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: Regal Heights Healthcare & Rehab Center **DATE SURVEY COMPLETED:** May 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 and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 05/19/26 - 05/23/26 Survey Census: 165 Sample Size: 56	Cross refer to CNS-2567-L survey completed May 23, 2026: F600, F609, F610, F628, F656, F679, F689, F695, F698, F726, F761, F804, F880, and F908.	7/14/2026
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed May 23, 2026: F600, F609, F610, F628, F656, F679, F689, F695, F698, F726, F761, F804, F880, and F908.		

Provider's Signature Sarah Thompson MHA Title Administrator Date 6/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE , HOCKESSIN, Delaware, 19707**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality on 05/19/26 - 05/23/26 The facility was found to be in compliance with 42 CFR 483.73.	E0000		06/11/2026
F0000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 05/19/26 - 05/23/26 Survey Census: 165 Sample Size: 56	F0000		06/11/2026
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record reviews, and review of the facility's policies, the facility failed to ensure residents received adequate supervision and assistance devices to prevent accidents for three of four residents (R58, R123, and R172) reviewed for accidents. The facility failed to ensure staff	F0689	F689 Free of Accident Hazards/supervision/devices A- Resident R172 was discharged from the facility. Regal Height Nursing & Rehab center had a standard practice of requiring residents on an air mattress to have 2 staff members while providing care in bed. Resident R172 had an air mattress requiring him to have a 2 person assist for bed mobility. On 9/28/25 1 staff member left the room during care and resident sustained a fall requiring hospital transfer. No injuries were identified. Resident R123 was screened by physical therapy on 5/22/26 for assistance with bed mobility. Resident continues to require 2 person assist with bed mobility. Resident R58 was screened by physical therapy on 5/22/26 for assistance with bed mobility. Resident requires 2 person assist with bed mobility. B-Residents residing at the facility who require 2	07/07/2026

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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F0689 SS = G	Continued from page 1 consistently followed care plans requiring two-person assistance during bed mobility, toileting, and showering, resulting in residents being left or cared for by a single staff member during high-risk activities. This deficient practice resulted in actual harm for Resident R58, who sustained a head laceration requiring emergency department evaluation and sutures after falling from the bed during care when a single staff member attempted to provide care without the required two-person assist. Additionally, Resident R123, who required two-person assistance at all times, sustained a fall from a shower bed with a head injury when care was provided by one staff member without required assistance, and Resident R172, who also required two-person assistance, experienced a fall from bed during care when left with one staff member, requiring hospital evaluation to rule out injury. Findings include: 1. Review of the "Face Sheet" located in the "Profile" tab of the electronic medical record (EMR) revealed R58 was admitted to the facility on 01/15/21 with diagnosis of multiple sclerosis, cerebrovascular disease, and unspecified convulsions. Review of R58's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/15/25, located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15, which indicated the resident was cognitively intact. Review of R58's "Care Plan," found under the "Care Plan" tab of the EMR, dated 11/13/25, revealed R58's current functional performance required the assistance of two-persons for bed mobility. Review of the document titled, "Documentation Survey Report v2" for the month of 12/25, on page three of 24, revealed that R58 had an intervention/task of bed mobility – assist of two staff. Review of the "Progress Note" found under the "Prog Note" tab of EMR, dated 12/01/25 at 6:01AM, indicated R58 had an unwitnessed fall on Monday 12/01/25 at 5:42AM, from the bed during care. He is on the left side of his bed, face down. There is blood coming from his head, but unable to determine exact location of bleeding. He is moaning	F0689	Continued from page 1 person assist with ADL care have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility reinforced education on two-person assist requirements, updated policies for dependent assistance needs, reviewed care plans and Kardexes for accuracy, and implemented ongoing observation audits and QAPI monitoring to ensure residents receive safe assistance and supervision during ADL care. C-DON/designee will educate current licensed nursing staff and certified nursing assistants on requirements of providing assistance to residents requiring a 2 person assist with ADL care. Including bed mobility, transfer, mechanical lift, and/or toileting assistance. C-DON/designee will educate current licensed nursing staff and certified nursing assistants on updated policy that includes providing assistance to resident, including: What to do if a resident requires dependent 2-person assistance and a second nurse aide isn't available to assist, if a resident is evaluated dependent with a 2 person assist of staff to perform ADL's (bed mobility, toileting, or transfer); these ADL must not be completed without a second staff member. If another nurse aide is not available to assist notify the nurse or nursing supervisor. The nurse or nursing supervisor will assist with necessary/immediate ADL care. RCA: the facility failed to ensure staff consistently followed care plans requiring two-person assistance during bed mobility, toileting, and showering resulting in residents being left or cared for by a single staff member. The facility policy for Activities of Daily Living, supporting was reviewed and updated to add what to do if a resident requires dependent 2-person assistance and a second nurse aide isn't available to assist. Update includes: Dependent 2 person assist- if a resident is evaluated dependent with a 2 person assist of staff to perform ADL's (bed mobility, toileting, or transfer); these ADL must not be completed without a second staff member. If another nurse aide is not available to assist notify the nurse or nursing supervisor. The nurse or nursing supervisor will assist with necessary/immediate ADL care.	07/07/2026

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F0689 SS = G	Continued from page 2 & has garbled speech. Staff did not move him from his position. Called 911.Power of Attorney and Nurse Practioner (NP) notified. Further review of the "Progress Notes" found under the "Prog Notes" tab of the EMR, dated 12/01/25 at 7:47AM, indicated, Certified Nurse Assistant (CNA) 21 reported to nurse that resident rolled and slip out of bed when she was giving care. This nurse found resident lying on his face bleeding, was not able to talk at the moment V/S [vital signs] were completed, ..." Review of the "Facility Reported Incident" revealed that on 12/01/25 at 5:42 AM, the CNA provided incontinent care by herself, the CNA turned the resident on his left side and turned her back on the resident to reach for a sheet and R58 slid off the bed, was found on the floor, on the left side of the bed in between the CNA and the bed. R58 sustained a head laceration which required him to be evaluated in the emergency department and returned to the facility with stitches on his head (measuring 3.2 centimeters x 2.7 centimeters). Review of the document titled, "CNA Fall Report Form," dated 12/01/25, located in the facility reported incident paper packet, CNA 21 stated, "...Was providing care, I went to roll him towards myself and I turned back to grab something and slipped right between me and the bed." Review of the document titled, " Occupational Therapy Discharge Summary" for the dates of service 01/05/26 through 02/20/26, stated, "...Discharge recommendations: patient continues to require total assistance with activities of daily living (ADLs), bed mobility, and transfers with mechanical lift assist of two staff members." During an interview on 05/21/26 at 4:18PM, Licensed Practical Nurse (LPN) 4 stated, "...Certified Nursing Aide (CNA) 21 called and said that the resident fell off the bed, so I went in the room and the CNA told me that she turned him towards her. CNA21 said she could not hold the resident because he slipped from her hands. He fell between her and the bed. I saw the supervisor call CNA21 and said that she was told to write a statement and was told to leave. The resident fell off the bed and busted his head. They talked to CNA21. They did in service, everybody at that time had to sign the in service. During an interview on 05/21/26 at 4:02 PM, R58 stated, "...There was only one aide helping me get cleaned up, she turned me, she then turned her back	F0689	Continued from page 2 The Policy update will be added to new hire orientation. Residents were evaluated by physical, occupational therapy and nursing staff during grand rounds within the quarter and with changes in resident condition. Current residents requiring assistance of 2 persons with transfer, bed mobility, and/or toileting were reviewed by therapy ad RNAC to ensure assistance level has not changed. The identified residents task list and Kardex's were reviewed to ensure correct assistance level is documented. Upon admission the assistance level from the hospital is used until the resident is evaluate by physical and occupational therapy. After therapy evaluation is completed and assistance level is determined the resident task and care Kardex are updated. During clinical review residents identified with a change in condition will trigger a rehab screen to be screened for assistance level changes. If changes are identified the DON/designee will ensure changes are noted on their task and Kardex. D-- Don/designee will perform audits of those residents who require a 2 person assist with ADL care. Observations of a least 5 residents per day will be observed for 5 days until we consistently reach 100% success over 3 consecutive evaluations , then 5 residents weekly until we consistently reach 100% success over 3 consecutive evaluations, then 5 residents monthly until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026

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F0689 SS = G	Continued from page 3 and I slid out of the bed, it damaged my head, and she turned me to the left side of the bed and she lost her grab to me and that's when my head went down first and caused damage to my head. There are supposed to be two people to do it, it still happens that only one person helps me get changed. There are no men that help me get changed, only girls and it still happens that only one girl helps me get changed to this day. Sometimes they get another person to help out but it's not all the time. I get changed two to three times a day, usually in the morning and at night." During an interview on 05/22/26 at 11:39 AM, the Director of Nursing (DON) stated, "...for residents that are care planned for "assist times two" with bed mobility, there must always be two staff. We have done training on paired care specifically due to false allegations. I don't recall doing education for "assist times two" with bed mobility and transfers lately, but these trainings are done during new hire orientation." 2. Review of R172's "Admission Record" located under the "Profile" tab of EMR revealed the resident was admitted on 07/27/23, with diagnoses of Alzheimer's disease, dementia, malignant neoplasm of prostate, contracture of muscle-left hand, blindness-one eye, and low vision other eye. R172 was discharged to the hospital on 12/04/25. Review of R172's quarterly "MDS," with an ARD of 09/09/25, located under the "MDS" tab of the EMR revealed R172 had a "Brief Interview for Mental Status" score of zero out of 15, which indicated R172 was severely cognitively impaired. The assessment documented R172 was dependent on staff or required maximal assistance for all activities of daily living. Review of R172's "Care Plan" located under the "Care Plan" tab of the EMR and updated 08/19/25 revealed R172 had impaired verbal communication and visual function, was incontinent of bladder and bowel, required the assistance of two staff for bed mobility and toileting, and had a low air loss mattress due to wounds. R172's "Kardex" was unavailable for review as the resident was no longer at the facility. Review of R172's "Progress Notes" located under the "Prog Notes" tab of the EMR dated 09/28/25, revealed "Writer was called to resident's room by nurse to assess resident. Writer walked in resident	F0689		07/07/2026

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F0689 SS = G	Continued from page 4 room and observed resident on floor lying on his back. CNA giving care stated that while she was giving the resident care the resident fell off of his bed. Writer assessed resident no bruises and no injuries noted. V/S [vital signs] recorded and within normal ref [reference] range. POA [Power of Attorney] and MD [physician] on-call notified. MD agreed to send resident to hospital to rule out head injury." Review of R172's "Hospital Records," located in the EMR under the "Misc [Miscellaneous] " tab dated 09/28/25, revealed documentation that R172 had no injuries. Review of the facility provided investigative documentation, dated 10/03/25, revealed, "Resident is an 80-year old male here for continued care and follows with hospice services. Nursing staff report patient with a witnessed fall on 09/28/25 and was sent to the emergency room for evaluation. Resident is seen today resting in bed in no acute distress. Resident with no visible signs of injury and his neurological status is at baseline. He was evaluated in the emergency room and per discharge orders patient CT [cat scan] scan head neck pelvis were negative for acute injury and chest x-ray was also negative. Resident with witnessed fall out of bed. Resident had been changed and treatment applied by nurse and CNA. Nurse had left room and CNA went to secure brief and turned resident in order to grab brief from underneath resident when resident moved his leg with heel bool on rotated over other leg and resident rolled out of bed onto fall mat." Review of a verbal statement by CNA1, provided by the facility, dated 09/29/25, revealed "[CNA1] stated [Licensed Practical Nurse (LPN) 1] and I were in the room performing care. [LPN1] was changing his wound and I had finished ADL [activities of daily living] care. I asked [LNP1] to help me pull up the side of resident's brief and turn him to the middle of the bed. [LPN1] did help me and he left the room. I continued to straighten up the draw sheet and attach his brief turning him slightly. Resident had heel boots on so I positioned his legs in order to fasten the brief when the resident moved his legs with boots on and fell out of bed onto his floor mat. First the boot went over the side then resident just slid out of bed and even though I was holding him I could not stop him from falling. I immediately got [LPN1] and the Supervisor was called." Review of a written statement by LPN1, provided by the facility, dated 09/28/25, revealed "This writer informed the CNA that the dressing on the patient	F0689		07/07/2026

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F0689 SS = G	Continued from page 5 needed to be changed and that when she was going to clean him up to come get me. This writer went in to help and change the dressing. After treatment was completed, this writer asked if she was ok from here and she said yes. This writer proceeded to exit the room. Approximately ten minutes later the CNA called for me in the room. In the room upon arrival, patient was on the fall mat laying on his back. This writer informed the supervisor and the patient's nurse for the shift about the fall." During an interview on 05/22/26 at 10:39 AM, CNA1 stated "The nurse and I were washing him up and the nurse did his wound care. The nurse left the room when wound care was finished. I finished attaching his brief and rolled him side-to-side. When I rolled him away from me, he rolled off the bed, onto the fall mat on the floor. I didn't realize he was on an air mattress. I'm not quite sure if he required two staff for care. He didn't have any bed rails. He was total dependent. After the incident, I was suspended pending investigation and allowed to return to work. I would check the chart to find out if the resident required two staff. There is a section that states two staff, when going into the computer." During an interview on 05/22/26 at 11:49 AM, the DON stated "If a resident is a two person assist, I would expect both staff to be at bedside." The DON stated staff should check the Kardex to determine the level of care needed. 3. Review of R123's "Admission Record," located under the "Profile" tab in the EMR revealed R123 was admitted to the facility on 11/19/24 with diagnoses of neuromyelitis optica (autoimmune condition causing vision loss, paralysis, nerve pain and quadriplegia) and quadriplegia (loss of motor function and sensation in all four limbs). Review of the annual "MDS," with an ARD of 10/21/25 and located under the "MDS" tab of the EMR, revealed R123 had a "BIMS" score of 15 out of 15, indicating intact cognition. The "MDS" indicated R123 had bilateral impairment in both upper and lower extremities and required the use of a mechanical lift. The "MDS" also indicated R123 was dependent for showering/bathing and for rolling left and right. Review of the "Care Plan," dated 11/03/25 and located under the "Care Plan" tab in the EMR, revealed, "Unable to do own ADLs [activities of daily living] without assistance R/T [related to] weakness and quadriplegia... Date Initiated: 11/19/2024... BED	F0689		07/07/2026

