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: Wilmington Nursing and Rehabilitation **DATE SURVEY COMPLETED:** May 11, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint and Extended survey was conducted at this facility from April 27, 2026 through May 11, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was (one hundred thirty-one) 131. The investigative sample totaled (thirty-one) 31 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**	**3201.1.2**	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement was not met as evidenced by: Cross Refer to the CMS 2567 – L survey completed May 11, 2026: F561, F609, F656 F684, F689, F760, F770, F842, F865 and F880.	Cross Refer to the CMS 2567 – F561, F609, F656, F684, F689, F760, F770, F842, F865 and F880. Date of compliance: 6/16/2026	6/16/2026

Provider's Signature Renee Boyer Title LNHA Date 6/4/2026

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Provider's Signature Renee Boyer Title LNHA Date 6/4/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD , WILMINGTON, Delaware, 19803

(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
F0000	INITIAL COMMENTS An unannounced complaint and extended survey was conducted at this facility from April 27, 2026 through May 11, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 131. The investigative sample totaled 31 residents. Abbreviations/definitions used in this report are as follows: AA - Activities Assistant; ADON - Assistant Director of Nursing; APN - Advanced Practice Nurse; CNA - Certified Nursing Assistant; CRN - Corporate Regional Nurse; DON - Director of Nursing; FM - Family Member; FNE - Forensic Nurse Examiner; HA - Housekeeping Assistant; LPN - Licensed Practical Nurse; MD - Medical Director; NHA - Nursing Home Administrator; NP - Nurse Practitioner; P - Physician; PT - Physical Therapist; PTA - Physical Therapy Assistant; RDCS - Regional Director of Clinical Services;	F0000		05/26/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. BUILDING B. WING	05/11/2026

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F0000	Continued from page 1 RA - Recreation Assistant; RD - Registered Dietician; RN - Registered Nurse; SS - Social Services; UM - Unit Manager Acute respiratory failure - sudden condition that occurs when fluid builds up in the air sacs in lungs then lungs are unable to release oxygen into blood and organs; Acute kidney failure - the kidneys suddenly become unable to filter waste products from the blood which can be fatal; ADLs - activities of daily living/tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; AKI - acute kidney injury/kidney suddenly can't filter waste products from the blood; BIMS (Brief Interview for Mental Status) - test to measure thinking ability with score ranges from 0 - 15. 13 - 15: Cognitively intact. 8 -12: Moderately impaired. 0 - 7: Severe impairment; BMP - Basic Metabolic Panel/ set of lab tests that measure blood sugar, calcium levels, kidney function, and chemical and fluid balance; BUN - blood urea nitrogen/lab test that determines how effectively kidneys filter out nitrogen. High BUN levels may indicate kidney problems, dehydration, or other conditions; C-difficile - highly contagious bacterium that causes diarrhea; Cerebral Palsy - disorder that affects muscle tone, movement and motor skills; Cerebral Vascular Accident (CVA) - stroke; CBC - complete blood count, a lab study that measure the red blood cells, white blood cells and platelets;	F0000		05/26/2026

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F0000	Continued from page 2 CMP - comprehensive metabolic panel/blood test that measures 14 different substances, like proteins and electrolytes in the blood; Congestive heart failure - heart unable to pump enough blood to meet the body's needs; Contact precautions - infection control measures, including but not limited to personal protective equipment, that are used to prevent the spread of infectious agents through direct or indirect contact with patients or their environment; Creatinine - waste product in the urine; lab test that measures how well the kidneys are filtering waste from the blood; Dehydration - a condition of abnormal water loss from the body; Dementia - A severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation or loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning; DM - Diabetes; eMAR - Electronic Medical Administration Record; ER - Emergency Room; GM - Gram; L - Liter; Hydration - the process of treating with water; Hypodermoclysis - method of administering fluids under the skin as opposed to intravenously; Hyponatremia - low blood concentration of sodium, below 135 mmol/L; Hypovolemia - condition that occurs when your bode loses fluid (blood or water); Intravascular - within the blood vessel; Medication Administration Record (MAR) - list of daily medications to be administered; Metabolic encephalopathy - change in how your brain works due to an underlying condition;	F0000		05/26/2026

