of the facility policy titled, "Call Lights: Accessibility and Timely Response" revised 07/2025 revealed, ". . . Staff will ensure the call light is within reach of the resident and secured as needed. . ."	F0558		03/11/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any	F0605	F 605 Right to be Free from Chemical Restraints Immediately, the attending physician of resident R11 was notified as well as the hospice provider, and the order for Ativan was reviewed, new order was received on 1/28/26 with a stop date of 2/11/26, and a re-evaluation was obtained, and the medical record was updated to reflect the continued need for Ativan. Current residents receiving PRN psychotropic medications including current hospice residents have the potential to be affected by the deficient practice. DON/designee completed an initial audit on 1/30/26 of current residents who received PRN psychotropic medications to ensure there is a 14 day stop date and those residents are not receiving the medication beyond 14 days without evaluation and documentation of the clinical indications to use the medication beyond 14 days. Any identified issues were corrected and the medical record updated Root Cause: Staff incorrectly assumed that hospice status exempted the resident from the required 14 day stop and evaluation requirement for PRN psychotropic medication. NPE/designee will provide re-education	03/11/2026

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F0605 SS = D	Continued from page 6 physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §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- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--	F0605	Continued from page 6 to current licensed nursing staff and providers on the CMS requirement emphasizing that a 14-day stop, and evaluation order is required for all residents including those residents receiving hospice services who receive PRN psychotropic medication The DON/ designee will audit current residents including hospice residents receiving PRN psychotropic medication to ensure there is an order for a 14 day stop and evaluation and to ensure appropriate documentation is in the medical record for use beyond the 14 days. 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 the 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.	03/11/2026

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F0605 SS = D	Continued from page 7 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure one of five residents (Resident (R) 11) reviewed for unnecessary medications, continued to receive as needed (PRN) psychotropic medication (lorazepam) beyond 14 days, without an evaluation and documentation of the clinical indications to use the medication beyond the 14 days. This failure had the potential to place the resident at risk of adverse consequences. Findings include: Review of R11's electronic medical record (EMR) located under the "Profile" tab indicated the facility admitted the resident on 11/04/24. Review of R11's EMR "Orders" located under the	F0605		03/11/2026

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F0605 SS = D	Continued from page 8 "Orders" tab dated 12/23/25 indicated, "lorazepam 0.5 milligrams (mg) [antianxiety medication] and take one half tab (0.25 mg) to be administered every four hours PRN [as needed] for agitation and restlessness." Review of R11's EMR "Medication Administration Record (MAR)" located under the "Orders" tab dated 12/25 indicated the facility administered the lorazepam on 12/24/25 one dose; on 12/26/25 one dose; 12/29/25 one dose; and on 12/30/25 one dose. Review of R11 EMR titled "MAR" located under the "Orders" tab for the month of 01/26 indicated the facility administered the lorazepam on 01/01/26 one dose; 01/08/26 one dose; 01/09/26 one dose; 01/11/26 one dose; 01/12/26 one dose; 01/15/26 one dose in the morning and one dose in the afternoon; 01/16/26 one dose in the morning and one dose in the evening; 01/17/26 one dose was administered; 01/18/26 one dose was administered; and on 01/21/26 one dose was administered. During an interview on 01/23/26 at 10:29 AM, the Consultant Pharmacist stated that any time a PRN psychotropic medication was ordered, there needs to be a 14-day stop date. The Consultant Pharmacist stated the medical provider then to reassess the continued use and provide justification and this needed to then be documented in the clinical record. The Consultant Pharmacist stated the use of PRN psychotropic medication applied to residents who received hospice services. During an interview on 01/23/26 at 10:38 AM, the Director of Nursing (DON) stated the PRN for lorazepam did not require a 14-day end date since R11 received hospice services. Review of a facility's policy titled "Use of Psychotropic Medications" dated 02/18/25 indicated, ". . .Psychotropic medications used on a PRN basis must have a diagnosed specific condition and indication for the PRN use documented in the resident's medical record and is subject to the limitations as noted. . .PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, until the attending physician or prescriber believes it is appropriate to extend the order beyond the 14 days. The medical record should include documentation from the physician or prescriber for the rationale for the extended time period and indicate a specific duration. . ."	F0605		03/11/2026