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F0689 SS = G	Continued from page 6 MOBILITY: assist of 2... Date Initiated: 11/19/2024... Current Functional Performance... Date Initiated: 06/29/2025... Functional Status will Maintain or Progress Towards Personal Goal During Stay... Date Initiated: 06/29/2025... Showers twice a week using shower bed & 2 Staff. 2 Staff to remain present during task... Date Initiated: 11/04/2025... Functional ability - Bed mobility Assist x 2... Date Initiated: 10/29/2025..." Review of the "Order Summary Report," dated 11/03/25 and located under the "Orders" tab in the EMR, revealed an order dated 10/16/25 indicating, "2 person care at all times." Review of R123's"Progress Notes," dated 11/03/25 at 9:52 AM and located under the "Progress Notes" tab in the EMR, revealed "Fall Note... Resident reported on floor in shower room, found face down by charge nurse upon her arrival. Resident alert and able to communicate. Resident noted with laceration to forehead. Resident assessed by DON and NP [name]. NP [name] gave verbal order to send resident to hospital ER [emergency room] for Evaluation..." Another nursing note dated 11/03/25 indicated, "LATE ENTRY... Fall Details: Date/Time of Fall: 11/03/2025 9:10 AM Fall... was witnessed. Who witnessed fall: Assigned CNA... Other fall location: Shower room... Did an injury occur as a result of the fall: Yes. Injury details: Abrasion to forehead... Scale: Mechanical Lift... " Review of the facility reportable documentation provided by the Administrator revealed, "Resident stated that the Aide had begun his shower and when she rolled him over to wash his back and the shower rail gave way and resident rolled out of shower bed onto the floor... CNA states went to give resident shower and placed the shower bed against the wall of shower stall entrance. CNA states she locked the wheels and rails of the shower bed. CNA states she rolled the resident over when the shower rail gave way and resident rolled out of shower bed onto the floor... Resident sustained a fall from the shower bed during his shower. Upon investigation and interview with CNA it was determined that the CNA started care by herself. Resident is a two person assist with all care." During an interview on 05/21/26 at 12:15 PM, R123 confirmed he fell in the shower in November of 2025. R123 stated when CNA22 "turned" him, "the rail broke and I fell and hit my head." R123 stated since the fall, "Sometimes" other CNA's have showered him by themselves using the shower bed. R123 stated CNA5 did it alone once since the fall. R123	F0689		07/07/2026

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F0689 SS = G	Continued from page 7 stated CNA5 "called out to the other Aides who were in the hall talking and no one would come help him." During an interview on 05/22/26 at 11:44 AM, the DON stated, "If they're assist times two, it takes two." She stated if a resident is a two person assist and one staff is turning the resident, they should not turn them away from themselves, but towards themselves. The DON stated, "If they can turn themselves independently, it can be one staff, but if they can't turn themselves independently, it should be two." She stated, "I think that the shower bed is always two people." During a phone interview on 05/22/26 at 12:46 PM, CNA22 she confirmed she was showering R123 on 11/03/25 when he fell. CNA22 stated, "I was a float that day and I asked for help. She stated she provided care for R123 before that day and most of the time she did it by herself because she could not get other staff to help. CNA22 stated when she took R123 in on the shower bed, she "called out the door for help but no one came." She stated, "When I went to roll him, the pin in the side rail maybe didn't latch on." CNA22 also stated R123 fell off the shower bed on the floor and hit his head. During an interview on 05/22/26 at 3:17 PM, LPN8, stated, "That day (11/03/25), I worked as a CNA on that unit." LPN8 stated when using a shower bed to shower a resident it should be "Always two." LPN8 stated, "I have provided care with him (R123) in bed by myself, yes, because I know how to position him... If I needed to turn him the other way I always pull him close to me, so when I turn him over away from me. If he falls forward it will be on the bed." LPN8 stated it was "Two supposed to" to provide care for R123 in bed. LPN8 CNA23 and CNA24 also provided care to R123 in the bed by themselves. Regarding R123's fall from the shower bed, she stated, "[R123's name] was on the floor. He was face down on the floor in a little pool of blood. It was a sight to see." LPN8 stated, "What I got from it, she (CNA22) was in there by herself in the shower room and thought it was a good idea to turn him to the side, and I don't know why she thought the rail would hold him up." During an interview on 05/23/26 at 10:53 AM, the Director of Rehabilitation (DOR) stated R123 "Has been a two person assist [assistance]" for bed mobility "since admission" and all other therapy evaluations after admission indicate "remains at baseline which means he is still a two person	F0689		07/07/2026

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F0689 SS = G	Continued from page 8 assist." During an interview on 05/23/26 at 2:09 PM, CNA5 stated he was working the day R123 fell in the shower in November 2025. CNA5 stated he heard the "girl who had him… screaming hysterically, "Help me! He fell!" CNA5 stated R123 "Was on the floor and he was facedown and blood was on his head." When asked if he has ever given R123 a shower on the shower bed by himself, CNA5 stated, "Ya… It's hard to find people so most people don't want to help. I asked everybody to come and help me, but nobody would come." When asked how he knew if a resident was a one or two person assist for a bed bath, CNA5 stated, It's in the Kardex. If it says two-person bed mobility, then it's two people. Air mattresses require two-person." During an interview on 05/23/26 at 2:45 PM, the Assistant Director of Nursing (ADON) stated she remembered when R123 fell in November of 2025. The ADON stated, "He fell out of the shower bed. It was just that CNA. When I got there, he was on the floor… bleeding from the forehead. The expectation at that time… it was just like there was an assumption or understanding that if it was two-person bed mobility then it would be two in the shower bed." When asked if CNA5 told her she couldn't get help that day, she stated, "I don't remember any details." Review of the "Facility Action Plan Checklist And AD HOC [specific committee] QAPI [quality assessment and performance improvement]," dated 11/03/25 revealed, "In depth review of How incident Occurred: Resident… with a BIMS of 15 [cognitively intact]… Resident has a history of requiring the use of a mechanical lift for transfers and 2 person assist for all care. Per the assigned CNA, she was showering [R123's name] alone when he is a 2 person assist at all times. She confirmed that she was alone in the shower room with the resident. The Task Kardex says resident is to be a two Person Assist… The resident continues to require two staff assistance for all care… Education to 100% of Nursing Staff was initiated on 11/3/25… b. If Resident's bed mobility status is 2 Assist- this requires two staff to assist with showers during the entire task… d. Residents are never to be turned away from you when providing care, they must always be turned towards you… e. If task in POC states 2 Person Assist; Do not attempt to provide care alone… f, Shower Rails are for Spatial Awareness Only & is not to be used as an enabler for Mobility/Turning or Repositioning... g. If You can not find assistance; a second person- Do not complete the task until a second Person is found…"	F0689		07/07/2026

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F0689 SS = G	Continued from page 9 During an interview with the Administrator on 05/23/26 at 7:40 PM, she stated the facility did not have policies and procedures regarding bed mobility, transfers, or shower beds. Review of the facility policy titled, "Activities of Daily Living (ADL), Supporting" dated 05/26, that on page one of two, stated, "Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal, and oral hygiene" and on page two of two item #7 stated, "A resident's ability to perform ADLs is measured using clinical tools, including the MDS. Functional decline and improvement are evaluated using the following MDS definitions: Dependent two-person assist – if a resident is evaluated dependent with a two-person assist of staff to perform ADL's (bed mobility, toileting, or transfer); these ADL must not be completed without a second staff member. If another nurse aide is not available to assist, notify the nurse or nursing supervisor. The nurse or nursing supervisor will assist with necessary/immediate ADL care."	F0689		07/07/2026
F0908 SS = F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain the vents on the hood above the stove and fryer in a safe and sanitary condition. This placed all 160 residents who received food from the kitchen, out of a total census of 165 residents, at risk of injury from fire in the hood or spread of food-borne illness. Findings include: Review of the facility's "Diet Type Report," provided on paper and dated 05/23/26, revealed there were five residents who did not consume any food orally. During initial tour of the kitchen on 05/19/26 at 9:55 AM, the vents in the hood above the stove and fryer were observed with caked on dark brown grease and debris. The Assistant Food Service Director (AFSD) stated they were cleaned every few months by a contracted company and were not cleaned by the dietary staff.	F0908	F908 Essential Equipment, Safe Operating Condition A-On 5/25/26, maintenance director removed the vents from the kitchen hood, cleaned and reinstalled. B-All residents have the potential to be affected by this deficient practice To prevent recurrence and protect residents, the facility has increased kitchen hood vent cleaning frequency, implemented monthly inspections, educated maintenance and dietary staff, and will monitor compliance through ongoing audits and QAPI review to ensure the equipment remains in safe operating condition. C-Administrator/Designee will educate maintenance and Dietary staff on the cleaning schedule of the kitchen hood vent and to report any grease or debris accumulation for additional cleaning. RCA: The cleaning schedule frequency from the contracted vendor was not sufficient for the amount of buildup noted on hood vents. The frequency of cleaning with the contracted vendor has been increased to quarterly from biannually starting this July 2026.	07/07/2026

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F0908 SS = F	Continued from page 10 During a subsequent observation of the kitchen on 05/21/26 at 12:04 PM, the vents in the hood above the stove and fryer were again observed with caked on dark brown grease and debris. During an interview on 05/21/26 at 1:43 PM, the Food Service Manager (FSM) agreed the vents were very dirty and needed to be cleaned. He stated a contract company came in to clean the vents but did not know the frequency. During an interview on 05/23/26 at 11:36 AM, the Maintenance Director (MD) stated he was not involved in cleaning the hood vents and a contracted company came every six months to clean them. He stated when it was brought to his attention, he cleaned the vents the best he could, and it would take another washing to get them thoroughly clean. The MD stated that going forward, cleaning the hood vents would be part of the monthly cleaning schedule. A policy addressing cleaning of the hood vents was requested but was not provided prior to facility exit.	F0908	Continued from page 10 Maintenance department added to Maintenance Care System to check cleanliness of kitchen hood vents monthly for additional cleaning needs. D-Administrator/designee will audit the cleanliness of the kitchen hood vent monthly until 100% success over 3 consecutive evaluations, Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026
F0600 SS = E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview and policy review, the facility failed to protect the residents' right to be free of physical and/or sexual abuse for three of 13 residents (Resident (R)82, R140 and R23). R82	F0600	F 600 Free from Abuse and Neglect A- Resident R153 care plan reviewed and updated 05/23/2026 with individualized triggers and interventions (continue monitoring to identify triggers; resident prefers control of her room and a quiet environment; offer assistance to accommodate needs). R153 currently has no roommate, removing the immediate exposure to others. Social Services met with R153 on 05/23/2026; she remains at baseline. Resident R48 care plan reviewed and interventions updated 05/23/2026 to reduce reach-out behavior (offer blanket to block light when over-stimulated; separate from other residents/staff when behavior indicators such as excessive rocking or reaching out are observed; offer weighted "waffle" item when restless). Social Services met with R48 on 05/23/2026; he is at baseline. Residents R82 and R140 — interviewed 05/22/2026 and confirmed they feel safe with no current concerns; no care-plan revision indicated. R140's exposure to R48 is now mitigated through R48's updated monitoring and separation interventions above.	07/07/2026

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F0600 SS = E	Continued from page 11 reviewed for abuse out of a total sample of 56. Resident (R)82 experienced physical abuse by R153, R140 experience sexual abuse by R48 and R23 experienced verbal abuse Certified Nurse Assistant (CNA) 28. The Findings Include: 1. Review of R153's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on 04/02/24 with diagnoses which included unspecified dementia and depression. Review of R153's quarterly "Minimum Data Set (MDS)," with an assessment reference date (ARD) of 05/08/26 and located under the "MDS" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of 00 out of 15, which indicated severely impaired cognition. Review of R153's "Care Plan," initiated on 06/16/25 and located under the "Care Plan" tab of the EMR, revealed ". . . The resident will not exhibit physical abuse more than twice per week for 90 days. . ." Further review revealed the care plan was not updated after the December 2025 or March 2026 incident. Additionally, R153 was care planned prior to this for being verbally aggressive towards others and but there had been no updates since 2024. Review of R153's "Nurses note," written on 06/14/25 by Registered Nurse (RN) 7 and located under the "Notes" tab of the EMR, revealed ". . . Supervisor called to the unit following an altercation between R153 and her roommate R82. R153 was witnessed hitting her roommate while the roommate was laying down in bed. Staff immediately intervened. R153 was noted to be cursing at staff members but denied reasoning behind her actions. She was able to calm down. Room changes implemented. Staff reported R153 was calm moments prior when she approached staff at the desk and asked for a cup of water which was given to her. It was later noted that R153 had thrown the water on her roommate while she slept. Resident assessed, now calm. . . ." Review of R82's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 12/11/24 with diagnoses which included unspecified dementia and depression. Review of R82's significant change "MDS," with an	F0600	Continued from page 11 Resident R23 interviewed 05/22/2026 and confirmed he feels safe; the staff member responsible (CNA28) was terminated. B- Residents residing at the facility have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility implemented abuse prevention education, strengthened behavior monitoring and individualized care planning, reviewed resident safety needs, and established ongoing staff competency checks, resident interviews, and QAPI monitoring to ensure a safe environment free from abuse and neglect. C- Staff Educator/designee will educate all current staff on recognition of the forms of abuse, the duty to intervene to ensure resident safety when abuse is reported, observed, or suspected, and immediate reporting requirements. Corporate Director of Clinical Services educated the NHA, DON, ADON, Unit Managers, and Department Directors on identifying, preventing, and responding to resident abuse. RCA: Facility staff normalized resident behaviors and failed to recognize the resident behaviors as potential for abuse. The facility failed to protect residents from abuse — R82 (physical abuse by resident R153), R140 (sexual abuse by resident R48), and R23 (verbal/physical abuse by CNA28). Social Services or designee interviewed all interviewable residents to determine whether they feel safe in their environment Skin checks were completed on all residents unable to be interviewed DON or designee reviewed all current residents with documented aggressive or sexually inappropriate behaviors — using clinical documentation, the Behavior Monitoring & Interventions report, and MDS triggers — to ensure a resident-specific, person-centered care plan is in place. Daily clinical meeting process revised so the DON/designee reviews the Behavior Monitoring & Interventions report to identify potential abuse and trigger protective action and care-plan revision.	07/07/2026