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F0000	Continued from page 3 MDS - standardized assessment form used in nursing homes; MG - Milligrams; Min - Minute; MRSA - Methicillin-resistant Staphylococcus aureus/a type of bacteria that can lead to serious infections and is resistant to many antibiotics, making it harder to treat; NS - normal saline; NSS - normal saline solution; OOB - Out of bed; Perineal - referring to the area between the thighs, external genitals and anus; Phlebotomy - the act of for drawing or removing blood from the circulatory system; Pneumonia - lung infection; PO - by mouth; PPE - personal protective equipment/gown and gloves; PRN - as needed; Pt - patient; Pulmonary embolism - sudden blockage in a lung artery by a blood clot; PVD - a condition where the arteries or veins become narrowed or blocked, reducing flow to the limbs; Q - Every; Renal - kidney; Schizoaffective Disorder - mental disorder involving symptoms such as hallucinations, delusions, depression and mania; SD - Staff Development; SQ - Subcutaneously; SSI - Sliding scale insulin;	F0000		05/26/2026

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F0000	Continued from page 4 Stat - at once; TID - three times a day.	F0000		05/26/2026
F0684 SS = SQC-K	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for one (R1) out of three residents reviewed for injuries, the facility failed to ensure that R1 received adequate care and treatment that met professional standards. R1, a cognitively impaired and dependent resident, was observed by a staff member with a visible head injury on 4/22/26 at approximately 6:00 AM and failed to inform the nursing staff at that time. The nurses were informed of the injury on 4/22/26 at approximately 8:30 AM, but failed to appropriately assess and provide care and treatment, including neurological checks. Each of the following shifts failed to identify and assess the injury, including failing to initiate neurological checks. As a result of this delay, R1 was found unresponsive in her bed on 4/23/26 at approximately 8:30 AM, more than 26 hours later, and was sent to the hospital, where emergency surgery was performed for a massive brain bleed. Due to this failure, an Immediate Jeopardy (IJ) was called at 1:30 PM on 4/30/26. For R11, the facility failed to ensure timely physician notification and follow-up of abnormal laboratory results. As a result, R11 experienced a delay in treatment and required emergent hospital transfer for acute kidney injury. Additionally, the facility failed to ensure that the physician's order for sodium chloride 0.9% intravenous infusion was administered when R11 developed signs and symptoms of dehydration on 3/18/26. The facility also failed to ensure R14 received timely care and services after a change in condition, and critical labs were identified, resulting in a hospital transfer requiring admission to the ICU for an acute kidney injury, resulting in harm.	F0684	F684 Quality of Care A1. R1 no longer resides in the facility; the facility is unable to correct the deficient practice for R1. B1. Residents currently residing in the facility have the potential to be affected. Head to toe assessments were completed on current in-house residents on the secured unit; no other injuries of unknown origin were identified 4/24/2026 through 4/27/2026; all other current residents had skin assessments completed with no other injuries of unknown origin identified. C1.Root cause analysis is related to assigned C.N.A.s failure to report injury to assigned licensed nurses as the C.N.A.s thought the injury had already been reported, failure of assigned nurses to identify and report injury as the nurses did not see the residents face nor did they identify the injury, failure of assigned nurse that identified injury to properly assess, including a neurological assessment and follow documentation and reporting requirements related to she got busy and forgot to document in the clinical record and forgot to report it to the oncoming nurse, and failure of Unit Manager to follow-up with licensed nurse related to the injury related to lack of follow-up communication with the licensed nurse regarding the injury. The facility failed to follow the Reporting Requirements Policy related to reporting Abused/Neglect/Misappropriation/Crime to include injuries of unknown origin, which requires reporting no later than 2 hours after the allegation. The primary nurse that failed to report and document the injury of unknown origin was suspended pending investigation and subsequently terminated after completion of investigation. The Director of Nursing completed 1:1 education with staff that failed to follow proper procedures upon identifying any injury of unknown origin to include reporting and documentation requirements, including a risk management report. The Director of Nursing/Staff Development Coordinator/designee educated licensed nurses and C.N.A.s to follow proper procedures upon identifying any injury of unknown origin to include reporting and documentation requirements. Education was initiated by the Director of Nursing/Staff Development Coordinator on 4/23/2026 for nurses and CNAs and reinforced through 4/29/2026. The Director of Nursing educated the Unit Manager regarding the	06/16/2026