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F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656	F656 Develop/Implement Comprehensive Care Plan Upon identification of the concern, R6's care plan was immediately reviewed and updated to include wound treatment interventions; care plan goals and evaluation of outcomes and wound care was verified as being provided per physician's orders. Current residents with wounds requiring treatment have the potential to be affected by the deficient practice. The DON/designee conducted an initial audit on 2/11/26 of current residents with wounds requiring wound care to ensure the care plan includes treatment interventions care plan goals and evaluation of outcomes for treatment of existing wounds and any concerns were addressed immediately. Root Cause: Although the diagnosis and risk were identified, the nursing leadership responsible for updating wound care plans did not include the treatment intervention for existing wounds which would indicate a need for re-education on updating skin integrity care plans to reflect the intervention for those residents requiring wound care. Director of nursing/designee will provide re-education to the nursing leadership team which includes unit managers, and nurse practice educator on the requirements to ensure skin integrity care plans include the intervention of treatment, care plan goals and evaluation of outcomes for those residents who have wounds that require treatment. Director of Nursing/designee will conduct audits to ensure those residents with active wound care treatments have their skin integrity care plans updated to include interventions, goals and evaluation of outcomes of wound treatment. Audits will occur daily x 3 days for 1 week or until 100% compliance is achieved then weekly for 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.	03/11/2026

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F0656 SS = D	Continued from page 10 Based on record reviews, interviews, and facility policy review, the facility failed to ensure a person-centered comprehensive care plan was developed for one of one resident (R)6 receiving wound care/treatment out of a total of 39 sampled residents. This deficient practice placed R6 at risk of worsening wounds, new wound development, and for unmet resident care needs and goals for care. Findings include: Review of R6's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR) revealed admission date of12/02/25 with diagnoses that included cellulitis, end stage renal disease (ESRD), dependence on renal dialysis, and difficulty in walking. Review of R6's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/04/25 located in the EMR under the "MDS" tab reflected R6 was at risk of developing pressure ulcers/injuries and had one or more unhealed pressure ulcers/injuries (PU/PI) present upon admission to the facility. The "MDS" reflected R6 had two Stage 3 pressure ulcers (Full thickness tissue loss) and moisture associated skin damage (MASD), a non-pressure skin issue. Review of R6's "Care Plan" located in the EMR under the "Care Plan" tab initiated on 12/04/25 (revision on 01/16/26) indicated, "The resident has potential impairment to skin integrity of the r/t ESRD, anemia, obesity, HTN [hypertension], diabetes, use of anticoagulants, and has actual skin breakdown to the right gluteal fold, and coccyx. I have a terminal prognosis r/t [related to] cancer of the lung." Further review of R6's Care Plan revealed it was not individualized and person-centered regarding treatment/services for Stage 3 pressure ulcers and MASD care. During an interview and record review on 01/23/26 at 9:17 AM, the MDS Coordinator (MDSC) stated that she initiated the comprehensive care plan based on a Care Area Assessment (CAA) that was triggered. The MDSC reviewed R6's admission MDS triggered CAAs for Pressure Ulcer. The MDSC reviewed the comprehensive care plan and confirmed that the care plan reflected objectives and interventions for the risk for pressure ulcers but did not have an objective and intervention to address actual wounds or a time frame to achieve desired outcomes. The MDSC stated that the care plan should reflect resident goals, desired outcomes, care/services	F0656		03/11/2026

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F0656 SS = D	Continued from page 11 provided, and specific services to be provided as reflected in the comprehensive assessment. The MDSC stated that she was responsible for the admission, quarterly, annual, and change in condition MDS completion. The MDSC stated that the Unit Managers reviewed the care plans for changes and updates. During an interview and record review on 01/23/26 at 10:24 AM, the Unit Manager (UM) stated that she tried to review the care plans for the residents assigned to his/her unit at least weekly. The UM said that she looked for care plans to address specific care needs, appropriate interventions that could prevent avoidable decline. During an interview on 01/23/26 at 11:59 AM, the Director of Nursing (DON) could not identify appropriate interventions in the care plan for delivery of care for the two actual Stage 3 wounds or MASD. Review of the facility's policy titled, "Comprehensive Care Plans" revised 02/18/25 revealed, "…All CAAs triggered by the MDS will be considered in developing the plan of care … 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."	F0656		03/11/2026
Γ0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following	Γ0676	Γ676 Activities Daily Living Residents R20 and R75 were immediately assessed to ensure personal hygiene needs were met and offered showers. Staff updated the medical record to reflect the care provided. Current residents have the potential to be affected by the deficient practice. DON/designee conducted an initial audit on 2/12/2026 of ADL shower documentatio n to identify residents with NA documented for showers and immediately assessed each resident to ensure personal hygiene needs were met and offered shower if applicable. Root cause: identified inconsistent follow-through on s cheduled showers and lack of understanding among the nursing assistants regarding the requirement to document reasons for missed care such as refusals. NPE/designee will provide re-education	03/11/2026