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F0600 SS = E	Continued from page 12 ARD of 03/31/25 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. Review of R82's "Nurses note," written on 06/14/25 by RN7 and located under the "Notes" tab of the EMR, revealed ". . . R82 was noted being struck by roommate R153, while she slept in bed. Staff immediately intervened. R82 was initially concerned about roommates R153's behavior and kept stating " I don't understand what I did to her". Denied pain. Small scratch to top of left hand noted. Area cleansed with NSS. No other injuries were noted. Nurse offered resident PRN medications and room change implemented." During an interview on 05/21/26 at 1:08 PM Licensed Practical Nurse (LPN) 21 stated R153 can be very unpredictable and will lash out with no warning. On 06/14/25 she was working when there was an incident with R153's roommate R82 at the time. She remembers R82 screaming after staff found R153 standing over R82 hitting her. During an interview on 05/21/26 at 3:47 PM RN7 stated she was the nurse manager working at the time of the incident that occurred on 06/14/25 between R153 and R82. She remembers staff coming to ger her after they observed R153 standing over R82 and hitting while she slept and the residents were immediately separated. 2. Review of R48's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 11/12/24 with diagnoses which included unspecified dementia, and major depressive disorder. Review of R48's quarterly "MDS," with an ARD of 05/07/26 and located under the "MDS" tab of the EMR, revealed a " BIMS" score of six out of 15, which indicated severely impaired cognition. Review of R48's "Care Plan," initiated on 04/29/17 and located under the "Care Plan" tab of the EMR, revealed ". . . The resident will have a decrease in behavior of making sexual comments or touching others. . ." Further review revealed the care plan had not been updated with new interventions since 2017. Review of R140's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 08/05/24 with diagnoses which included unspecified dementia. During an interview on 05/22/26 at 9:22 LPN25 said	F0600	Continued from page 12 D-- DON /designee will conduct audits of staff knowledge of abuse recognition by verbal teach-back of at least 5 staff per day for 5 days for 100% success over 3 consecutive evaluations, then 5 staff weekly for 100% success over 3 consecutive evaluations, then 5 staff monthly for 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. DON/ Designee will perform interviews with residents at least 3 residents per day for 5 days to insure residents are free from physical abuse and or sexual abuse until we consistently reach 100% success over 3 consecutive evaluations, then 3 residents weekly until we consistently reach 100% success over 3 consecutive evaluations, then 3 residents monthly until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026

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F060C SS = E	Continued from page 13 R48 will touches, grab and will violate women. He was unable to see but he would feel out. She said there was an incident when R48 grabbing R140's breasts and they were separated. She said it was documented in either progress notes or on the MAR, and the family was notified but she was unsure if it was reported to management. `3. Review of R23's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 09/19/25 with diagnoses which included anxiety and depression. Review of R23's quarterly " MDS," with an ARD of 05/11/26 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. Review of the facility's "5 Day Follow Up," dated 01/22/26, revealed that a verbal exchange was witnessed by nursing staff. Further review revealed CNA28 was terminated after the incident. Review of statement written on 01/14/26 by LPN31 revealed she witnessed a verbal exchange between CNA28 and R23 that LPN31 described as "escalated exchange of words" after he asked for some ice. LPN31 further wrote that she witnessed CNA23 go behind R23 and yanked him to get him from the nurse's desk area and resident grabbed onto the nurse's desk resisting the move." An attempted phone interview was conducted on 05/22/26 at 12:28 with LPN31 but was unsuccessful. During an interview on 05/19/26 at 1:05 PM R23 stated CNA28 came into his room and threw his covers back and was rude to him when he told her he was independent and did not need any ADL or incontinent care. He stated that CNA28 said something rude to him and left his room. He stated a few minutes later that her went to the nurse's station to request some ice and was waiting for the nurse when CNA28 told him she would get the ice but he declined. CNA28 at that time became upset and came behind him and grabbed his wheelchair and pulled him back so hard that he had to grab ahold of the nurse's station. During an interview on 05/22/26 at 11:28 AM the Director of Nursing (DON) said all residents should feel safe and be kept safe and free from any resident-to-resident abuse. She stated she was unaware of R153 attacking R82 or R48 sexually fondling R140 or any other female residents.	F0600		07/07/2026

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F0600 SS = E	Continued from page 14 During an interview on 05/22/26 at 11:58 AM the Administrator stated she was unaware of any current issues with R48 or R153. She stated it was the facility's responsibility to ensure all residents were safe and free from any type of sexual fondling or physical aggression. She further stated she was unable to recall if she was aware of the incident that occurred on 06/14/25 with R153 and R82 or that staff observed R48 sexually fondling R140 or any other residents. Review of the facility's policy titled, "Abuse Investigation and Reporting," dated July 2017, revealed, "The Administrator will ensure that any further potential abuse, neglect, exploitation, or mistreatment is prevented . . ."	F0600		07/07/2026
F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of	F0609	F609 Reporting of alleged Violations A-Residents R82, R136, and R55 — the resident-to-resident incidents were reviewed retrospectively Resident R153 has had care plan reviewed and updated and currently has no roommate . Resident R34 - Unable to retroactively fix this deficient practice as it is past time of occurrence. B- Residents residing at the facility have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility reinforced staff education on immediate abuse reporting requirements, implemented ongoing review of incidents and injuries of unknown origin, and established audits and QAPI monitoring to ensure timely reporting, investigation, and protection of residents. C-DON/designee will re-educate on immediate reporting requirements, including the 2-hour and 24-hour timeframes and the requirement to report injuries of unknown origin. Corporate Director of Clinical Services educated the NHA, DON, ADON, Unit Managers, and Department Directors (05/22/2026) that abuse (including injuries of unknown origin), physical, sexual, neglect, exploitation, and theft/misappropriation of resident property are reported to local, state, and federal agencies as required by current regulations, and	07/07/2026

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F0609 SS = E	Continued from page 15 facility policy, the facility failed to: 1.) report incidents and/or allegations of resident to resident physical and/or sexual abuse to the Administrator within two hours for three of 17 sampled residents (Resident (R) 82, R136, and R55) reviewed for abuse out of a total sample of 56, and 2.) report injuries of unknown origin to the State Survey Agency (SSA) for one of four residents (R34) reviewed for accidents out of a total sample of 56. This had the potential to allow for continued abuse. Findings Include: 1. Review of R153's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on 04/02/24 with diagnoses which included unspecified dementia and depression. Review of R153's quarterly "Minimum Data Set (MDS),""with an assessment reference date (ARD) of 05/08/26 and located under the "MDS" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of 00 out of 15, which indicated severely impaired cognition. a. Review of R82's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 12/11/24 with diagnoses which included unspecified dementia and depression. Review of R82's significant change "MDS," with an ARD of 03/31/25 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. Review of R153's "Nurses note," written on 06/14/25 by Registered Nurse (RN) 7 and located under the "Notes" tab of the EMR, revealed, ". . . Supervisor called to the unit following an altercation between [R153] and her roommate [R82]. [R153] was witnessed hitting her roommate while the roommate was laying down in bed. Staff immediately intervened. [R153] was noted to be cursing at staff members but denied reasoning behind her actions. She was able to calm down. Room changes implemented. Staff reported [R153] was calm moments prior when she approached staff at the desk and asked for a cup of water which was given to her. It was later noted that [R153] had thrown the water on her roommate while she slept. Resident assessed, now calm . . ." During an interview on 05/21/26 at 1:08 PM, LPN21 stated on 06/14/25 she was working when there was	F0609	Continued from page 15 thoroughly investigated, with findings documented and reported. DON/designee will review all incidents from the previous day, during morning meeting to rule out the potential for abuse. RCA: The facility failed to report resident-to-resident abuse to the Administrator within two hours (R82, R136, R55) and failed to report injuries of unknown origin to the State Survey Agency (R34). Social Services or designee interviewed all interviewable residents to determine whether they feel safe in their environment Skin checks were completed on all residents unable to be interviewed. DON or designee reviewed incidents, injuries of unknown origin, and potential neglect events for two week look-back period to ensure each was thoroughly investigated; any incomplete investigations were completed. IDT will review resident incidents in morning clinical meeting to ensure incident was reported and investigated timely if indicated. NEW PROCESS CHANGE: IDT will review resident behavior documentation in morning clinical meeting. D. DON/Designee will review behavior documentation for all residents, as all residents have behavior documentation in place, daily for 5 days, weekly for 3 weeks, then at least monthly for 3 months to ensure any identified resident to resident behaviors and/or behaviors that result in suspicion of abuse are reported to the abuse coordinator to ensure a thorough timely investigation, more timely reporting, and ensure appropriate interventions are in place to mitigate risk of further episodes. New process change initiated for behavior documentation to be reviewed in morning clinical meeting.	07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE , HOCKESSIN, Delaware, 19707**

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F0609 SS = E	Continued from page 16 an incident with R153's roommate at the time, R82. LPN21 stated she remembered R82 screaming after staff found R153 standing over R82 hitting her. LPN21 stated she reported it to the nurse supervisor. During an interview on 05/21/26 at 3:47 PM, RN7 stated she was the nurse manager working at the time of the incident that occurred on 06/14/25 between R153 and R82. RN7 stated she remembered staff coming to ger her after they observed R153 standing over R82 and hitting R82 while she slept, and the residents were immediately separated. RN7 stated she did not remember if she reported it but she should have. RN7 stated she thought she did but was unsure to whom it was reported. b. Review of R136's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 09/03/22 with diagnoses which included unspecified dementia and anxiety disorder. Review of R136's quarterly "MDS," with an ARD of 12/09/25 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. Review of R136's "Nurse's Note," dated 12/31/25 at 11:12 PM, written by LPN22, and located under the "Notes" tab of the EMR, revealed, ". . . While doing oncoming rounds, upon exiting a resident's room, an aide came down the hall telling me [R136] reports to have been hit by her roommate, [R153]. Upon entering the room, this resident was seen lying in bed, when asked what took place, she states she attempted to pull the privacy curtain between both beds because the light on the other side of the room was too bright and bothering her, when her roommate started hitting her on her arm. Incident reported to RN supervisor . . ." c. Review of R55's "Admission Record," located under the "Profile" tab of EMR, revealed the resident was admitted to the facility on 03/14/23 with diagnoses which included anxiety disorder and major depressive disorder. Review of R55's quarterly "MDS," with an ARD of 03/12/26 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. Review of R153's "Nurse's Note," dated 3/17/26 at 2:07 PM, written by LPN24, and located under the "Notes" tab of the EMR, revealed, ". . . [R153] hit roommate, [R55] in the chest. [R55] was moving the	F0609		07/07/2026

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F0609 SS = E	Continued from page 17 phone cord, and [R153] struck her in the chest. After, she started throwing things across the room. DON and Unit manager notified." During an interview on 05/22/26 at 9:03 AM, LPN24 stated R55 told her that she was trying to move the phone cord when R153 started yelling and hit R55 in the chest. LPN24 stated when she went into the room, R153 was still yelling and there were items that had been thrown on the floor. LPN24 stated she said the unit manager at the time had her write a progress note about the incident, but she did not report it. LPN24 stated she assumed the unit manger did. 2. a. Review of R48's "Admission Record," located under the "Profile" tab of EMR, revealed the resident was admitted to the facility on 11/12/24 with diagnoses which included unspecified dementia, and major depressive disorder. Review of R48's quarterly "MDS," with an ARD of 05/07/26 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of six out of 15, which indicated R48 was severely cognitively impaired. b. Review of R140's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 08/05/24 with diagnoses which included unspecified dementia. Review of R140's quarterly "MDS," with an ARD of 03/25/25 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of 04 out of 15, which indicated severe cognitive impairment. Review of R48's "Medication Administration Record (MAR)," for the period from August 2025 until May 2026 revealed a total of six documented incidents of sexual inappropriate behavior towards others. The last date documented occurred on 05/07/26. There was no documentation to show which residents had been affected by R48's sexual inappropriate behaviors. During an interview on 05/22/26 at 9:22, LPN25 stated there was an incident when R48 was in his wheelchair and she heard a female resident screaming and she observed R48 feeling on the resident's breasts. LPN25 stated she could not remember who the resident was and she did not report it. LPN25 stated she assumed other staff that observed it reported it. LPN25 stated she did remember observing R48 grabbing R140's breasts, and the residents were separated. LPN25 stated the	F0609		07/07/2026

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F0609 SS = E	Continued from page 18 incident was documented in either progress notes or on the MAR, and the family was notified. She stated she was unsure if it was reported to management. Review of facility "reportable log" revealed none of the incidents involving R153 or R48 had been reported. During an interview on 05/22/26 at 10:15 AM, the Social Services Director (SSD) stated she was unaware of any incidents involving residents in the last year or longer and was confident if there had been any issues involving residents, she would have been made aware of it. The SSD stated she would expect staff to report any behaviors they observed and document on the MAR. The SSD stated she was unaware there were any documented sexual inappropriate behaviors that had been documented on the MAR or that staff had observed R48 fondling female residents. During an interview on 05/22/26 at 11:28 AM, the Director of Nursing (DON) stated staff should immediately report any physical aggression between residents or sexually inappropriate behaviors to their supervisor. The DON stated when one or more staff were aware of the same incident, she would expect both staff to report the incident. During an interview on 05/22/26 at 11:58 AM, the Administrator stated she was unaware of any current issues with R48 or R153, and she confirmed that none of the incidents involving these resident-to-resident incidents of physical and sexual abuse had been reported. The Administrator stated it was the responsibility of the facility to follow their abuse protocol and ensure the safety of all residents. Review of the facility's policy titled, "Abuse Investigation and Reporting," dated July 2017, revealed,". . . all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be promptly reported to local, state, and federal agencies (as defined by current regulations) . . ." 3. Review of R34's "Admission Record," located under the "Profile" tab of the EMR, revealed R34 was admitted to the facility on 04/20/23 with diagnosis of dementia with behavioral disturbance, type 2 diabetes, and repeated falls. Review of R34's quarterly "MDS," with an ARD of 02/23/26 and located under the "MDS" tab of the	F0609		07/07/2026