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F0684 SS = SQC-K	Continued from page 5 Findings include: 1. 1/29/24 – A facility document entitled, "Neurological Assessment," included, "A neurological assessment will be completed by a licensed nurse in order to detect potential early signs of brain injury. Complete the neurological checklist assessment in the medical record. Assess vital signs, orientation, level of consciousness, pupillary response, verbal response, pain, and movement and sensation of extremities. Complete assessment every 15 minutes for the first hour, every 30 minutes for the next two hours, and every hour for the next four hours. Notify provider and responsible party of any abnormal findings. Document in the medical record and follow provider recommendations." R1's clinical record revealed: 12/26/25 – R1 was admitted to the facility with diagnoses including, but not limited to, a stroke, deep vein thrombosis, heart failure, and dementia. 12/26/25 – R1's care plan (reviewed 3/24/26) included, "... At risk for bleeding, hemorrhage, excessive bruising and complications related to anticoagulant use..." The interventions included, "...Monitor for signs/symptoms of bleeding, bruising, and complications and notify MD as indicated." 3/12/26 – R1's medications included aspirin 81 mg daily and Eliquis 5 mg, two times a day for deep vein thrombosis. 3/13/26 – R1's quarterly MDS assessment documented a BIMS score of 5, indicating a severe cognitive impairment. R1 required substantial to maximum assistance from staff for bed mobility and was totally dependent for all transfers between surfaces. 4/23/26 8:58 AM – R1's physician clinical record included, "Right periorbital [tissues surrounding the eye socket, including the eyelid, skin and underlying soft tissue] bruising, right temporal hematoma, altered mental status... evaluated emergently at this a.m., nursing informed me that the aide had gone into her room and noticed that the resident was not communicating with her and [was] concerned for her level of responsiveness. The	F0684	Continued from page 5 need for follow-up with the primary nurse for assessment regarding change in condition of a resident. The facility will utilize the homework sheet to communicate clinical information between Unit Managers and Supervisors. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D1. Director of Nursing/designee will conduct audits to ensure staff is following proper procedures upon identifying any injury of unknown origin to include reporting and documentation requirements and follow-up with nursing by Unit Manager/designee. These audits will be completed daily x5 days until 100% compliance, then weekly x3 weeks until 100% compliance, then monthly x2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. A2. R11 no longer resides in the facility, the facility is unable to correct the deficient practice for R11. Cross reference F770 B2. Residents currently residing in the facility have the potential to be affected. An initial audit of lab orders from May 1 through May 31 was completed to ensure current in-house resident's labs were collected, resulted, and reported to and reviewed by the provider. C2. Root cause analysis related to a change in laboratory vendor causing a delay in receiving laboratory results, difficult venous access; inability to access for ordered lab draw, and required rescheduling including rescheduling and communication with providers in the event labs are not collected, follow-up regarding pending lab results and abnormal lab results to ensure timely physician notification. Staff Development Coordinator/designee will educate licensed nurses regarding the facilities' laboratory ordering, collection, requesting reports of difficult or inability to access vein result follow-up and reporting process, including physician notification of results to address. Root cause is also related to Unit Managers' failure to follow the facility Laboratory/Diagnostic Testing Policy which includes but is not limited to ensuring that tests are completed as ordered and communication of results to the provider and utilizing the Lab Tracking Form. The Unit Managers will be responsible for ongoing oversight of ensuring completion of labs ordered	06/16/2026

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F0684 SS = SQC-K	Continued from page 6 nurse was called, and upon examination, noted the patient had a right periorbital bruise and what appeared to be a right temporal sub-gluteal hematoma....No apparent reports of a fall...Patient is on Eliquis as well as a baby aspirin... Advised nursing to call 911 immediately to transport to the hospital for further evaluation...Patient was lying on her left side and also noticed a small area of what appeared to be vomitous on her sheet. I attempted to awaken the resident by calling her name but no response and I also attempted to touch her arm to see if she would respond and she did not...Patient with apparent fall, however no report of a fall at this time and I did speak to the assistant director of nursing to contact the night nurse to further discuss whether or the patient may have had a fall during the course of the evening hours... Sent to the emergency room for further evaluation as patient needs an emergent heat CT [scan]...altered mental status...nonresponsive to verbal or stimulus." 