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F0676 SS = D	Continued from page 12 activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview and policy review, the facility failed to ensure residents maintained good hygiene for two (Resident (R) 20 and 75) of five residents reviewed for activities of daily living (ADL) in the sample of 39 residents. This failure has the potential for the residents to develop skin infections, social isolation, and a general decline in health. Findings included: 1. Review of R20's "Record of Admission" located in the "Profile" tab of the electronic medical record (EMR) revealed admission date 11/26/24 with diagnoses including major depressive disorder, Parkinson's disease, dizziness, anxiety, and difficulty in walking. Review of R20's "Care Plan Report," dated 04/23/25 in the "Care Plan" tab in the EMR revealed, [R20] had an ADL self-care performance deficit due to activity intolerance. A care plan dated 04/24/25 revealed [R20] had potential for skin impairment due to decreased mobility, high blood pressure (HTN), fragile skin, and poor safety awareness. An intervention for this was to R20's skin will be assessed on a weekly basis on my scheduled bath day.	F0676	Continued from page 12 to current nursing assistants related to the importance of providing scheduled showers and maintaining personal hygiene, includ ing expectations for timely completion of assigned showers. Education will include appropriate action for when a shower cannot be completed as scheduled, including a prompt notification to the nurse, rescheduling and ensuring completion as soon as possible. Education will also reinforce accurate documentation of care provided, documentation of refusals when applicable, and avoiding the inappropriate use of not applicable in the medical record. DON/designee will audit 20% of current resident population ADL Shower documentation to validate showers were provided as scheduled; any missed showers were documented with a reason, and not applicable is not used in the ADL documentation inappropriately. 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.	03/11/2026

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F0676 SS = D	Continued from page 13 Review of R20's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/27/25 and located in the "MDS" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident had intact cognition. The "MDS" also indicated R20 required set-up or clean-up assistance with showers and bathing. Review of "Documentation Survey Report V2" dated 12/25 and located under the "Tasks" tab of the EMR, revealed under "Shower/Bathing/Personal Care" R75 had "NA (not applicable)" on Wednesday and Saturday during the month of December 2025. Review of "Documentation Survey Report V2" dated 01/26 and located under the "Tasks" tab of the EMR, revealed under "Shower/Bathing/Personal Care" R20 had "NA" on Wednesday and Saturday during the month of January 2026. During the Resident Council meeting on 01/22/26 at 2:09 PM, R20 stated she should be getting a shower twice a week and this was not happening. She added there had been times when she gathered all her shower items, placed them on her over the bed table, and she ended up falling asleep only to wake in the morning realizing no one came and got her for her shower. She stated she should get showers on Wednesday and Saturday. During a follow-up interview with R20 on 01/23/26 at 8:50 AM, R20 stated she still had not received a shower She added no one had come to talk to her about it and she had not refused the shower. 2. Review of R75s "Record of Admission," located in the "Profile" tab of the EMR revealed admission date of 12/05/23 with diagnoses including seizures, major depressive disorder, and difficulty walking. Review of R75's "Care Plan Report," dated 03/11/24 and found in the "Care Plan" tab in the EMR revealed, [R75] had an ADL self-care performance deficit due to disease process, general body weakness, impaired balance, limited mobility, and limited range of motion (ROM). A care plan dated 03/11/24 revealed [R75] had potential for skin impairment due to hypothyroidism, polyneuropathy, and use of anticoagulants. An intervention for this was to R75's skin will be assessed on a weekly basis on my scheduled bath day. Review of R75's quarterly "MDS", with an ARD of 12/20/25 and located in the "MDS" tab of the EMR, revealed a "BIMS" score of 14 out of 15, which	F0676		03/11/2026