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F0609 SS = E	Continued from page 19 EMR, revealed a "BIMS" score of zero out of 15, which indicated that her cognitive function was severely impaired. Review of R34's "Care Plan," initiated on 05/21/26 and located under the "Care Plan" tab of the EMR, revealed R34 was dependent on staff for leisure involvement and required prompting and encouragement to engage. It also revealed R34 had dementia, constant re-direction was needed, had a very short attention span in groups, and strolled around the unit. Review of the incident report dated 01/26/26 at 5:30 AM, reported by RN3, revealed R34 was noted with a bruise of unknown origin to her right shin. R34 was noted with a gray bruise to the right shin measuring 6.0 centimeters (cm) by 4.0 cm with a maroon-red line through the center of the gray bruise. R34 was unable to state the reason for the bruise. Review of the document titled, "CNA Statement," dated 01/26/26, revealed that R34 was asleep in bed prior to finding the bruise of unknown origin. The document was not signed by any staff member. Review of the incident report dated 11/06/25 at 8:00 PM, reported by LPN12, revealed during activities of daily living (ADL) care, CNA 16 noticed bruises to R34's right breast and left upper arm. R34 was also noted with a contusion to her left great toenail. Review of the document titled, "Wound Notification," dated 11/06/25 revealed that LPN12 assessed R34 and found a bruise on the right outer breast and left arm measuring a length of 4.2 cm by width of 3.2 cm. The bruises were noted to be of unknown origin. Review of the document titled "Staff Statement," dated 11/06/25 by LPN12, stated "During ADL care, staff noticed bruises to resident's right breast and left upper arm. Resident had no idea what had happened to her breast or to her arm. Her breast was noted to be purple in nature and left upper arm seems to be purple also. Resident grimaced when breast was touched and stated, "it hurts." During an interview on 05/21/26 at 3:49 PM, the Administrator stated the facility found no documented evidence that R34's injuries of unknown origin had been reported to the SSA. Review of the facility policy titled, "Investigating Resident Injuries," on page one of two, stated, ". . . All resident injuries are investigated" and on page one of two under item seven, stated, "If the nursing	F0609		07/07/2026

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F0609 SS = E	Continued from page 20 and medical assessment determines an "injury of unknown source" the investigation will follow the protocols set forth in our facility's established abuse investigation guidelines. . ."	F0609		07/07/2026
F0610 SS = E	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, document review, and policy review, the facility failed to investigate: 1.) incidents of resident to resident physical and/or sexual abuse for three of 17 sampled residents (Resident (R) 82, R136, and R55) reviewed for abuse out of a total sample of 56 after R153 physically assaulted R82, R136, and R155; 2.) injuries of unknown origin for one of three residents (R34) reviewed for accidents out of a total sample of 56; and 3.) a potential incident of neglect for one of three residents (R172) reviewed for accidents out of a total ample of 56. These failures placed residents at continued risk of abuse and neglect. Findings Include: 1. Review of R153's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed the resident was admitted to the facility on 04/02/24 with diagnoses which included unspecified dementia and depression. Review of R153's quarterly "Minimum Data Set	F0610	F610 Investigate/Prevent/Correct Alleged Violations A- Residents R82, R136, R55 — each resident-to-resident incident was investigated retrospectively (R153) care plan has been reviewed and updated and currently has no roommate Resident R34 — Unable to retroactively fix this deficient practice as it is past time of occurrence. Resident R172 — the 09/28/25 fall was re-investigated as a potential neglect event: the staff involved were identified and suspended pending investigation at the time of the event, R172 Has since been discharged from the facility. B- Residents residing at the facility have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility educated staff on timely and thorough incident investigations, implemented investigation tracking tools and daily clinical review processes, and established ongoing audits and QAPI monitoring to ensure incidents are properly investigated, reported, and corrective actions are implemented. C- DON/designee will educate licensed nursing staff on conducting thorough investigations, securing resident safety during the investigation, identifying all persons involved, reviewing the medical record and care plan, determining whether abuse or neglect occurred, completing the investigation within 5 working days, and reporting the results. RCA: The facility failed to thoroughly investigate resident-to-resident abuse (R82, R136, R55), injuries of unknown origin (R34), and a potential incident of neglect (R172). DON or designee reviewed incidents, injuries of unknown origin, and potential neglect events for two week look-back period to ensure each was thoroughly investigated; any incomplete investigations were completed. Results reported to the QAPI Committee.	07/07/2026

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F0610 SS = E	Continued from page 21 (MDS),""with an assessment reference date (ARD) of 05/08/26 and located under the "MDS" tab of the EMR, revealed a "Brief Interview for Mental Status (BIMS)" score of 00 out of 15, which indicated severely impaired cognition. a. Review of R82's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 12/11/24 with diagnoses which included unspecified dementia and depression. Review of R82's significant change "MDS," with an ARD of 03/31/25 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. Review of R153's "Nurses note," written on 06/14/25 and located under the "Notes" tab of the EMR, revealed, ". . . Supervisor called to the unit following an altercation between [R153] and her roommate [R82]. [R153] was witnessed hitting her roommate while the roommate was laying down in bed. Staff immediately intervened. [R153] was noted to be cursing at staff members but denied reasoning behind her actions. She was able to calm down. Room changes implemented. Staff reported [R153] was calm moments prior when she approached staff at the desk and asked for a cup of water which was given to her. It was later noted that [R153] had thrown the water on her roommate while she slept. Resident assessed, now calm . . ." b. Review of R136's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 09/03/22 with diagnoses which included unspecified dementia and anxiety disorder. Review of R136's quarterly "MDS," with an ARD of 12/09/25 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. Review of R136's "Nurse's Note," dated 12/31/25 at 11:12 PM and located under the "Notes" tab of the EMR, revealed, ". . . While doing oncoming rounds, upon exiting a resident's room, an aide came down the hall telling me [R136] reports to have been hit by her roommate, [R153]. Upon entering the room, this resident was seen lying in bed, when asked what took place, she states she attempted to pull the privacy curtain between both beds because the light on the other side of the room was too bright and bothering her, when her roommate started hitting her on her arm. Incident reported to RN supervisor . . ."	F0610	Continued from page 21 Investigation tool to be used to determine if all aspects of the investigation are completed. Daily clinical meeting includes DON/designee will review behavior and incident reports to ensure investigations are initiated and tracked to completion. D- DON/designee will audit completed investigations for thoroughness (staff identified, care plan reviewed, protective action documented, neglect determination made) and for 5-working-day timeliness: each investigation initiated during the period: weekly for 4 weeks until 100% success over 3 consecutive evaluations, then monthly for 3 months until 100% success over 3 consecutive evaluations. DON /designee will conduct audits of staff knowledge of abuse recognition by verbal teach-back of at least 5 staff per day for 5 days for 100% success over 3 consecutive evaluations, then 5 staff weekly for 100% success over 3 consecutive evaluations, then 5 staff monthly for 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026

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F0610 SS = E	Continued from page 22 c. Review of R55's "Admission Record," located under the "Profile" tab of EMR, revealed the resident was admitted to the facility on 03/14/23 with diagnoses which included anxiety disorder and major depressive disorder. Review of R55's quarterly "MDS," with an ARD of 03/12/26 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of 15 out of 15, which indicated no cognitive impairment. Review of R153's "Nurse's Note," dated 3/17/26 at 2:07 PM and located under the "Notes" tab of the EMR, revealed, ". . . [R153] hit roommate, [R55] in the chest. [R55] was moving the phone cord, and [R153] struck her in the chest. After, she started throwing things across the room. DON and Unit manager notified." 2. a. Review of R48's "Admission Record," located under the "Profile" tab of EMR, revealed the resident was admitted to the facility on 11/12/24 with diagnoses which included unspecified dementia, and major depressive disorder. Review of R48's quarterly "MDS," with an ARD of 05/07/26 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of six out of 15, which indicated R48 was severely cognitively impaired. b. Review of R140's "Admission Record," located under the "Profile" tab of the EMR, revealed the resident was admitted to the facility on 08/05/24 with diagnoses which included unspecified dementia. Review of R140's quarterly "MDS," with an ARD of 03/25/25 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of 04 out of 15, which indicated severe cognitive impairment. Review of R48's "Medication Administration Record (MAR)," for the period from August 2025 until May 2026 revealed a total of six documented incidents of sexual inappropriate behavior towards others. The last date documented occurred on 05/07/26. There was no documentation to show which residents had been affected by R48's sexual inappropriate behaviors. During an interview on 05/22/26 at 9:22, Licensed Practical Nurse (LPN) 25 stated she did remember observing R48 grabbing R140's breasts, and the residents were separated. LPN25 stated the incident was documented in either progress notes or on the	F0610		07/07/2026

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F0610 SS = E	Continued from page 23 MAR, and the family was notified. During an interview on 05/22/26 at 11:28 AM, the Director of Nursing (DON) stated any incident of a resident sexually groping another resident or physical assaults would immediately initiate an investigation, and staff should ensure that the residents involved along with all other residents were safe. She stated staff should have monitored the aggressor resident's behaviors and taken statements from anyone in the general area and continued monitoring until they had completed the investigation and decided if abuse occurred. During an interview on 05/22/26 at 11:58 AM, the Administrator was asked to provide the investigative files for the incidents of physical and sexual abuse. She confirmed that none of the incidents involving these resident-to-resident incidents of physical and sexual abuse had been investigated. The Administrator stated it was the responsibility of the facility to follow their abuse protocol and ensure the safety of all residents. Review of the facility's policy titled, "Abuse Investigation and Reporting," dated July 2017, revealed,". . . all reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source ("abuse") shall be . . thoroughly investigated by facility management . . . The Administrator will ensure that any further potential abuse, neglect, exploitation, or mistreatment is prevented . . ." Review of the facility policy titled, "Investigating Resident Injuries," on page one of two, stated, ". . . All resident injuries are investigated" and on page one of two under item seven, stated, "If the nursing and medical assessment determines an "injury of unknown source" the investigation will follow the protocols set forth in our facility's established abuse investigation guidelines. . ." 3. Review of R172's quarterly "MDS" with an ARD of 09/09/25, located under the "MDS" tab of the EMR, revealed R172 had a "BIMS" score of zero out of 15, which indicated he was severely cognitively impaired. Review of R172's "Progress Notes" located under the "Prog Notes" tab of the EMR dated 09/28/25 at 11:35 AM, revealed the following documentation, "Writer was called to resident's room by nurse to assess resident. Writer walked in resident room and observed resident on floor lying on his back. CNA giving care stated that while she was giving the	F0610		07/07/2026

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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
F0610 SS = E	Continued from page 24 resident care the resident fell off of his bed. Writer assessed resident no bruises and no injuries noted. V/S [vital signs] recorded and within normal ref [reference] range. POA [power of attorney] and MD [medical doctor] on-call notified. MD agreed to send resident to hospital to rule out head injury." Review of R172's hospital records, dated 09/28/25, provided by the facility, revealed R172 had imaging studies and had no injuries. Review of the intake form, provided by the facility and submitted to the State Agency (SA), regarding a fall without injury for R172, revealed the report was submitted to the SA on 09/28/25 at 1:28 PM. Review of the facility's investigative documentation, provided by the facility, dated 10/03/25, and submitted to the SA, indicated the conclusion, "Resident is an 80-year old male here for continued care and follows with hospice services. Nursing staff report patient with a witnessed fall on 9/28/2025 and was sent to the emergency room for evaluation. Resident is seen today resting in bed in no acute distress. Resident with no visible signs of injury and his neurological status is at baseline. He was evaluated in the emergency room and per discharge orders patient CT [cat scan] scan head neck pelvis were negative for acute injury and chest x-ray was also negative. Resident with witnessed fall out of bed. Resident had been changed and treatment applied by nurse and CNA. Nurse had left room and CNA went to secure brief and turned resident in order to grab brief from underneath resident when resident moved his leg with heel boot on rotated over other leg [the CNA crossed one leg over the other one when turning the resident] and resident rolled out of bed onto fall mat." The investigation did not include the names of the CNA and nurse that cared for R172. The investigation did not include review of R172's care plan that identified R172 required the assistance of two staff for bed mobility and toileting and had a low air loss mattress. During an interview on 05/22/26 at 1:16 PM, the Director of Nursing (DON) reviewed the facility investigation and stated, "I did not work here at the time of this incident. I am responsible for investigating incidents. The names of the staff involved should have been included in the investigation. The care plan should have been reviewed to identify that two people were required for repositioning and care. Neglect is not providing care that you know someone is supposed to have. This could be neglect. This was not a thorough investigation. Staff were not identified. Staff were not	F0610		07/07/2026

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F0610 SS = E	Continued from page 25 documented as suspended. It should tell the whole story. There was no perpetrator identified. If two people were required, then two people should have been providing care the entire time. The plan of care should have been reviewed." Review of the facility's undated policy titled, "Abuse Investigating and Reporting," indicated "The individual conducting the investigation will, as a minimum: . . . review the resident's medical record to determine events leading up to the incident . . . Reporting. Notices will include, as appropriate: . . . the names of all persons involved in the alleged incident, and what immediate action was taken by the facility."	F0610		07/07/2026
F0804 SS = E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and policy review, the facility failed to serve perishable cold foods at appropriate temperatures for palatability and food safety for 94 residents who received regular or mechanical soft texture diets out of a total census of 165 residents. This failure had the potential to increase dissatisfaction with meals or spread of foodborne illness. Findings include: Review of the facility's "Diet Type Report," provided on paper and dated 05/23/26, revealed there were 86 residents who received a regular texture diet and eight residents who received a mechanical soft diet. During meal service observations in the kitchen on 05/21/26 beginning at 12:04 PM, the bowls of lettuce salad and fruit cocktail were observed in trays that were not on ice or cooled in any way. These salads and bowls of fruit cocktail were served to residents receiving regular and mechanical texture	F0804	F804 Nutritive Value/Appear Palatable/Prefer Temp A- Unable to retroactively fix this deficient practice as it is past time of occurrence. B- Residents residing at the facility who receive regular or mechanical soft texture diets have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility implemented proper storage procedures for cold food items during meal service, educated dietary staff on temperature control requirements, and established ongoing tray line audits and test tray monitoring through QAPI to ensure meals are served safely and at appropriate temperatures. C-Dietary manager/designee will educate dietary staff on serving perishable cold food items at appropriate temperatures for palatability and food safety. RCA: Perishable cold food items were not stored during meal service to ensure proper temperatures were maintained. Facility will purchase a speed rack for the walk-in cooler to store perishable cold food items prior to meal service. Small batches of items will be brought to tray service and placed in cooler on tray line to maintain proper cold temperatures. Upon arrival of the speed rack education and demonstration will be performed to maintain proper food temperatures on food tray line.	07/07/2026