4/23/26 9:36 AM – E12 (LPN) documented in R1's nursing clinical record, "Resident discovered in bed sleeping not easily aroused in deep sleep not able to explain what happen. Observation hematoma to right [forehead] and right eye bruising. Fully dressed... [Name of doctor] assessed resident and ordered to send resident out to the hospital for further evaluation." 4/23/26 12:24 PM – A facility reported incident report submitted to the Division documented, "On 4/23/26 at approximately 0830 [8:30 AM], CNA reported to the Unit Manager that resident [R1] has a hematoma to the right side of her forehead and a right periorbital bruising." 4/28/26 1:20 PM – During a telephone, FNE1 (Forensic Nurse Examiner) stated, "[R1] was completely unconscious when she arrived at the hospital. She went immediately to surgery and did not regain coconsciousness. App roximately one quarter of her brain was filled with blood. She had a massive brain bleed and was dying. It did not look like she was going to recover, and her family decided to put her on end-of-life care because she would not want to live like that." 4/29/26 9:00 AM – During a telephone interview, E8 (CNA) stated, "My shift started on 4/21/26 at 11:00 PM and ended at 4/22/26 at	F0684	Continued from page 6 and results reported. The Lab Tracking Form will be brought through the daily scheduled clinical meetings for review. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D2. Director of Nursing/Designee will conduct audits to ensure staff is following proper procedures related to the facility's laboratory process to include ordering, collection, result follow-up and reporting process, including physician notification. These audits will be completed daily x5 days until 100% compliance, then weekly x3 weeks until 100% compliance, then monthly x2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. A3. R11 no longer resides in the facility, the facility is unable to correct the deficient practice for R11. Cross reference F692 B3. Residents currently in the facility with orders for IV fluids have the potential to be affected. An initial audit from 5/1/2026 through 5/31/2026 was completed, two residents were identified that received fluids via hypodermoclysis. C3. Root cause analysis related to licensed nurse's failure to ensure intravenous fluid infusion was administered and documented is related to the improper/inaccurate order entry related to intravenous fluids/intravenous access, documentation required to monitor intravenous fluid intake and required assessments and documentation for residents receiving intravenous fluids. In addition, the facility failed to add supplementary documentation regarding amount (ML) of fluids infused during each shift to the intravenous fluid orders due to lack of knowledge regarding order entry as well as the facilities failure to document the monitoring of fluid intake and required assessments and documentation for residents receiving intravenous fluids related to the staffs lack of knowledge regarding required documentation. The Staff Development Coordinator will incorporate the education regarding proper order entry of intravenous fluids to include monitoring intake, site assessments and required documentation of residents receiving intravenous fluids, including competencies during the new hire orientation process. The Staff Development Coordinator/designee will educate licensed nurses regarding proper order entry of intravenous fluids to	06/16/2026

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F0684 SS = SQC-K	Continued from page 7 7:00 AM. I provided care to the resident [R1] two or three times during the night. Around 6:00 AM, I saw a discoloration on the right side of her forehead, but I forgot to tell the nurse." The Surveyor asked E8 if R1 showed any signs of pain when care was provided was provided to her. E8 stated, "No." The Surveyor then asked E8 about R1's status during the 11-7 shift of 4/22/26 to 4/23/26. E8 stated, "I saw the bruise around 5:00 AM but I did not see any additional injuries. The resident was responsive when I provided care to her during the shift." The Surveyor asked E8 if he reported the bruise to the nurse on duty or the oncoming aide. R8 stated, "No." E8 failed to notify the nurse despite observing the bruise on R1's face on two separate occasions. 