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F0676 SS = D	Continued from page 14 indicated the resident had intact cognition. The "MDS" also indicated R75 was independent with showers and bathing. Review of "Documentation Survey Report V2" dated 12/25 and located under the "Tasks" tab of the EMR, revealed under "Shower/Bathing/Personal Care" R75 had "NA" on 12/22/25 and 12/25/25. Review of "Documentation Survey Report V2" dated 01/26 and located under the "Tasks" tab of the EMR, revealed under "Shower/Bathing/Personal Care" R20 had "NA" on 01/05/26 and 01/22/26. During the Resident Council meeting on 01/22/26 at 2:09 PM, R75 stated she was not getting showers all the time. She added she will ask for them, but she still does not get them. During an interview on 01/23/26 at 8:15 AM, Certified Nurse Aide (CNA) 5 stated if the resident refused showers or baths she would reapproach the resident a second time. If the resident continues to refuse, she notified the nurse. She added she does document the refusal in the resident's chart. During an interview on 01/23/26 at 8:19 AM, CNA3 stated the resident is reapproached and if they continue to refuse a shower or bath the nurse is notified. She stated she will also document the refusal in the resident's chart. During an interview on 01/23/26 at 8:21 AM, CNA2 stated she will reapproach the resident and let the nurse know. She added if the resident does refuse all together then she documents it in the resident's chart. She added she did work with R75, and she will refuse at times, and she does document the refusal. During an interview on 01/23/26 at 9:51 AM, Registered Nurse (RN) 4 stated they really try to accommodate the resident. If the resident refused a shower or bath we see if they wanted it at a different time. Staff will also educate the resident about the importance of bathing. She added both the nurse and the CNA document the refusal in the resident's chart. During an interview on 01/23/26 at 8:19 AM, the Director of Nursing (DON) stated the expectation is for the CNA to ask the resident about their shower. If the resident refused the shower, the CNA should tell their nurse so they can reapproach the resident. She stated the nurse is responsible to verify the CNA offered the shower and whether the resident	F0676		03/11/2026

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F0676 SS = D	Continued from page 15 received a shower or the resident refused. The DON stated they recognized there was a problem. Review of the facility's policy titled, "Activities of Daily Living" dated 12/15/23 revealed, "The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Policy Explanation and Compliance Guidelines…6. The facility staff will document the provision of ADL care and/or refusals of care."	F0676		03/11/2026
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, interview and policy review, the facility failed to ensure one resident (Resident (R) 71) of two residents who were unable to carry out activities of daily living (ADLs) received the necessary services to maintain good personal hygiene out of a total survey sample of 39 residents. This failure has the potential for the residents to develop a general decline in health. Findings include: 1. Review of R71's "Admission Record" located in the electronic medical records (EMR) under the "Profile" tab indicated admission date 01/06/23, with diagnoses of dementia with agitation. Review of R71's "Care Plan" located in the EMR under the "Care Plan" tab dated 12/17/25 indicated that the resident has an Activities of Daily Living (ADL) self-care performance deficit related to (r/t) limited mobility." Review of R71's quarterly "Minimum Data Set (MDS)" located in the EMR with an Assessment Reference Date (ARD) of 10/16/25 indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of nine out of 15 which resident was cognition was moderately impaired. The assessment indicated the resident was dependent on staff for baths/showers. Review of the "POC (Plan of Care) Response	F0677	F677 ADL Care Provided for Dependent Residents Resident R71 was immediately assessed to ensure no adverse effects from missed care. The resident was offered a shower, and the medical record was updated. Current residents who are dependent for care have the potential to be affected by the deficit practice, especially those with cognitive impairment. DON/designee conducted an audit on 2/12/2026 current residents who are dependent for care with cognitive impairment who refused showers over the last 7 days to ensure nursing staff was notified of that refusal and follow up was documented Root Cause: is a breakdown in the process of managing resident refusals of showers between nursing assistants and licensed nursing staff. Nursing assistants documented the refusal of the showers but did not consistently communicate the refusal 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. 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, and the importance of documenting in the medical record the nurse assessment and encouragement to allow care. DON/designee will audit 20% of current resident populations ADL Shower documentation to verify nurse notification, assessment, and documented follow up when a dependent resident	03/11/2026

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F0677 SS = D	Continued from page 16 History" located in the EMR under the "Task" tab indicated the task for the resident was "Shower/Bathing/Personal Care Monday and Thursday 7-3." The follow up question indicated, "Was a shower given" revealed the resident refused a shower on 12/25/22, 12/29/25, 01/01/26, 01/05/26, 01/08/26, 01/12/26, 01/15/26 and 01/19/26. During an interview on 01/20/26 at 3:10 PM, R71 stated she would like a shower, but she never gets one. She stated she only received sponge baths. During an interview on 01/22/26 at 3:30 PM, Certified Nursing Assistant (CNA) 10 stated she received the shower schedule with her resident assignment sheet. She stated she would ask the resident if they wanted a shower and if they refused, she would notify the nurse. During an interview on 01/22/26 at 3:43 PM, Registered Nurse (RN) 9 stated if a resident refused their shower she would attempt to educate the resident. If they continued to refuse, she would document the refusal and inform the family. She stated she would use the shower sheet to know who needed a shower for her shift. During an interview on 01/22/26 at 3:47 PM, RN8 stated if a resident refused a shower the CNA should tell her and she would document the refusal. RN8 stated she did not see any documentation in R71's EMR indicating she had refused her shower. During an interview on 01/22/26 at 3:57 PM, Unit Manager (UM) stated when a resident is scheduled for their shower and they refuse, the CNA should let the nurse know. The nurse should then speak with the resident to encourage her to take a shower. If the resident continues to refuse, the nurse should document the resident's refusal. The UM confirmed, upon review of the EMR there were multiple occasions where the CNA documented that the resident refused a shower but there was not any nursing documentation indicating they were aware of the refusal and that the nurse had spoken with the resident to discuss the refusal. During an interview on 01/23/26 at 8:19 AM, the Director of Nursing (DON) stated the expectation for the CNA was to ask the resident about their shower. If the resident refused the CNA should tell their nurse so they can reapproach the resident. She stated the nurse is responsible for verifying with the CNA showers offered and whether the resident received a shower or the resident refused. The DON	F0677	Continued from page 16 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 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.	03/11/2026