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F0804 SS = E	Continued from page 26 diets. During a test tray observation in H Hall on 05/21/26 at 1:28 PM, the food cart was brought to the hall and staff began serving. The last tray was served at 1:40 PM; at this time, a test tray was evaluated. The salad, fruit cocktail, and pureed fruit cocktail tasted warm to the palate. The temperature of the salad was 72 degrees Fahrenheit (F), and the fruit cocktail was 62 degrees F. During a concurrent interview on 05/21/26 at 1:43 PM, the Assistant Food Service Director (AFSD) stated the salads and fruit cocktail were kept on the tray line on top of a pallet, not cooled in any way. Dietary Aide (DA) 1 added that they used to have cold boxes for keeping cold food items cold, but they no longer used them. The Food Service Manager (FSM) stated he expected cold foods to be held and served at 40 degrees F or below and the facility would devise a system for keeping foods cold on the tray line. Review of the policy titled, "Food: Preparation," dated February 2026 revealed, "All foods will be held at appropriate temperatures . . . less than 41 [degrees] F for cold food holding."	F0804	Continued from page 26 D-Dietary manager/designee will audit tray line meal service daily to ensure proper cold food temperatures are maintained. Audits will continue until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. Dietary manager/designee will conduct test trays 3 times a week to insure proper food temperatures are maintained for palatability and food safety until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026
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 prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F0880	F880 Infection Prevention and Control A-Resident R81 is currently out to the hospital and will be reassessed for precautions upon readmission. Resident R84 is no longer on contact precautions. Resident R5 is no longer on contact or droplet precautions. Resident R19 continues on EBP. Resident R130 is no longer on contact precautions. Resident R111 does not have any history of C-diff, Resident R50 is not listed on resident sample list but able to determine that possible noted resident is still on EBP. Unable to retroactively fix this deficient practice as it is past time of compliance. B- Residents residing at the facility have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility implemented enhanced infection prevention education, updated precaution tracking processes, reinforced proper PPE use, hand hygiene, linen handling, and single-use supply practices, and established ongoing audits and QAPI monitoring to ensure compliance and reduce the risk of infection transmission.	07/07/2026

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F0830 SS = E	Continued from page 27 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by:	F0880	Continued from page 27 C- DON/Designee will educate current nursing staff and new orientees on decreasing the risk of contamination and the spread of infections throughout the facility by: properly transporting and handling resident linen to resident rooms in a sanitary manner along with Incontinence care supplies are being use for single-resident, single-use purposes. following isolations signs for different levels of precautions pertaining to use of PPE, properly using gloves and hand hygiene to prevent the spread between patients, surfaces and staff. RCA: Employee CNA 25 failed to transport linen in a clean and sanitary manner to prevent cross contamination and did not use incontinence care supplies as single-resident use. Employee CNA 20 did not properly follow precautions listed for Droplet precautions prior to entering a room to pick up a meal tray and noted that she should have. Employee LPN 19 failed to properly follow contact precautions that were posted on residents' room when entering and did not use proper hand hygiene when exiting. Employee noted that they thought they didn't need to wear a gown as they were not performing hands on care. Employee LPN 19 failed to wear a gown with a resident on Enhance Barrier precautions while administering medication via a peg tube. Employee noted that she typically wore a gown but forgot this time. Employee LA 1 failed to properly follow contact precautions that were posted on residents' room by not wearing a gown. Employee noted that a nurse told her that she did not need to wear a gown when in room. Employee LPN 20 failed to properly follow contact precautions that were posted on resident's room. employee noted that they thought the precautions had been discontinued. Employee CNA 26 and 27 failed to properly follow contact precautions that were posted on resident's room. Employee noted that they went into room quickly as resident was calling out for help, noted that they should have followed precautions.	07/07/2026

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F0880 SS = E	Continued from page 28 Based on observations, record reviews, interviews, and policy reviews, the facility failed to ensure 1.) Ensure linens and resident care items were maintained and transported in a clean and sanitary manner to prevent potential cross contamination and disease transmission for residents 2.) Failed to wear appropriate Personal Protective Equipment (PPE) in rooms with Droplet, Contact, and Enhanced Barrier Precautions (EBP) 3.) Failed to use appropriate hand hygiene and 4.) Failed to change soiled gloves after providing peri-care and getting a resident dressed. These deficient practices had the potential to affect all residents receiving incontinent care and linen services, to increase the risk for cross contamination and the spread of infections throughout the facility. Findings include: 1. During an observation on 05/22/26 at 6:41 AM, Certified Nurse Aide (CNA) 25 was observed pushing an overbed table down the hallway in and out of resident rooms A32, A31, and A30. The overbed table contained wipes, peri-care cleanser, towels, and briefs. During the observation, a laundry staff member told CNA25 they could not have those items in the hallway while pushing them room-to-room. CNA25 stated she was using the items and could not place them back onto the clean cart. During an interview on 05/22/26 at 7:08 AM, the Director of Nursing (DON) stated the wipes and peri-care cleanser should be dedicated to one resident only and should not be transported on an overbed table in and out of rooms for use among multiple residents. During an interview on 05/23/26 at 11:32 AM, the Infection Preventionist (IP) stated linens should be removed from the linen cart and taken directly into the resident rooms, not taken in and out of multiple resident rooms. The IP stated staff should place linens into a plastic bag and take them directly into the resident room. The IP further stated CNAs were expected to use individualized linens and supplies during resident care to mitigate disease transmission. 2. Review of Resident (R) 81's "Admission Record," located under the "Profile" tab in the electronic medical record (EMR), indicated R81 was admitted to the facility on 05/02/25 with diagnoses of diabetes mellitus, end stage renal disease, dependence on renal dialysis, chronic atrial fibrillation, essential (primary) hypertension, and chronic kidney disease.	F0880	Continued from page 28 Employee LPN 19 failed to wear a gown with a resident on Enhance Barrier precautions while administering medication via a peg tube. Employee noted that she typically wore a gown but forgot this time. Employee CNA 6 failed to properly follow contact precautions that were posted on resident's room. Employee noted that she thought the resident was negative for C-diff and didn't know why the contact sign was still up. Employee CNA 7 failed to transport linen in a clean and sanitary manner to prevent cross contamination. Employee noted that she should not have put the clean linens against her clothes. Employee CNA 3 failed to change her gloves after she performed peri care on a resident. Employee noted that she should have the same gloves in after peri care. Employee E17 failed to properly use the PPE when assisting another employee with resident care. Employee LPN 29 failed to secure the ties of the gown around her neck and on her back when entering resident room with EBP. Employee noted exiting room with PPE still on and going back to remove but did not sanitize hands when exiting. Facility developed a tool to track residents on precautions. The tracking tool will be use to audit posted signage and availability of PPE. D- DON/designee will perform audits of those residents who are on isolation precautions to ensure staff are decreasing the risk of contamination and the spread of infections throughout the facility, this includes the following; isolation signs for different levels of precautions pertaining to use of PPE and proper hand hygiene. DON/ designee will perform audits of staff performing bed bathes to insure proper use and changing of gloves during care. DON/designee will perform audits of staff transporting linen to resident rooms to ensure proper transport and handling of resident linen to in a sanitary manner. Audits will be completed 5 times a week until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue 3 times a week until 100% success over 3 consecutive evaluations, and then continue	07/07/2026

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F0880 SS = E	Continued from page 29 Review of R81's quarterly "Minimum Data Set (MDS)," with an assessment reference date (ARD) of 05/14/26 and located under the "MDS" tab in the EMR, revealed R81 had a "Brief Interview for Mental Status (BIMS)" score of six out of 15, which indicated R81 was severely cognitively impaired. The assessment also documented R81 had respiratory syncytial virus (RSV). Review of R81's "Comprehensive Care Plan," located under the "Care Plan" tab of the EMR, revealed the care plan did not indicate R81 had a contagious virus or was on droplet precautions. During an observation 05/19/26 at 1:32 PM, CNA 20 entered R81's room and picked up R81's meal tray. CNA20 was not wearing a gown, gloves, or mask. CNA20 carried the tray with used dishes to the tray cart located in the hallway and placed the tray on the cart. A "Droplet precautions" sign was posted on the door that read, "Everyone must: clean their hands, including before entering and when leaving the room. Make sure their eyes, nose and mouth are fully covered before room entry or remove face protection before room exit." A "Contact Precautions" sign was also posted on the door that read, "Everyone must: clean their hands, including before entering and when leaving the room. Providers and staff must also: put on gloves before room entry. Discard gloves before exiting the room. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reuseable equipment before use on another person." During an interview on 05/19/26 at 1:50 PM, CNA20 stated "I did enter [R81's] room." CNA20 was unaware of the precaution signs posted on the door until she read them and stated, "I think it's just because she's on dialysis. Contact precautions should wear gown, and gloves during contact. Droplet precautions should have gown and mask on when entering room. I did not wear [a] gown, gloves, or mask when entering the room and should have." During an interview on 05/20/26 at 1:27 PM, the IP stated, "The expectation of staff regarding contact precautions is staff should get dressed outside the room with gown and gloves every time they enter the room. The expectation of staff regarding droplet precautions is the same as contact precautions plus an N95 mask and face shield. Staff should not enter the room without wearing the required PPE."	F0880	Continued from page 29 monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. Environmental Director/ designee will perform observations on environmental staff on cleaning practices of contact/droplet isolation rooms, to ensure staff are preventing the spread of infections throughout the facility, between patients, surfaces and staff. This includes the following isolation signs for different levels of precautions pertaining to use of PPE and proper hand hygiene and glove change. Audits will be completed 5 times a week until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue 3 times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026

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F0880 SS = E	Continued from page 30 3. Review of R84's "Admission Record," located under the "Profile" tab of the EMR, revealed she was admitted to the facility on 04/10/25 with a diagnosis of brain cancer and leukemia. Review of R84's "Physician's Order," dated 03/25/26 and located under the "Orders" tab in the EMR, revealed an order for Contact Precautions as a prophylactic measure due to radiation treatments. During an observation on 05/19/26 at 11:07 AM, a sign posted on R84's room door directed staff to follow Contact Precautions and don a gown and gloves upon room entry. Licensed Practical Nurse (LPN) 19 entered R84's room without donning a gown or gloves, turned off the call light, and entered the bathroom where R84 was seated. He then exited the room without performing hand hygiene and found additional staff to help the resident. At 11:10 AM, LPN19 again entered R84's room without donning a gown. During an interview on 05/19/26 at 11:12 AM, LPN19 stated staff only needed to wear a gown and gloves if they were providing high-contact care to R84. LPN19 confirmed he did not put on a gown because he was not providing hands-on care. During an observation on 05/21/26 at 11:05 AM, a sign posted on R84's room door directed staff to follow Contact Precautions and don a gown and gloves upon room entry. Laundry Aide (LA) 1 was inside R84's room wearing only gloves and was emptying the trash can. She exited the room with the trash can, emptied it into a bag in the hall, then entered the room again and replaced the trash can. She then proceeded to wipe the room with cleaning solution. LA1 did not wear a gown during the observation. At this time, the IP approached LA1 to correct her, telling her she had to wear a gown while in the room. During an interview on 05/21/26 at 11:09 AM, LA1 stated she did not put a gown in R84's room and was told by a nurse that she did not need to wear a gown when in the room. During an observation on 05/22/26 at 5:20 AM, a sign posted on R84's room door directed staff to follow Contact Precautions and don a gown and gloves upon room entry. LPN20 entered R84's room without a gown or gloves and administered medications to the resident. During an interview on 05/22/26 at 5:22 AM, LPN20 stated she did not wear a gown or gloves because	F0880		07/07/2026

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F0880 SS = E	Continued from page 31 she thought R84's Contact Precautions had been discontinued. During an interview on 05/23/26 at 11:24 AM, the IP stated for R84, the staff needed to wear a gown and gloves every time they entered the room for contact precautions due to R84's radiation treatments. She stated Contact Precautions had not been discontinued. 4. Review of R5's "Admission Record," revealed she was admitted to the facility on 05/31/23 with a diagnosis of dementia. Review of R5's "Physician's Orders," dated 05/11/26 and located under the "Orders" tab in the EMR, revealed orders for droplet, and contact isolation due to diagnoses of respiratory syncytial virus (RSV) and COVID-19. During an observation on 05/20/26 at 9:05 AM, a sign posted on R5's room door indicated contact and droplet precautions were in place and directed staff to wear a gown, gloves, mask, and eye protection when entering the room. CNA26 and CNA27 entered R5's room without donning a gown, gloves, mask, or eye protection. CNA26 touched R5's bed and turned off the call light. CNA26 and CNA27 assisted R5's roommate with using the bathroom. During an interview on 05/20/26 at 9:10 AM, CNA26 stated she did not wear the appropriate PPE when entering R5's room because her roommate had been calling out for help and she wanted to get into the room quickly. She stated she should have donned a gown, gloves, mask, and eye protection before entering. During an interview on 05/20/26 9:12 AM, CNA27 stated she did not wear PPE because she was only assisting R5's roommate, and R5 was the only resident under precautions. During an interview on 05/23/26 at 11:24 AM, the IP stated staff needed to don PPE every time they entered R5's room, no matter with which resident they were working. 5. Review of R19's "Admission Record," located under the "Profile" tab of the EMR revealed he was admitted to the facility on 09/22/22 with a diagnosis of anoxic brain damage. Review of R19's EMR under the "Orders" tab revealed a physician's order, dated 02/26/26, for	F0880		07/07/2026