4/29/26 9:15 AM – During a telephone interview, E16 (LPN) stated, "I worked the 11:00 PM to 7:00 AM shift on 4/21/26 into 4/22/26. I did an initial round when I came on the shift, and the resident [R1] was in her bed. I did not observe anything unusual with her. I gave her the morning medication between 5:30 AM to 5:45 AM, but I did not turn on the light in the room." The Surveyor asked E16 how she was able to see to give the resident her medication and if the resident was awake enough to take the medication. E16 stated, "There was some light in the room, so I was able to see. And the resident took the medication fine." The Surveyor asked E16 if E8 informed her about any bruising or other concerns with R1. E16 stated, "No." 4/29/26 9:30 AM – During an interview, E7 (CNA) stated, "I was helping to feed the residents breakfast in the dining/activity room around 8:30 AM on 4/22/26. I saw the bruising and swelling on the resident's [R1] right-side temple and forehead area. I asked if anyone saw this. I told E6 (UM) and she told me to tell the resident's nurse. I told the nurse [E15 LPN] and she stated, "I will take a look at it." 4/29/26 9:45 AM – During an interview, the Surveyor asked E6 (UM) whether she was informed of the discoloration and swelling on R1's head. E6 stated, "The aide told me, and I told him to tell her nurse." The Surveyor asked E6 whether she assessed R1, informed the ADON, DON, updated the provider or	F0684	Continued from page 7 include monitoring intake, site assessments and required documentation of residents receiving intravenous fluids. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D3. Director of Nursing/designee will audit orders for intravenous fluids to ensure orders include monitoring intake, assessments and required documentation of residents receiving intravenous fluids are being completed. These audits will be completed daily x5 days until 100% compliance, then weekly x3 weeks until 100% compliance, then monthly x2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. A4. R14 currently resides in the facility; R14's Sodium is within normal limits and Acute Kidney Injury has resolved, and labs are being collected as ordered and reviewed by provider. B4. Residents currently residing in the facility have the potential to be affected. Initial audit of critical lab results for current in-house residents from 5/1/2026 through 5/31/2026 to ensure they were reviewed by the provider, and residents were transferred out timely per provider orders. C4. Root cause analysis related to lack of communication to the provider regarding the residents' change in condition, review of lab results with provider, as well as lack of timely follow-up of lab results, and resident not being transferred out for evaluation per physician order. In addition, the root cause if also related to the facilities failure to follow the Significant Change Policy which includes but is not limited to notification of provider and required documentation, Unit Managers' failure to follow the facility Laboratory/Diagnostic Testing Policy which includes but is not limited to ensuring that tests are completed as ordered and communication of results to the provider and utilizing the Lab Tracking Form. The Lab Tracking Form will be brought through the daily scheduled clinical meetings by the Unit Managers for review. The Director of Nursing educated the nursing staff involved related to communication to provider related to resident change in condition, timely review of lab results with provider, and timely transfer out of a resident for further evaluation per provider orders. The Staff Development Coordinator/designee will educate licensed nursing staff related to	06/16/2026

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

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F0684 SS = SQC-K	Continued from page 8 documented the change in the resident's status. E6 stated, "No." 4/29/26 10:00 AM – During a telephone interview, E13 (AA) stated, "[E7] and I were in the dining room around 8:30 AM to 9:00 AM on 4/22/26. We saw the bruise on the resident's face and the CNA went to tell the nurses. I stayed in the dining room to watch the residents." 4/29/26 10:30 AM – During a telephone interview, E14 (CNA) stated, "This was my assignment on 4/22/26 on the 7-3 shift. I gave morning care to the resident and saw the bruise when I was washing her face. I dressed her and brought her into the hallway, and I asked her nurse [E15], "Did you see this? What happened to her?" The nurse replied, "It happened overnight," and remained at the medication cart. I took the resident into the dining room for breakfast." 4/29/26 11:00 AM – During a telephone interview, E15 stated, "The night nurse did not tell me anything about a bruise on this resident. It was around 8:30 AM to 9:00 AM on 4/22/26 when the aide [E7] told me that [R1] had a "knot" on her head. I was passing medications, and I stopped and checked on the resident. I took her vital signs and checked her neuros [neurological status]. I saw a mildly raised area on the right side of her forehead, but there was no discoloration and her eyes were clear". The Surveyor asked E15 if she reported her observations to the supervisor or the medical provider. E15 stated, "No, I did not report it to anyone. I don't work with this resident very often and I thought it was an old bruise that was already addressed and did not need to be reported again." The Surveyor asked E15 if she documented the results of R1's neurological check and updated the 3-11 shift nurse about the bruise. E15 stated, "No, I did not tell the 3-11 nurse, and I forgot to document the neuros." The facility lacked evidence that R1's neurological status was monitored, or the medical provider was notified of the swelling and discoloration on the right side of her face. R1's medication administration record revealed that E15 administered oral medic	F0684	Continued from page 8 communication to provider related to resident change in condition, timely review of lab results with provider, and timely transfer out of a resident for further evaluation per provider orders. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D4. Director of Nursing/designee will audit residents with change in condition to ensure licensed nurse communicated the change to the provider, labs were reviewed timely with provider, and timely transfer out of a resident for further evaluation per provider orders. These audits will be completed daily x5 days until 100% compliance, then weekly x3 weeks until 100% compliance, then monthly x2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. 5. Date of compliance: 6/16/2026	06/16/2026

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F0684 SS = SQC-K	Continued from page 9 ations to R1 at 9:00 AM and oral supplements at 1:00 PM on 4/22/26 but failed to identify, assess or report the visible bruise on the right side of her head. 4/29/26 11:30 AM – During a telephone interview, E19 (CNA) stated, "I was in the hallway around 8:30 AM or 9:00 AM on 4/22/26 when I heard the aide [E14] tell the nurse [E15] that the resident had a "knot" on her forehead. The nurse replied, "It was not reported to me from the previous shift," and "I saw the injury already." 4/29/26 1:30 PM – During a telephone interview, E17 (LPN) stated, "I worked on the 3-11 shift on 4/22/26 but I did not see any bruising or swelling on the resident." R1's medication administration record revealed that E17 gave her oral medications at 4:00 PM and 8:00 PM but failed to identify the obvious bruise on the right side of her head. 4/29/26 2:00 PM – During a telephone interview, E21 (CNA) stated, "I worked with the resident [R1] on the 3:00 PM to 11:00 PM shift of 2/22/26. I saw the bruise on the right side of her head. I don't usually work with her. When I saw the fall mat near her bed, I thought that she had a previous fall, and the nurses already knew about it. That is why I did not think the bruise was new and did not report it." E21 failed to report the bruise on R1's face despite the lack of a report of an injury from the previous shift. 4/30/26 9:00 AM – During a telephone interview, E20 (RN) stated, "I worked with the resident [R1] on the 11:00 PM to 7:00 AM shift on 4/22/26 to 4/23/26. I checked on all the residents at the start of the shift. I did not turn on the lights because I didn't want them to wake up. [R1] slept all night and took her medication in the morning around 5:45 AM." The Surveyor asked R20 if R1 was awake and alert when she gave her the medication. R20 replied, "I did not turn on the light when I gave her the medication with some applesauce. I did not give her water or anything else to drink."	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 10 4/30/2026 9:30 AM – During a telephone interview, E11 (CNA) stated, "The resident [R1] was on my assignment on 4/22/26 on the 7:00 AM to 3:00 PM shift. I did a quick round when I came on the shift to check that none of the residents had fallen out of bed. [R1] appeared to be sleeping so I went and got a couple of other residents up and then went to get her up. She was breathing in and out but I could not wake her up. And I saw bruises on her forehead and right eye. I told the unit manager who was outside of the room." 4/30/26 11:30 AM – During a telephone interview, E5 (MD) stated, "I was in the facility for a meeting on 4/23/26. At approximately 8:30 AM, I received a message that [R1] had a head injury and she was unresponsive. I told the staff to call 911 and went up to the unit. The emergency personnel were already there working on her. I saw that she was unresponsive and had a large, bruised area on the right side of her forehead/eye area. There was also some vomit on her bed sheet. I asked nurse if the resident had fallen, and she said, "No." The Surveyor asked E5 what his expectation from the facility would be about a resident who was taking two blood thinning medications and had an obvious head injury. E5 stated, "I would expect to be informed immediately, especially if she is on two blood thinners. And she should get medical treatment right away." The facility failed to ensure that R1 received medical care and treatment for more than 26 hours after the injury was identified by the staff. 4/30/26 1:15 PM – An Immediate Jeopardy was called due to the seriousness of this incident. 