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F0677 SS = D	Continued from page 17 stated they recognized there was a problem.. During an observation and interview on 01/23/2026 at 12:30 PM, R71 stated she had not had a shower in the last few days. R71's hair appeared oily and pungent. Review of the facility's policy titled, "Activities of Daily Living " revised 12/15/23 revealed, "...A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good grooming..."	F0677		03/11/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record reviews, interviews, and facility policy review, the facility failed to follow care plan interventions to set the low air loss (LAL) mattress at 150 for one of one (Resident (R)66) out of a total of 39 sampled residents. This deficient practice placed R66 at risk of worsening non-pressure wounds, new wound development, and for unmet resident care needs and goals for care. Findings include: Review of R66's "Admission Record" located under the "Profile" tab of the electronic medical record (EMR) revealed R66 admitted to the facility on 08/27/25, initial admission date 06/05/25, with diagnoses that included Type 2 diabetes mellitus with foot ulcer, non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin, non-pressure chronic ulcer of right ankle with unspecified severity, non-pressure chronic ulcer of left heel and midfoot with other specified severity, and hemiplegia and hemiparesis following cerebral infarction affecting right dominant side. Review of R66's "Care Plan" located in the EMR under the "Care Plan" tab initiated on 09/02/25	F0684	684 Quality of Care 1. Upon identification R66's low air loss mattress was adjusted to the manufacturer's recommended setting based on the R66's weight Current residents utilizing low air loss mattresses have the potential to be affected by the deficient practice. DON/designee conducted an initial audit on 2/13/2026 of those residents with existing physicians ordered mattress inflation settings were reviewed to ensure those orders aligned with manufacture recommendations based on the residents weight if discrepancies were identified the mattress settings were adjusted immediately to ensure resident safety and comfort the attending physician was notified of the setting changes made and updated orders obtained as indicated. Root cause: The need for re-education of current nursing staff related to understanding the settings requirements and verification for low air loss mattresses. NPE/designee will provide re-education to current nursing staff on how to properly set the inflation on low air loss mattresses based on the resident's current weight and how to verify settings in effort to prevent worsening of current wounds and development of new wounds. Education related to low air loss mattress settings and weight-based adjustments will also be incorporated into new nurse orientation and ongoing annual clinical education. Documentation of mattress settings will be incorporated into the physician's order in the EMAR system upon receiving orders for a LAL mattress the documentation to check the inflation daily will be added to the low air loss order in the EMAR system for licensed nurses to document the validation of the ordered setting.	03/11/2026

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F0684 SS = D	Continued from page 18 (revision on 12/18/25) indicated, "the resident has potential for impairment to the skin integrity related to CKD (chronic kidney disease), diabetes, hemiplegia, limited mobility, history of skin breakdown, PVD (Peripheral Vascular Disease), anemia, HTN (hypertension), and has actual skin breakdown right medial foot and right heel. Interventions included "low air loss mattress set at 150." During an observation on 01/22/26 at 12:51 PM, the Infection Preventionist (IP) stated that the pump settings for LAL mattresses were based on the resident's weight unless otherwise written in the physician orders. The IP said the residents were at risk of delayed wound healing or worsening of wounds if the LAL mattresses were too hard or too soft. Record review of an "Order Listing" dated 01/23/26 provided by the Director of Nursing (DON) reflected all residents with LAL mattresses and the physician ordered setting. The Order Listing indicated R73's LAL setting was 150. During an observation on 01/23/26 at 8:15 AM, R73's LAL mattress was set between 200 – 240. During an interview on 01/23/26 at 11:21 AM, the Unit Manager (UM) said that the nurses and nurse aides checked the residents' LAL mattresses to ensure that they functioned appropriately during rounds. Review of the facility's policy titled, "Use of Support Surfaces" revised 03/13/23 revealed, "Policy: Support surfaces will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries. … Support surface" refers to a specialized mattress, mattress overlay, or chair cushion designed to manage pressure, shear, microclimate, or friction forces on tissue. … for powered devices, orthose requiring air, the licensed nurse will check each shift and prn (as needed) for proper functioning and/or inflation. … guidelines for support selection may be utilized in obtaining physician orders."	F0684	Continued from page 18 DON/designee will conduct audits of current residents utilizing low air loss mattresses to ensure the bed setting is based on the resident's current weight and to validate whether the setting is correct on the bed. These 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.	03/11/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F0686	F686 Treatment and services to prevent/heal Pressure ulcers Upon identification, R73's low air loss mattress was adjusted to align with the physician's order and manufacture recommended setting based on the R73's weight. R73's skin was assessed with no	03/11/2026