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F0880 SS = E	Continued from page 32 Enhanced Barrier Precautions due to use of a feeding tube. During an observation on 05/21/26 at 2:02 PM, R19's room door had a sign indicating EBP were in place and directed the staff to wear a gown and gloves for all high-contact activities. LPN9 entered R19's room to provide medications and water flushes through his feeding tube. LPN9 donned gloves but did not wear a gown as she checked the tube's placement and administered the medications and water flushes. During an interview on 05/21/26 at 2:59 PM, LPN9 stated she typically wore a gown in addition to gloves when administering medications through a feeding tube, but she forgot to do it this time. During an interview on 05/23/26 at 11:46 AM, the IP stated staff should be wearing gown and gloves during medication administration through a feeding tube. 6. a Review of R130's "Admission Record," located under the "Profile" tab of the EMR revealed R130 was admitted to the facility on 10/01/25 with diagnosis of vascular dementia, cerebral infarction, and atrial fibrillation. Review of R130's annual "MDS," with an ARD of 12/29/25 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of four out of 15, which indicated severely impaired cognition. Review of the document titled, "Lab Results Report," with a printed date 05/22/26, revealed that R130's clostridium Difficile (C. Diff) results came back "Positive" for the C. Diff toxin. b. Review of R111's "Admission Record," located under the "Profile" tab of the EMR revealed R 111 was admitted to the facility on 04/04/25 with diagnosis of dementia, psychotic disturbance, and peripheral vascular disease. Review of R111's admission "MDS," with an ARD of 04/08/26, and located under the "MDS" tab of the EMR, revealed a "BIMS" score of zero out of 15, which indicated severely impaired cognition. Review of R111's "Progress Note," dated 05/23/26 at 8:07 AM, written by Registered Nurse (RN) 6 and located under the "Progress Notes" tab of the EMR, revealed, "Resident's provider team was notified regarding recent C. diff result. The Nurse Practitioner called and ordered Vancomycin 150 milligrams tablet	F0880		07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = E	Continued from page 33 every six hours by mouth for ten days." c. Review of R123's "Admission Record," located under the "Profile" tab of the EMR revealed R130 was admitted to the facility on 11/19/24 with quadriplegia, hepatomegaly, and atelectasis. Review of R123's quarterly "MDS," with an ARD of 05/07/26, and located under the "MDS" tab of the EMR, revealed a "BIMS" score of 15 out of 15, which indicated cognitively intact. During an observation on 05/19/26 at 12:28 PM, Laundry Aide (LA) 2 was standing by the nurses' station wearing gloves and was touching the nurses' station counter. LA2 proceeded to go into one of the rooms on the B hall, came back out to get the mop, with the same gloves on, then came back out of the room to grab a cleaning solution from the housekeeping cart still wearing the same gloves, then went back into the room to start mopping the floor. LA2 came back out with the same gloves on. During an observation on 05/22/26 at 3:39 PM, CNA7 was taking clean linens out of the A Hall linen cart and placed them under her arm, covered the clean linen cart, and proceeded to walk towards R123's room. While walking, CNA7 took the clean linens, hugged them, and entered R123's room and placed them on top of the chest of drawers. During an observation on 05/22/26 at 5:36 AM, CNA6 entered R130 and R111's room without donning on PPE. CNA6 came out of the room, with gloves on, took off the gloves and threw the gloves in the combo trash and linen hamper cart, and performed hand hygiene with hand sanitizer. During an interview on 05/22/26 at 5:47 AM, CNA6 stated, "I was in R130's room, and I assisted her with incontinent care. She is negative for C. Diff; I was told that she was negative for it. I don't know why the "Contact Precaution" sign is still up on the door, I'm sorry that I don't know." During an interview on 05/22/26 at 3:42 PM, CNA7 stated, "We are not supposed to keep the clean linens close to our clothes and we are supposed to put it in a fresh bag while taking it to the patient's room. I realized I put the clean linens against my clothes and that was not correct." 7. During an observation on 05/22/26 at 5:25 AM, CNA3 and CNA2 were observed providing a partial bed bath to R43. CNA3 had gloves on and was	F0880		07/07/2026

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F0880 SS = E	Continued from page 34 observed to bathe R43 including providing peri-care. CNA3 did not remove the gloves she had on while performing the peri-care. CNA3 then applied lotion to R43 and dressed her with the same gloves still on. During an interview on 05/22/25 at 5:25 AM with CNA3 as soon as she completed dressing R43, CNA3 confirmed she did not remove the gloves she wore while providing peri-care before applying lotion and clothing. CNA3 stated it was not ok to leave the same gloves on after providing peri-care. During an interview on 05/23/2026 at 11:39 AM, the IP stated, "They should change the gloves after providing peri-care." 8. During an observation on 05/21/26 at 5:44 AM, revealed R50 had signage on the outside of door indicated EBP. LPN29 was administering medications to the residents in bed A with the gown only covering her arms and not pulled over her and secured in the back with the straps. LPN29 walked out of the room still wearing the gown and gloves and started walking down the hallway before realizing she was still donning gown and gloves. LPN29 walked back inside room A31 and removed the gown and gloves and walked out without sanitizing her hands. During an interview on 05/21/26 at 5:46 AM LPN29 stated she was aware that she was supposed to remove her gown and gloves and sanitize her hands prior to exiting the resident on EBP's room. She also stated she does not wear the gown completely due to it not being large but stated she has never reported that to staff because she does not work on the A unit that often. During an interview on 05/23/26 at 4:17 PM the IP said when staff are administering medications or any direct care to a resident on EBP they need to don a gown and gloves, and a facemask if there is any risk for splashes of bodily fluids. They should remove the gown, gloves and mask if worn and sanitize their hands prior to leaving the room. The IP said the items should be discarded in the trash inside the room. She also expected staff to completely wear the gown and have it secured with the two ties in the back. She stated it increases the risk of spreading infection if they are not wearing PPE appropriately. During an interview on 05/23/26 at 7:23 PM the Assistant Director of Nursing (ADON) stated nursing staff were expected to wear gown, and gloves at a	F0880		07/07/2026

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F0880 SS = E	Continued from page 35 bare minimum when providing direct care to any resident on EBP. Staff should also be removing the PPE (gown and gloves) prior to exiting the room and sanitizing their hands. The gown should also be secured fully on the body, with the ties and staff need to ask for help if they are unable to do that. She said if PPE was not working appropriately or not discarded it increases the risk of contamination. Review of the facility policy titled, "Handwashing/Hand Hygiene," dated October 2023 revealed, ". . . Indications for Hand Hygiene ... Hand hygiene is indicated ... after contact with blood, body fluids, or contaminated surfaces ... (f). before moving from work on a soiled body site to a clean body site on the same resident ..." Review of the facility's policy titled, "Isolation - Categories of Transmission-Based Precautions," dated September 2022, revealed, ". . . Contact Precautions. Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment." The policy did not include any information regarding Droplet Precautions. . ."	F0880		07/07/2026
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §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.	F0628	F628 Discharge Process A-Resident R81 and resident R137, the deficient practice could not be retroactively corrected due to being past the time of occurrence. B- Residents residing at the facility have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility revised the Notice of Transfer form to include the full name and address of the receiving facility, educated staff on proper completion requirements, and implemented ongoing audits and QAPI monitoring to ensure compliance with discharge notification regulations. C-DON/designee will educate licensed nursing and staff responsible for discharge notices on proper completion of the form and necessary information that should be included. RCA: The Notice of Transfer form did not prompt the staff to enter the full name and address of the receiving facility. Abbreviations were used and this may not be understood by all involved.	07/07/2026

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F0628 SS = D	Continued from page 36 (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. §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	F0628	Continued from page 36 The Notice of Transfer form has been updated to include the full name and address of the receiving facility. D-DON/designee will perform audits three times a week of residents who were transferred out of the facility to ensure the Notice of Transfer form was fille out as required. Audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will be monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026

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F0628 SS = D	Continued from page 37 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written 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	F0628		07/07/2026

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F0628 SS = D	Continued from page 38 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 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	F0628		07/07/2026

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F0628 SS = D	Continued from page 39 include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to 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, interviews, and facility policy the facility failed to provide the resident/resident representative (RR) with a written notice of transfer in a language that could be understood and the address of the facility the resident was transferred to for two (Resident (R) 81 and R137) of ten residents reviewed for notice of transfer out of 56 total sampled residents. This failure had the potential for the residents and RR to be misinformed of the transfer out of the facility. Findings include: 1. Review of R81's undated "Admission Record" located under the "profile" tab in the electronic medical record (EMR) indicated R81 was admitted to the facility on 05/02/25 with diagnoses of diabetes mellitus, end stage renal disease, dependence on renal dialysis, chronic atrial fibrillation, essential (primary) hypertension, and chronic kidney disease. Review of R81's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab in the EMR with an Assessment Reference Date (ARD) of 07/31/25 revealed R81 was coded as having a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 which indicated R81 was cognitively intact. Review of R81's "Progress Notes" located under the "Prog Notes" tab in the EMR revealed R81 had been transferred to the emergency room (ER) on 10/18/25 at 4:14 PM for slurred speech, nausea, and vomiting post dialysis. Review of R81's "Notice of Transfer" dated 10/18/25, located under the "Documents" tab of the EMR, revealed R81 was transferred to "CCHS" and did not state the address of the facility R81 was transferred to. 2. Review of R137's undated "Admission Record" located under the "profile" tab in the EMR revealed R137 was admitted to the facility on 04/08/21 with diagnoses of dementia, depressive disorders, atrial fibrillation, impulse disorders, cerebral infarction,	F0628		07/07/2026

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F0628 SS = D	Continued from page 40 long term use of anticoagulants, and obsessive-compulsive disorder. Review of R137's quarterly "MDS" located under the "MDS" tab in the EMR with an ARD of 11/10/25 indicated R137 was coded as having a "BIMS" score of zero out of 15 which indicated R137 was severely cognitively impaired. The assessment also revealed R137 took an anticoagulant medication. Review of R137's "Progress Notes" located under the "Prog Notes" tab in the EMR revealed R317 had been transferred to the emergency room (ER) on 01/05/26 at 8:00 AM after hitting her head during a fall and being on anticoagulant medication. Review of R137's "Notice of Transfer" dated 01/05/26, located under the "Documents" tab of the EMR, stated R137 was transferred to "CCHS" and did not state the address of the facility R137 was transferred to. During an interview on 05/22/26 at 12:57 PM, the Director of Nursing (DON) reviewed R81's "Notice of Transfer" dated 10/18/25 and R137's "Notice of Transfer" dated 01/05/26 and stated, "No, it does not include the address of the facility the resident was transferred to." The DON stated, "The name of the facility should be spelled out. CCHS as an abbreviation of the receiving facility is not understood if the family didn't live here or know what that was. It is not in a language that the resident/RR could understand. It's important so the family knows where the resident was sent to." Review of the facility's policy titled, "Transfer or Discharge, Facility-Initiated", revised October 2022, indicated "Notice of Transfer or Discharge (Planned). . . The resident and representative are notified in writing of the following information: The specific reason for the transfer or discharge, . . . The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is being transferred or discharged. . . Notice of Transfer or Discharge (Emergent or Therapeutic Leave) . . . Notices are provided in a form and manner that the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments."	F0628		07/07/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F0656	F656 Develop/Implement comprehensive care plan A-Resident R81 is currently hospitalized: comprehensive care plan will be updated and	07/07/2026

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F0656 SS = D	Continued from page 41 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and interviews, the facility failed to develop and implement a comprehensive care plan that included	F0656	Continued from page 41 reviewed as indicated upon return. Resident R58's care plan and Kardex were reviewed to confirm they reflect two-person assist for bed mobility B- All residents on transmission-based precautions and residents with two-person-assist have the potential to affected by this deficient practice. To prevent recurrence and protect residents, the facility educated interdisciplinary team members on timely, individualized care plan updates, implemented routine reviews of new admissions, readmissions, condition changes, transmission-based precautions, and two-person-assist residents, and established ongoing audits and QAPI monitoring to ensure care plans and interventions remain accurate and comprehensive. C- DON/designee will educate the IDT, nurse management, and the Infection Preventionist (for infection-control care plans) on developing and timely updating individualized, person-centered care plans — including upon readmission and change in condition — and on the assigned responsibility for infection-control care planning. RCA: Accountability for infection-control care planning had shifted between the unit manager and the Infection Preventionist, so new precautions and special-care needs were not reliably captured in the care plan. New admissions/readmissions and residents with a change in condition will be reviewed in morning clinical meeting to ensure accurate care plans and interventions are in place. The DON/Designee to review all residents that are two people assist for bed mobility to ensure both care plan and Kardex are accurate. The DON/Designee to review all residents on transmission-based precautions to ensure appropriate care plans and interventions are in place. D- DON /designee will audit care plans for newly initiated precautions and condition changes 5 times a week until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3	07/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085006	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE , HOCKESSIN, Delaware, 19707

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F0656 SS = D	Continued from page 42 instructions needed to provide effective and person-centered care for two (Resident (R) 81 and R58)) of 44 sampled residents. Failure to develop and implement a comprehensive person-centered care plan could place residents at risk for unmet care needs. Findings include: 1. Review of R81's undated "Admission Record," located under the "Profile" tab in the electronic medical record (EMR), indicated R81 was originally admitted to the facility on 05/02/25 with diagnoses of diabetes mellitus, end stage renal disease, dependence on renal dialysis, chronic atrial fibrillation, essential (primary) hypertension, and chronic kidney disease. Review of R81's quarterly "Minimum Data Set (MDS)," located under the "MDS" tab in the EMR with an Assessment Reference Date (ARD) of 02/16/26, indicated R81 was coded as having a "Brief Interview for Mental Status (BIMS)" score of three out of 15, which indicated R81 was severely cognitively impaired. Review of R81's "Progress Notes," located under the "Prog Notes" tab of the EMR, dated 04/02/26, revealed R81 was sent to the emergency room for cough, congestion, wheezing, nausea, vomiting, and elevated blood pressure. Review of R81's "Medical Diagnosis" screen located in the EMR, revealed a diagnosis of "Respiratory Syncytial Virus (RSV)" dated 04/05/26. Review of R81's "Hospital discharge" records dated 04/15/26 and located under the "Misc" tab of the EMR, revealed a diagnosis of RSV. Review of R81's "Physician Note," located under the "Prog Notes" tab of the EMR dated 05/11/26, revealed "[R81] was evaluated for infection, and was determined to still be shedding RSV . . . " During an observation on 05/19/26 at 1:32 PM, R81's room had "Droplet Precautions" and "Contact Precautions" signs on the door. Review of R81's "Comprehensive Care Plan," located under the "Care Plan" tab of the EMR, revealed the care plan did not indicate R81 had a contagious virus or was on droplet precautions. During an interview on 05/20/26 at 1:27 PM, the Infection Preventionist (IP) nurse stated, "I determine	F0656	Continued from page 42 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026