4/30/26 3:00 PM – The facility provided the Surveyor with the following action plan for the abatement for the Immediate Jeopardy: Education to CNA to notify nurse immediately up identifying and injury of unknown origin Nurse to notify supervisor and/or physician immediately upon identifying any injury	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 11 of unknown origin Performing resident evaluation/assessments with change in condition and/or injury of unknown origin and completion of required documentation including risk management report as indicated Completion of incident reports to include any injury of unknown origin Neurological assessments Mandatory reporting requirements 1:1 education has been completed with staff that failed to follow the proper procedures Primary nurse that failed to report and document injury of unknown origin on 4/22/26 was suspended pending investigation Unit Manager was educated regarding following up with the primary nurse regarding change in condition of a resident ADHOC QAPI was held immediately which include department heads Head-to-toe skin assessments completed for all residents on the secured unit Any injuries of unknow origin will be reviewed to ensure that all proper documentation is completed Education was initiated on 4/23/26 for nurses and CNAs and reinforced through 4/29/26. Staff were educated via telephone and will be required to sign the education record upon next working shift. Director of Nursing/designee will conduct audits to include documentation compliance,	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 12 physician notification and proper reporting procedures. Results will be reviewed through QAPI committee and acted upon immediately if concerns are identified. 4/30/26 5:15 PM – Based on the Surveyor's review of the facility's investigation, documented response, completion of audits from 4/23/26 to 4/29/26, staff interviews and no further injuries of unknow origins, the IJ was considered abated on 4/30/26 at 5:00 PM. 2. Cross refer F770 Review of R11's clinical record revealed: 1/17/26 – R11 was admitted to the facility with diagnoses including CKD (chronic kidney disease). 3/12/26 – R11 had a physician's order for CBC, CMP thyroid panel and A1C (blood test for diabetes) for chronic kidney disease. 3/13/26 – R11 had CBC, CMP thyroid panel and A1C labs drawn. 3/14/26 – R11 had a physician's order for BMP (basic metabolic panel) and Mg (magnesium) level. 3/16/26 2:14 PM – A medical note from P2 (PA) documented, "labs drawn this morning and pending ..." 3/17/26 – R11 had BMP and Mg labs drawn. Despite the physician's order on 3/14/26, R11's BMP and Mg levels were not collected until 3/17/26. 3/17/26 2:33 PM – A medical note from P2 documented, "... CKD (stage) 3 overall stable labs from 03/13 showing crt (creatinine) 1.6 BUN (blood urea nitrogen) 19 ... this is in-line with pt's (patient's) prior labs with no notable acute changes ...". 3/18/26 5:12 PM – A medical note from P1 (physician) documented, "... Acute on chronic renal failure worsened related to pre-renal azotemia (abnormally high levels of nitrogen – containing waste products in blood) ... I reviewed BMP 3/17/2026. BUN/creatinine: 53/2.9 ...Follow serial BMP... [R11] is at risk for deterioration, hospitalization."	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 13 Despite laboratory values reviewed on 3/17/26, additional follow-up laboratory monitoring continued to be ordered due to ongoing concerns regarding R11's kidney function and risk for deterioration. P1's documentation identified concern for worsening renal function and specifically noted R11 was at risk for deterioration and hospitalization. 3/18/26 - An additional physician's order was written for a CBC, CMP, magnesium and phosphorous level for R11. 3/19/26 – A facility lab results report, with a collection date of 3/19/26 and reported on 3/23/26, documented R11's, "… albumin please reschedule … difficult draw specimen not obtained … WBC please reschedule … difficult draw … CBC, CMP difficult stick …" Although additional laboratory testing was ordered, portions of the ordered specimens were not obtained due to difficult venous access and required rescheduling. 3/20/26 8:43 AM – A medical note from P2 (PA) documented, "… Hypokalemia/Hyponatremia/concern for Dehydration … labs from 03/13 showed potassium of 2.8, received supplementation over the weekend, repeat BMP from yesterday [3/19/26, although it was noted in the lab results report that R11's specimen was not obtained] showed improvement in potassium to 3.4 will continue with supplementation and continue to monitor – repeat labs also showed mild hyponatremia at 131 with acute drop in baseline kidney function … crt 2.9, BUN 53 … appear mildly dehydrated … mildly dry mucous membranes … repeat labs ordered for tomorrow … based on results of labs from today, will determine further need for supplementation…" The medical note reflected continued concerns regarding dehydration, worsening kidney function, electrolyte imbalance, and the need for repeat laboratory monitoring. 3/20/26 – R11 had a physician's order for a stat CBC, CMP, magnesium, phosphate, B12, folate and Vitamin D for electrolyte derangement. 3/21/26 – R11 had CBC, CMP, magnesium, phosphate, B12, folate and Vitamin D labs drawn. Further review of R11's clinical record lacked evidence that the results of the stat laboratory testing collected on 3/21/26 were reviewed by P1 or	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 14 P2 prior to 3/26/26. 3/24/26 2:47 PM – A medical note from P1 documented, "… Acute on chronic renal failure worsened related to pre-renal azotemia … I reviewed BMP 3/17/2026. BUN/creatinine: 53/2.9 … awaiting follow up BMP… she is at risk for deterioration, hospitalization..." 