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F0686 SS = D	Continued from page 19 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record reviews, interviews, and facility policy review, the facility failed to follow physician orders and care plan interventions for one of one Resident (R)73 to set the low air loss (LAL) mattress at 250 out of 39 sampled residents. This deficient practice placed R73 at risk of worsening pressure wounds, new wound development, and for unmet resident care needs and goals for care. Findings include: During an observation on 01/21/26 at 1:45 PM, R73's LAL pump was set at greater than 300. Review of R73's "Admission Record" located under the "Profile" tab of the electronic medical record (EMR) revealed R73 admitted to the facility on 11/27/23, initial admission date 05/20/21, with diagnoses that included morbid (severe) obesity due to excess calories, cellulitis of left lower limb, and paraplegia (paralysis that affects the lower half of the body). Review of R73's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 09/29/25 located in the EMR under the "MDS" tab reflected R73 was at risk of developing pressure ulcers/injuries and had one or more unhealed pressure ulcers/injuries (PU/PI) present upon admission to the facility. The "MDS" reflected R73 had one Stage 4 pressure ulcers (Full thickness tissue loss with exposed bone, tendon, or muscle). Review of R73's EMR revealed in "Orders" under the "Orders" tab a verbal order dated 07/26/25 indicated, "Low air loss mattress set at 250 every shift for wound, check setting and function." Review of R73's "Care Plan" located in the EMR	F0686	Continued from page 19 further skin breakdown noted. Ongoing monitoring continues to ensure physicians ordered intervention for the low air loss mattress setting remains in place Current residents utilizing low air loss mattresses have the potential to be affected by the deficient practice. DON/designee conducted an initial audit on 2/13/2026 of those residents with physicians ordered low air loss mattresses to ensure the settings are set per the physician's order and documented resident weights. Any discrepancies were corrected immediately. Root Cause: Identified the need for re-education to current licensed nursing staff regarding proper verification of physician orders and correct mattress inflation settings based on the resident's weight. NPE/designee will re-educate current licensed nurses on proper adjustment of low air loss mattress inflation per physician order and manufacturer guidance using the resident's documented weight. Education on low air loss mattress management, including weight-based settings and the meaning and appropriate use of a low air loss static setting should be returned to the therapeutic setting afterward, will be incorporated into new nurse orientation and ongoing annual clinical education. Additionally, nursing assistants and therapy staff will receive education on the purpose of the static setting, when it may be used to facilitate care, when it should not remain engaged for therapeutic support, the importance of returning the mattress to the prescribed setting after care activities, and prompt notification to licensed nursing staff if mattress settings appear altered or unclear. Documentation of resident weight review related to low air loss mattress inflation settings and daily verification of appropriate mattress function will be recorded in the electronic medical record within the physician's order. Daily mattress setting verification will be documented by licensed nursing staff (RN/LPN). Oversight of shift/daily (Sunday–Saturday) verification of correct low air loss mattress settings, including confirmation that the static setting is not engaged unless clinically indicated or ordered, will be completed by the RN Supervisor, Director of Nursing, or licensed nurse designee to ensure ongoing compliance, appropriate mattress function, and resident safety.	03/11/2026