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F0656 SS = D	Continued from page 43 what precautions residents are placed on. [R81] had RSV and was on droplet precautions." During a follow-up interview on 05/22/26 at 5:03 PM, the IP nurse stated, "I was just recently assigned to update care plans regarding infection control issues, previously it was the unit manager. RSV and droplet precautions should be included on the care plan. [R81] was not care planned for RSV and droplet precautions." Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," revised March 2022, indicated, "The comprehensive, person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; . . . and which professional services are responsible for each element of care; includes the resident's stated goals upon admission and desired outcomes; . . . and reflects currently recognized standards of practice for problem areas and conditions. . . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. . . The interdisciplinary team reviews and updates the care plan: . . . when the resident has been readmitted to the facility from a hospital stay. . ." 2.Review of R58's "Admission Record," located under the "Profile" tab of the EMR revealed R58 was admitted to the facility on 01/15/21 with diagnosis of multiple sclerosis, cerebrovascular disease, and unspecified convulsions. Review of R58's quarterly "MDS," with an ARD of 03/25/26 and located under the "MDS" tab of the EMR, revealed a "BIMS" score of eight out of 15, which indicated the resident's cognitive function was moderately impaired. Review of R58's "Care Plan," dated 11/13/25 and located under the "Care Plan" tab of the EMR, revealed R58's current functional performance required the assistance of two-persons for bed mobility. Review of the document titled, "Documentation Survey Report v2," for the month of 12/25 and located under the "Reports" tab of the EMR on page three of 24, revealed that R58 had an	F0656		07/07/2026

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F0656 SS = D	Continued from page 44 intervention/task of bed mobility – assist of two staff. Review of the document titled, "Occupational Therapy Discharge Summary," for the dates of service 01/05/26 through 02/20/26, provided by the Director of Rehab, indicated, "…Discharge recommendations: patient continues to require total assistance with activities of daily living (ADLs), bed mobility, and transfers with mechanical lift assist of two staff members. . ." Review of Facility Reported Incident (FRI) revealed that on 12/01/25 at 5:42 AM, the certified nurse aide (CNA) provided incontinent care by herself, when R58 was care planned for "assist x 2" for bed mobility. The CNA turned the resident on his left side and turned her back on the resident to reach for a sheet and R58 slid off the bed. R58 was found on the floor, on the left side of the bed in between the CNA and the bed. R58 sustained a head laceration which required him to be evaluated in the emergency department and returned to the facility with stitches on his head (measuring 3.2 centimeters x 2.7 centimeters). During an interview on 05/21/26 at 4:02 PM, R58 stated, "There was only one aide helping me get cleaned up, she turned me, then turned her back and I slid out of the bed, it damaged my head, and she turned me to the left side of the bed and she lost her grab to me and that's when my head went down first and caused damage to my head. There are supposed to be two people to do it, it still happens that only one person helps me get changed. There are no men that help me get changed, only girls and it still happens that only one girl helps me get changed to this day. Sometimes they get another person to help but it's not all the time. I get changed two to three times a day, usually in the morning and at night." During an interview on 5/21/26 at 4:18 PM, Licensed Practical Nurse (LPN) 4 stated, "…It's been a while now, but I would initially do my rounds. The CNA called and said that the resident fell off the bed, so I went in there and the CNA told me that she turned him towards her. She said she could not hold the resident because he slipped from her hands. He fell between her and the bed. I saw the supervisor call the CNA and said that she was told to write a statement and was told to leave. The resident fell off the bed and busted his head. They talked to the CNA. They did in-service, everybody at that time had to sign the in service. . ."	F0656		07/07/2026

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F0656 SS = D	Continued from page 45 During an interview on 05/22/26 at 11:39 AM, the Director of Nursing (DON) stated, "For residents that are care planned for "assist times two" with bed mobility, there must always be two staff. We have done training on paired care specifically due to false allegations. I don't recall doing education for "assist times two" with bed mobility and transfers lately, but these trainings are done during new hire orientation." Review of the facility policy titled, "Care Plans, Comprehensive Person-Centered," on page one of two, revealed, ". . . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. . . and on page two of two, under item nine, "Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. . ."	F0656		07/07/2026
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, interview, and policy review, the facility failed to ensure an ongoing program of activities to meet the needs of one of two residents (Resident (R) 45) reviewed for activities out of a total sample of 56. This failure had potential to cause boredom and lead to increased anxiety or depression. Findings include: Review of R45's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed she was admitted to the facility on	F0679	F679 Activities Meet Interest/Needs Each Resident A-Resident R45 's care plan and Kardex was reviewed and updated to include in room sensory activities. B-Residents residing at the facility who require individualized room activity and unable to communicate preferences have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility reviewed and updated care plans and Kardexes for residents requiring individualized room activities, educated staff on implementing sensory stimulation interventions as care planned, and established ongoing audits and QAPI monitoring to ensure residents receive activities that meet their interests and needs. C-DON/Designee will educate nursing staff and on ensuring sensory stimulation items are being provided during times of alone time consistent with resident's care plan. RCA: Facility staff failed to implement sensory stimulation items for resident R45 during times of alone time as indicated in care plan. Reviewed and updated care plans and Kardex for sensory activities for residents who require	07/07/2026

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F0679 SS = D	Continued from page 46 04/09/24 and had diagnoses including anoxic brain damage, epilepsy, chronic respiratory failure with tracheostomy, and quadriplegia. Review of R45's annual "MDS" with an ARD of 01/29/26 and located under the "MDS" tab of the EMR, revealed she was interested in reading, music, animal visits, news/current events, religious activities, and her favorite activities. Review of R45's "Care Plan" dated 02/18/26 and located under the "Care Plan" tab of the EMR revealed, "Requires 1:1 [one-to-one] room visits for socilization [sic] and stimulation . . . Activity staff will provide 1:1 visits at bedside a minimum of 3x per week for minimum of 15 minutes per session . . . Offer favorite music to listen too for independent activity in room . . . Offer to turn TV on and to favorite channel to help fill alone time . . . Provide resident a variety of activities to promote choice and independence in leisure participation." Review of R45's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 04/28/26 and located under the "MDS" tab of the EMR, revealed she was rarely/never able to make herself understood. R45 was assessed with severely impaired cognition. She was dependent on staff for all activities of daily living and mobility. During an observation in R45's room on 05/19/26 at 11:22 AM, R45 was lying in bed with her eyes open. When questioned, she did not make eye contact or respond in any way. There was a TV in the room over her bed, though it was not turned on. There was no radio or music in her room. Her roommate's TV was not on and there was no sound other than the oxygen machine in the room. During periodic observations on 05/19/26 in R45's room from 1:05 PM to 4:37 PM, R45 was lying in bed with her eyes open. The TV was not on and there was no music or sound in the room. Her roommate's TV was not on. During periodic observations in R45's room on 05/20/26 from 9:18 AM to 10:18 AM, R45 was lying in bed with her eyes closed. The TV was not on and there was no music or sound in the room. Her roommate's TV was not on. During periodic observations in R45's room on 05/20/26 from 1:29 PM to 5:05 PM, R45 was lying in	F0679	Continued from page 46 individualized room activity and who are unable to communicate preferences. Nursing and Activities staff will provide sensory stimulation such as access to window view, touch, television or radio during care or visits. Some type of sensory stimulation will remain in place when appropriate staff exits the room. D- DON/designee will perform audits on residents who require individualized room activities and unable to communicate preferences to ensure sensory stimulation items are being provided, weekly times 5 days until we consistently reach 100% success over 3 consecutive evaluations. Audits will be monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026

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F0679 SS = D	Continued from page 47 bed with her eyes open. The TV was not on and there was no music or sound in the room. Her roommate's TV was not on. During periodic observations in R45's room on 05/21/26 from 9:00 AM to 11:17 AM, R45 was lying in bed with her eyes open. The TV was not on and there was no music or sound in the room. Her roommate's TV was not on. During observation in R45's room on 05/21/26 at 3:03 PM, R45 was lying in bed with her eyes open. The TV was not on and there was no music or sound in the room. Her roommate's TV was not on. During an interview on 05/22/26 at 4:28 PM, the Activity Director (AD) stated R45 received one-to-one visits from activity staff for 15 minutes at least three times week, where she was provided with audiobooks, music, or sensory stimulation and received "meet and greet" visits daily. The AD stated R45 would benefit from having music or TV on in her room throughout the day during her alone time and he did not know why the TV was not on in her room. The AD stated even the sound from her roommate's TV would be beneficial and the TV should be turned on daily. Review of the policy titled, " Individual Activities and Room Visit Program" dated June 2018 revealed, "Individual activities are provided for individuals who have conditions or situations that prevent them from participating in group activities . . . For those residents whose condition or situation prevents participation in group activities, . . . the activities program provides individualized activities consistent with the overall goals of an effective activities program . . . Individualized activities offered are reflective of the resident's activity interests, as identified in the activity assessment, progress notes, and the resident's comprehensive care plan."	F0679		07/07/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.	F0695	F695 Respiratory/tracheostomy Care and Suctioning A-Resident R4 currently does not have a tracheostomy. Employee LPN16 was educated and addressed per the disciplinary policy. B- Residents who are currently receiving tracheostomy care and or have a HME device have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility updated tracheostomy care education and competencies to include HME devices, provided staff training and competency validation, and implemented	07/07/2026

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F0695 SS = D	Continued from page 48 This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews, the facility failed to perform tracheostomy (trach) care as ordered by the physician for one of two residents (Resident (R) 4) reviewed for tracheostomy care out of a total sample of 56. Specifically, nursing staff failed to change the resident's Heat and Moisture (HME) device for the tracheostomy. This deficient practice could result in the trach becoming occluded, infection, or other respiratory emergency. Findings include: Review of R4's "Admission Record" located under the "Profile" tab in the electronic medical record (EMR) indicated R4 was originally admitted to the facility on 02/26/25 with diagnoses of intracranial injury with loss of consciousness, tracheostomy, quadriplegia, acute respiratory failure with hypoxia, traumatic brain injury, epilepsy, and dysphagia. Review of R4's "Care Plan" located under the "Care Plan" tab of the EMR, dated 03/02/25, revealed R4 had a tracheostomy. It was recorded that trach care was to include ensuring trach ties were secure at all times, trach site was to be kept clean and dry every shift, suction as necessary, enhanced barrier precautions, and extra trach tube and obturator were to be kept at bedside. Review of R4's "Physician Order" dated 09/10/25 and located under the "Orders" tab of the EMR revealed, ". . . Change HME every 24 hours and as needed for saturation, clogging, or visibly soiled . . ." Review of R4's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab in the EMR with an Assessment Reference Date (ARD) of 09/30/25 indicated R4 was assessed by staff with severe cognitive impairment. The assessment also indicated R4 had a tracheostomy, required tracheostomy care, and was dependent on staff for all activities of daily living. Review of R4's "Medication/Treatment Administration (MAR/TAR)" record located under the "Orders" tab of the EMR, dated 10/04/25 and 10/05/25, revealed documented evidence that LPN16 signed R4's HME had been changed as ordered by the physician. Review of the facility's investigative documentation, provided by the facility, dated 10/05/25, revealed	F0695	Continued from page 48 ongoing observation and documentation audits through QAPI monitoring to ensure accurate respiratory care is provided. C- DON/designee will educate licensed nursing staff on accurate real time documentation for tracheostomy care. DON/designee will educate and competency licensed nursing staff on tracheostomy care including the use of Heat and Moisture Exchange Devices (HME). RCA: Employee did not understand the difference between the trach collar and the HME device and documented the task as complete without performing the task. Education was provided to employee after the incident. The facility competency for tracheostomy care did not include the use of HME devices. The facility competency for Tracheostomy Care has been updated to include the use of HME devices. Current licensed staff will complete a competency on trach care including the use of HME devices. New Hire Orientation for licensed nurses will include the use of a HME device. D--Staff Development/designee will conduct direct observations of residents with tracheostomies (could include residents with/without HME valve) and record review to verify that documentation matches the care that was provided and observed 3 times a week until we consistently reach 100% success over 3 consecutive evaluations. Audits will be monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026

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F0695 SS = D	Continued from page 49 that on 10/05/25, R4's family member brought a care concern to staff regarding R4's trach care. An investigation was conducted, and the conclusion was, "[LPN 16] charted that the HME was changed, however it was not. When interviewed [LPN16] stated the reason I did not change the HME was because I thought it was the trach collar and I did not change the trach collar because it was not visibly soiled or wet. Staff member was educated and received a discipline." During an interview on 05/22/26 at 9:49 AM, LPN16 stated "The HME goes on the trach. I forgot to change it for two days. I clicked it off in the computer and forgot to go back and replace the HME. I just made a mistake . . . I did not go back and correct the documentation." During an interview on 05/22/26 at 4:22 PM, the Director of Nursing (DON) stated, "I expect nurses to complete trach care as ordered." Review of the facility's policy titled, "Tracheostomy Care," revised November 2023, indicated ". . . Procedures Guidelines. Preparation and Assessment. Check physician order. . . "	F0695		07/07/2026
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and policy review, the facility failed to: 1.) ensure ongoing communication occurred between the facility and the dialysis center for one of two residents (Resident (R) 81) reviewed for dialysis out of a total sample of 56, and 2.) ensure there was a physician order in place for one of two residents (R6) reviewed for dialysis treatments out of a total sample of 56. These deficient practices could result in residents who are on dialysis not receiving the needed care or services. Findings include: 1. Review of R81's undated "Admission Record,"	F0698	F698 Dialysis A-For Resident R81, dialysis communication form was obtained and uploaded to resident's clinical record. For Resident R6, a current physicians order for Dialysis was obtained and missing dialysis communication forms were obtained and uploaded into resident's chart. B-Residents who are currently receiving dialysis have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility implemented staff education on dialysis documentation requirements, added dialysis communication review to the daily clinical process, verified current dialysis orders are in place, and established ongoing audits and QAPI monitoring to ensure timely receipt, review, and documentation of dialysis information. C-DON/designee will educate licensed staff on verifying dialysis communication form was received and reviewed. DON/designee will oversee that nursing has received the dialysis communication form and unit clerks uploading dialysis communication forms timely.	07/07/2026