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F0686 SS = D	Continued from page 20 under the "Care Plan" tab initiated on 11/16/22 (revision on 01/22/26) indicated, "the resident has potential for altered skin integrity ... and has actual skin breakdown to right medial gluteal fold, excoriation to bilateral buttocks, and left glute and left glute fold. Interventions included, "low air loss mattress keep setting at 250." During an interview on 01/22/26 at 12:51 PM, the Infection Preventionist (IP) stated that the pump settings for LAL mattresses were based on the resident's weight unless otherwise written in the physician orders. During an observation and interview on 01/22/26 at 1:00 PM, the IP visualized R73's LAL and confirmed the pump was set between 300 and 350 and the static setting was turned on. The IP said that the static setting on the air mattress provided a stable and firm support surface. The IP said that it should only be used to allow a resident to have a firm surface when transferring from the bed. The IP said that R73's static setting should not be turned on. During an observation and interview on 01/22/26 at 1:05 PM, Licensed Practical Nurse (LPN)4 said that she checked R73's LAL pump each shift and that it was checked that morning. LPN4 said that the LAL setting should be at 250, as she pointed out a piece of tape with "250" written on it placed across the top of the pump. LPN4 visualized the LAL pump and confirmed it was set between 300 and 350 and the static pressure was turned on. LPN4 that she would go check the physician orders. LPN4 returned and stated the setting was supposed to be at 250. During an interview on 01/23/26 at 10:30 AM, the IP agreed that the pump setting between 300 - 350 was too high. She stated that the "static" setting was a firm mode and defeated the purpose of the alternating pressure therapy. Review of the facility's policy titled, "Use of Support Surfaces" revised 03/13/23 revealed, "Policy: Support surfaces will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries. ...Support surface" refers to a specialized mattress, mattress overlay, or chair cushion designed to manage pressure, shear, microclimate, or friction forces on tissue. ... for powered devices, orthose requiring air, the licensed nurse will check each shift and prn (as needed) for proper functioning and/or inflation. ... guidelines for support selection may be utilized in obtaining physician orders."	F0686	Continued from page 20 DON/designee will conduct audits of current residents utilizing low air loss mattresses to ensure the bed setting reflects the physician's order and the resident's current documented weight. These 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.	03/11/2026

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F0690 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 observations, interviews, record review, and policy review, the facility failed to ensure the indwelling urinary catheter tubing and collection bag were not in contact with the floor and a securement device was in place for one resident (Resident(R)24) of one resident reviewed for indwelling urinary catheters out of 39 sampled residents. This failure placed the residents at risk for transmission of infection to the urinary tract or injury from tension, pulling, and accidental dislodgement of the catheter from the bladder. Findings include:	F0690	F690 Bowel/Bladder Incontinence, Catheter Upon identification of the concern, R24's indwelling catheter was immediately secured to the resident and the drainage bag was repositioned to remain off the floor. Current residents with indwelling foley catheters are at risk of being affected by the deficient practice. DON completed an audit on 2/12/2026 to identify those residents currently in the facility with indwelling Foley catheters Root Cause: Inconsistent adherence to the foley catheter care standards by nursing staff. NPE/designee will provide re-education to current nursing staff on Indwelling Foley catheter care standards with a focus of securing catheters to the residents to avoid accidental dislodgement and maintaining drainage bags off the floor to prevent infection. This education will be included in new hire orientation as well as annual clinical education. DON/designee will audit current residents with indwelling foley catheters to ensure the catheters are secured to the residents to prevent accidental dislodgement and remain off the floor to prevent infection. Audits will occur daily x 3 days or until 100% compliance is achieved then weekly for 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.	03/11/2026

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F0690 SS = D	Continued from page 22 During observations on 01/20/26 at 1:00 PM, 01/21/26 at 9:37 AM, and 01/21/26 at 2:37 PM, R24's indwelling urinary catheter rested on the floor hanging from the right side of the bedframe. There was not a securement device in place to immobilize the catheter tube against the skin on R24's right or left thigh. Review of R24's "Admission Record" located under the "Profile" tab of the electronic medical record (EMR) revealed R24 was admitted to the facility on 09/07/24 with diagnoses that included benign prostatic hyperplasia with lower urinary tract symptoms, obstructive and reflux uropathy, unspecified hydronephrosis, and retention of urine. Review of R24's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/13/25 located in the EMR under the "MDS" tab reflected R24 had an indwelling urinary catheter. Review of R24's "Care Plan" located in the EMR under the "Care Plan" tab initiated on 09/07/24 (revision on 01/17/26) indicated, "the resident has a 16 French [16F] coude (curved-tip tube) indwelling catheter for enlarged prostate/retention and obstructive uropathy." Interventions include, "Catheter strap. Change catheter strap weekly; Catheter Strap – check placement of catheter strap every shift." During an interview and observation on 01/21/26 at 2:55 PM, Licensed Practical Nurse (LPN)4 said that her responsibility was to make sure that the certified nursing assistants (CNAs) provided catheter care to residents. LPN4 said that she did not assess R24 to see if a catheter securement strap was in place. R24 was sitting up to the right side of the bed. LPN4 pulled back the cover placed across R24's lap and lower legs revealed that there was no catheter securement strap in place and the catheter drainage bag rested on the floor. LPN4 said that she would let the on-coming nurse know that R24 did not have a catheter securement strap in place. LPN4 did not attempt to replace a catheter securement strap. During an interview and observation on 01/21/26 at 3:15 PM, RN1 pulled the covers back to reveal that she replaced the securement strap to R24's left thigh. When the covers were pulled back, the indwelling catheter tubing was under R24's right thigh. RN1 repositioned the tubing from under R24's right thigh to under the right knee. A securement strap was observed on the left thigh. RN1 said that she was informed by LPN4 during shift change	F0690		03/11/2026

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F0690 SS = D	Continued from page 23 report that R24 did not have a securement strap in place. RN1 said that R24 was at risk of injury if the catheter tubing is pulled or could be yanked from the insert site. During an interview on 01/22/26 at 12:51 PM, the Infection Preventionist (IP) stated that resting an indwelling catheter drainage bag on the floor placed the resident at risk of bacterial contamination. Record review of LPN4's "annual competency training" dated 07/25/25 revealed LPN4did not have a competency skill check off for indwelling catheters. Review of the facility's policy titled, "Indwelling Catheter Care" revised 08/11/24 revealed, "Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. ... 6.... Ensure straps are snug but not tight."	F0690		03/11/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §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	F0880	F880 Infection Prevention and Control Upon identification of the concern, LPN 6 was immediately educated on proper PPE use by the NPE/Infection Preventionist and instructed to don appropriate PPE prior to entering resident rooms on Contact Precautions. Current residents and staff have potential to be affected by the deficient practice related to the risk of infection transmission throughout the facility. DON completed an audit on 2/12/2026 to identify those residents who are on transmission-based precautions Root Cause: A knowledge deficit of transmission-based precautions. LPN 6 did not believe he was not required to don PPE during medication administration because he did not physically touch the residents, indicating lack of understanding of contact/droplet precautions and when PPE must be worn. NPE/designee will provide re-education to current licensed nursing staff on facility policy regarding contact/droplet precautions with a focus on required PPE for contact/droplet precautions, rationale for PPE usage including the risk to residents and other staff when appropriate PPE is not utilized. Education regarding transmission-bas ed precautions, including facility policy on	03/11/2026

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F0880 SS = D	Continued from page 24 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure the infection prevention and control program was implemented to prevent the transmission of communicable diseases, including ensuring staff adherence to required personal protective equipment (PPE) and isolation precautions	F0880	Continued from page 24 contact/droplet precautions, required PPE use, and the rationale for PPE utilization to reduce risk of transmission to residents and staff, is included in new nurse orientation and reinforced through ongoing annual infection prevention education. NPE/designee will conduct compliance rounds to ensure licensed nursing staff are donning required PPE for those residents on contact/droplet transmission-based precautions. Rounds will occur daily x 3 days or until 100% compliance is achieved then 3 times a week or until 100% compliance is achieved then weekly x 3 weeks or until 100% compliance is achieved the 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.	03/11/2026

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COMPLETE CARE AT SILVER LAKE LLC	**1080 SILVER LAKE BLVD , DOVER, Delaware, 19904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 25 for two residents (Resident (R)2 and R91) who were in Contact/Droplet isolation out of 114 residents. Findings include: During an observation on 01/23/26 at 9:04AM, Licensed Practical Nurse (LPN)6 prepared Resident (R)2's medications then entered R2's room without donning (put on) PPE. Observation of R2's room entrance indicated signage for "Contact/Droplet Precautions" which indicated that gown, N95 mask, face shield, and gloves to be applied prior to entering the room. During an interview on 01/20/26 at 2:10PM, LPN8 stated that R2 was positive for flu. During an observation on 01/23/26 at 9:20AM LPN6 prepared R91's medications then entered R91's room without donning PPE. Observation of R91's room entrance indicated signage for "Contact/Droplet Precautions." During an interview on 01/20/26 at 2:18PM, LPN8 stated that R91 was positive for flu. During an interview on 01/23/26 at 9:20AM, LPN6 stated he only used PPE when he makes contact with the residents and that he does not make contact when giving medications. During an interview on 01/23/26 at 9:53AM the Infection Preventionist (IP) stated that LPN6 should have donned PPE, N95 mask, face shield, gown, and gloves, before entering the room and doffed (take off) the PPE before exiting the residents' rooms. Review of the facility's policy titled "Influenza Exposure Control" dated 2024 indicated: "6. Infection control: a. Standard Precautions shall be maintained in accordance with facility policy. b. Contact/Droplet Precautions shall be implemented for residents with suspected or confirmed respiratory virus with the presentation of symptoms... c. Staff shall follow the facility's transmission-based procedures while the Contact/Droplet Precautions are in effect."	F0880		03/11/2026