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	**6525 LANCASTER PIKE , HOCKESSIN, Delaware, 19707**

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F0698 SS = D	Continued from page 50 located under the "Profile" tab in the electronic medical record (EMR), indicated R81 was originally admitted to the facility on 05/02/25 with diagnoses of diabetes mellitus, end stage renal disease, dependence on renal dialysis, chronic atrial fibrillation, essential (primary) hypertension, and chronic kidney disease. Review of R81's quarterly "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 07/31/25 and located under the "MDS" tab in the EMR, indicated R81 was coded as having a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 which indicated R81 was cognitively intact. The assessment also indicated R81 received dialysis. Review of R81's "Physician's Orders," dated October 2025 located under the "Orders" tab in the EMR, revealed R81 receives dialysis on Tuesday, Thursday, and Saturday each week. Review of R81's "Progress Notes," located under the "Progress Notes" tab in the EMR, revealed documentation that R81 left for dialysis on 10/18/25 at 6:00 AM and returned from dialysis on 10/18/25 at 1:15 PM. Review of R81's "Misc," tab in the EMR, revealed there was no "Dialysis Treatment Summary (used to document communication between the facility and the dialysis center)" for 10/18/25. Review of R81's "Progress Notes," located under the "Prog Notes" tab in the EMR reflected R81 had been transferred to the emergency room (ER) on 10/18/25 at 4:14 PM for slurred speech, nausea, and vomiting post dialysis. When the facility was asked for the "Dialysis Treatment Summary" for 10/18/25, the facility provided notes from the dialysis center dated 10/18/25 with a fax date/time of 5/21/26 at 8:10 AM. During an interview on 05/22/26 at 12:38 PM, the Director of Nurses (DON) reviewed R81's EMR and stated, "[R81] went to dialysis on 10/18/25. After she returned, she was sent to the hospital. I do not find a communication from dialysis for 10/18/25. It's important to receive communication from the dialysis facility to know how much fluid was removed, the resident's response to dialysis, blood pressure issues, and pre/post weights." 2. Review of R6's "Admission Record," located under the "Profile" tab of the EMR, revealed the	F0698	Continued from page 50 DON/designed will educate licensed staff on ensuring residents on dialysis have an order for dialysis treatment. RCA: Facility staff did not follow-up on the receipt of the dialysis communication form. Facility did not ensure all residents on dialysis services had a current physicians order for dialysis. DON/Designee will review resident appointments during morning clinical meeting to ensure proper receipt and upload of documents timely. DON/Designee completed review of residents on Dialysis to confirm clinical records were reviewed to ensure a current physicians order for dialysis is in place. D-DON/designee will perform audits 3 times a week of residents on dialysis to ensure they have an order for dialysis treatment. DON/designee will perform audits 3 times a week of residents on dialysis that their communication forms from dialysis were received and uploaded timely. Audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will be monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026

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F0698 SS = D	Continued from page 51 resident was admitted to the facility on 05/24/22 with diagnoses that included end stage renal disease and dependence on renal dialysis. Review of R6's admission "MDS," with an ARD of 02/28/26 and located in the EMR under the "MDS" tab, revealed a "BIMS" score of 15 out of 15, which indicated R6 was not cognitively impaired. R6 was documented as receiving hemodialysis. Review of R6's "Care Plan," dated 05/25/22 and located under the "Care Plan" tab of the EMR, revealed R6 was care planned for a diagnosis of end stage renal disease and received dialysis. Further review revealed R6 attended dialysis on Tuesday, Thursday, and Saturday. Review of R6's "Physician Orders," dated 05/23/26 and located under the "Orders" tab in the EMR, revealed no current order for dialysis treatment. Review of R6's "Dialysis Treatment Report," forms dated March 2025 through May 2026 revealed two days were missing in March, April, and in May. There was no additional documentation from the dialysis center for that time. Further review revealed the dates missing in March were 03/19/26 and 03/21/26, in April were 04/11/26 and 04/23/26, and in May were 05/02/26, and 05/12/26. Review of R6's "Medication Administration Record (MAR)," for the period for pre and post dialysis weights for the months of March, April, and May 2026 revealed R6 went to dialysis on 03/19/26 and 03/31/26, 04/11/26 and 04/23/26, 05/02/26 and 05/12/26. During an interview on 05/23/26 at 7:23 PM the Assistant Director of Nursing (ADON) stated nursing staff were expected to capture communication between the center and the facility each time a resident received dialysis services. She stated nurses would document on the communication for review, the nurse practitioner (NP) would review it, and it was uploaded. She stated the NP would probably not notice when there were missing communication forms. She also stated there should be an order for a resident to receive dialysis. Review of the facility's contract titled, "SNF Outpatient Dialysis Services Agreement," dated 06/23/11, indicated, "Interchange of information. The Nursing Facility shall provide for the interchange of information useful or necessary for the care of the ESRD Residents. . . Obligations of the ESRD Dialysis Unit and or Company. . . To provide to the Nursing	F0698		07/07/2026

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F0698 SS = D	Continued from page 52 Facility information on all aspects of the management of the ESRD Resident's care related to the provision of services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding, infection, and care of dialysis access site. . . Mutual Obligations. Collaboration of Care. Both parties shall ensure that there is documented evidence of collaboration of care and communication between the nursing facility and ESRD Dialysis unit." Review of the facility's undated policy titled, "End-Stage Renal Disease, Care of a Resident with," revealed ". . . Agreements between this facility and the contracted ESRD facility include all aspects of how the resident's care will be managed, including: how fie care plan will be developed and implemented; how information will be exchanged between the facilities; . . ."	F0698		07/07/2026
F0726 SS = D	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides.	F0726	F726 Competent Nursing staff A-Employee LPN1 and LPN14 completed trach care competencies. Employee LPN 16 was trained on the use of HME devices following the incident. Resident R4 currently no longer has a tracheostomy and no other residents currently have a Heat and Moisture Exchange Device (HME). B-Residents who are currently receiving tracheostomy care and or have a HME devise have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility updated tracheostomy care competencies to include HME devices, completed competency validation for licensed nursing staff, incorporated annual competency reviews, and implemented ongoing audits and QAPI monitoring to ensure staff provide safe and competent respiratory care. C-DON/designee will educate and competency licensed nursing staff on tracheostomy care including the use of Heat and Moisture Exchange Devices (HME). RCA: The facility competency for tracheostomy care did not include the use of HME devices. The facility failed to have completed competencies for all licensed nurses. The facility competency for Tracheostomy Care has been updated to include the use of HME devices.	07/07/2026

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F0726 SS = D	Continued from page 53 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record reviews, the facility failed to: 1.) ensure seven of nine nurses reviewed for tracheostomy (trach) care competency (Licensed Practical Nurse (LPN) 16, LPN10, LPN15, LPN17, LPN18 and Registered Nurse (RN) 4 and RN6) were competent in providing trach care that included Heat and Moisture Exchanger (HME) devices; and 2.) the competency of overall trach care for two of nine nursing staff reviewed for trach care (LPN1 and LPN14). This had the potential to affect two of two residents residing in the facility with tracheostomies and could result in the residents not receiving appropriate care which could result in respiratory emergencies. Cross Reference: F695 Findings include: 1. Review of R4's "Admission Record" located under the "Profile" tab in the electronic medical record (EMR) indicated R4 was originally admitted to the facility on 02/26/25 with diagnoses of intracranial injury with loss of consciousness, tracheostomy, quadriplegia, acute respiratory failure with hypoxia, traumatic brain injury, epilepsy, and dysphagia. Review of R4's "Physician Order" dated 09/10/25 and located under the "Orders" tab of the EMR revealed, ". . . Change HME every 24 hours and as needed for saturation, clogging, or visibly soiled . . ." Review of the facility's investigative documentation, provided by the facility, dated 10/05/25, revealed that on 10/05/25, R4's family member brought a care concern to staff regarding R4's trach care. An investigation was conducted, and the conclusion was, "[LPN 16] charted that the HME was changed [on 10/04/25 and 10/05/25] however it was not. When interviewed [LPN16] stated the reason I did not change the HME was because I thought it was the trach collar and I did not change the trach collar because it was not visibly soiled or wet. Staff member was educated and received a discipline." Review of LPN16's "Tracheostomy Care Competency	F0726	Continued from page 53 DON/Designee will competency all licensed staff and newly hired staff on Tracheostomy Care including the use of HME devices. Tracheostomy competencies will be conducted annually. D-Staff Development/designee will conduct direct observation for current residents with tracheostomy (current sample size is 1 resident); and record review to verify that documentation matches what was observed 3 times a week until we consistently reach 100% success over 3 consecutive evaluations. Audits will be monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. Staff Development/designee will track tracheostomy competency completion to 100% of licensed nurses. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026

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F0726 SS = D	Continued from page 54 Checklist" dated 08/14/25 and provided by the facility, revealed LPN16 had been assessed to be competent in providing trach care; however, the competency check did not include competency in the use of HME devices. During an interview on 05/22/26 at 9:49 AM, LPN16 stated he now knew what an HME was and that it attached to the trach. LPN16 stated he had been trained at the facility in the use of HME devices following the incidents on 10/04/25 and 10/05/25 where he had not changed the HME. 2. Review of "Tracheostomy Care Competency Checklist" for LPN15, RN4, LPN10, RN6, LPN17, and LPN18 revealed the nurses were assessed for competency in providing trach care on the following dates: LPN15 - 11/19/25 RN 4 - 03/14/25 LPN10 - 08/15/25 RN6 - 03/14/25 LPN17 - 08/12/25 LPN18 - 03/14/25 Further review of the nurses' trach care competency verifications revealed no documented evidence the nurses' competency related to the use of HME devices was assessed. During an interview on 05/22/26 at 10:35 AM, LPN15 stated "I do not know what an HME is. I have only cared for one resident with a trach and had another nurse with me since I'm new. I don't have any trachs on the hall that I work. I do not recall any training or education regarding caring for residents with trachs." 3. Review of "Employee Staff List," provided by the facility, revealed LPN1 was hired on 07/23/24 and LPN14 was hired on 01/23/24. Review of "Tracheostomy Care Competency Checklists" for the facility's nursing staff revealed no documented evidence LPN1 and LPN14 had been assessed for competency related to tracheostomy care. During an interview on 05/22/26 12:05 PM, LPN1 stated, " I do not provide care for residents with	F0726		07/07/2026

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F0726 SS = D	Continued from page 55 trachs. I have not had any training on trach care." During an interview on 05/22/26 at 4:22 PM, the Director of Nursing (DON) stated "I have only worked here a couple of months. All nurses should be trained to care for residents with a trach. To ensure competency, I would take them to the bedside and have them demonstrate the care and complete a competency checklist. HMEs are not listed on the Trach care competency checklist and should be." Review of the facility's "Facility Assessment Tool," reviewed 04/14/26, revealed, "List any special equipment needed . . . Trach . . . Special Treatments and Conditions . . . Tracheostomy. Average number of residents = 2. Care provided . . . Tracheostomy Care . . . Competencies include: . . . Trach Care . . . Staff Training, education, and competencies. [Facility name] nursing staff and contract nursing staff complete core competencies associated with the provision of care in the SNF [skilled nursing facility] and LTC [long term care] setting. Examples include but are not limited to: . . . Tracheostomy Care and Emergency Tracheostomy Care . . . "	F0726		07/07/2026
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F0761	F761 Label/storage Drugs and Biologicals A-Unable to retroactively secure the medication cart or the computer screen due to being past time of occurrence. B-Residents residing at the facility have the potential to be affected by this deficient practice. To prevent recurrence and protect residents, the facility educated licensed nursing staff on securing medication carts and computer screens when unattended, incorporated this expectation into new hire orientation, and implemented ongoing audits and QAPI monitoring to ensure medications and resident information remain secure. C-DON/designee will educate license nursing staff to lock the medication cart and computer screen whenever the cart is unattended to ensure resident medical information is not visible. RCA: Nurse LPN 29 noted that she was aware of her medication cart being locked but had not locked it. Nurse was aware that the cart should be locked anytime she walked away from it. Nurse LPN 30 noted that her cart should have been locked but was concerned that a resident who was a fall risk needed assistance and walked away from his cart quickly to assist the resident. Nurse noted	07/07/2026

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F0761 SS = D	Continued from page 56 be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to ensure that one of the medication carts on Unit A Hall was secure when staff were not present. This had the potential to affect all residents who were walking by the cart. Findings include: An observation on 05/21/26 at 5:28 AM and again at 9:34 AM revealed a medication cart sitting in the hallway between room A26 and A25 was not locked and the computer screen was open with resident medical information visible due to the screen not being locked. There were several residents in the area along with other staff that walked by. During an interview on 05/21/26 at 5:32 AM, Licensed Practical Nurse (LPN) 29 walked up and stated she knew it was unlocked. She stated that she does not normally work on Unit A Hall but stated she was aware she should lock her cart anytime she walked away from it. During an interview on 05/21/26 at 9:34 AM, LPN30 walked up and stated he knew the cart should be locked, but he was concerned that a resident who was a fall risk needed assistance and he walked away quickly without thinking of locking the cart first. He stated that he was usually always good at making sure to lock his cart and the screen before walking away. He said this was a mistake on his part. During an interview on 05/23/26 at 7:23 PM, the Assistant Director of Nursing (ADON) stated nursing staff were expected to lock their medication carts and computer screen anytime they walked away. She said the medication carts should be locked at all times, along with the screen and there should never be any resident information visible on the screen. She stated all medications need to be secured because there could be potential side effects for any medication that a resident takes when they are not prescribed.	F0761	Continued from page 56 that he should have locked his cart and screen before walking away. New hire orientation will include the importance of locking the medication cart and the computer screen whenever the cart is unattended to ensure resident medical information is not visible. D-DON/designee will audit medication carts and computer screens to confirm that they are locked and resident medical information is not visible when nurse is not present. Audit will be conducted 5 times a week, including every shift, until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	07/07/2026