3/24/26 – R11 had a physician's order for CBC, CMP, magnesium and phosphate. Despite ongoing concerns regarding deterioration and hospitalization risk, the follow-up BMP referenced by P1 had not yet been reviewed. 3/25/26 – R11 had CBC, CMP, magnesium and phosphate labs drawn. 3/26/26 – 7:11 AM (another fax transmittal time stamped 7:14 AM) - A laboratory results of R11's labs drawn on 3/21/26 revealed the following results: elevated phosphorous 4.7 (2.6 – 4.5) BUN 44 (5-20) creatinine 2.6 (0.5 – 1.3) WBC 15.20 (4.5 – 11.00) and low hemoglobin 8.2 (11.7 – 16.1). Results of R11's physician order for stat lab work on 3/21/26 were not reported to the facility until five days later on 3/26/26. Results of R11's physician order for stat laboratory work collected on 3/21/26 were not reported to the facility until five days later, on 3/26/26. The laboratory results reflected continued worsening renal function and abnormal findings. Despite the stat laboratory order and documented concerns regarding worsening kidney function and hospitalization risk, the facility lacked evidence of timely follow-up regarding the pending laboratory results prior to 3/26/26. 3/26/26 9:35 AM – A laboratory results of R11's labs drawn on 3/25/26 revealed the following: elevated phosphorous 5.8 (2.6 – 4.5) BUN 56 (5-20) creatinine 4.6 (0.5 – 1.3) WBC 16.30 (4.5 – 11.00) low sodium 130 (133- 145) and low hemoglobin 7.6 (11.7 – 16.1). Results of R11's physician order for lab work on 3/25/26 were not reported to the facility until the next day, on 3/26/26. 3/26/26 2:46 PM – A nurse progress note documented, "New labs received., pt (patient) in AKI (acute kidney injury) and also not eating and drinking more than 50% per meal for the least two	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 15 days. New order to send pt to ED (Emergency Department) for further eval ... ". 3/27/26 10:33 PM – A medical note from P1 documented, "... Acute on chronic renal failure worsened related to pre-renal azotemia ... I reviewed BMP 3/26/2026. BUN/creatinine: 56/4.6 ... She is acutely ill and at high risk for further deterioration. Transfer the patient to hospital for further evaluation and management." 5/4/26 10:08 AM – In an interview, P1 (physician) confirmed that R11 was sent out to the hospital when the abnormal lab results came back indicating that R11 had an acute kidney injury. 5/8/26 9:05 AM – In an interview, P2 (PA) stated that he was not immediately notified of the results of R11's stat lab draw order. "I think it was that weekend. We had a third-party lab issue that time. We didn't know whom to call for follow up results". 5/8/26 9:10 AM – During an interview, E47 (LPN) stated, "... When there's a stat lab order, the nurses should call and follow up with the lab and notify the physician, especially if the results are critical and the resident is going through a change in condition." 5/5/26 4:00 PM – Findings were discussed with E1 (NHA), E2 (DON) and E3 (CRN). 3. Cross-refer F692 Review of R11's clinical record revealed: 3/18/26 5:12 PM – A medical note from P1 (physician) documented, "... poor oral intake ... optimize fluid intake ... she is at risk for deterioration, hospitalization..." 3/18/26 – R11 had a physician's order for "Sodium Chloride 0.9 % (also known as normal saline solution) use 50 ml/hr intravenously every shift for hydration for 1 Day ... for total of 1 Liter." 3/18/26 – A review of R11's eMAR lacked evidence that R11's sodium chloride intravenous solution was patent and infusing well on the 3-11 shift. 3/18/26 11:55 PM – A nurse progress note documented, "IV access present: No. " 3/19/26 12:48 AM – A nurse progress noted documented, "IV site infiltrated, RN supervisor ... notified".	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 16 3/20/26 8:49 AM – A medical note by P2 (NP) documented "… pt refused IV fluids, … states … they were trying to "stab her belly" yesterday when they were attempting to place the hypodermoclysis … appears pt refused hypodermoclysis and NSS yesterday…" 5/8/26 9:00 AM – During an interview, P2 (PA) confirmed that he did not receive any notification from the nursing staff that R11's IV site was infiltrated on 3/18/25 evening shift and that R11 refused the IV fluids until he learned about it on 3/20/26. 5/5/26 4 PM – Findings were discussed with E1 (NHA), E2 (DON) and E4 (CRN). 4. Review of R14's record revealed: 10/11/24 – R14 was admitted to the facility with diagnoses including psychosis, Alzheimer's Disease, cerebrovascular disease, bipolar disorder, hypertension, and aneurysm of the vertebral artery. 10/15/25 – Lab results include Sodium 142 (normal 135-145); BUN 22 (normal 10 – 26); Creatinine 0.8 (normal 0.5 – 1.5); WBC 7.6 (normal 4.8 – 10.8). 11/3/25 – R14's quarterly MDS documented a BIMS score of 0 (indicating severe cognitive impairment). The MDS further documented that the resident was able to ambulate at least 150 feet without assistance, was dependent for personal and oral hygiene, and was independent for eating. 12/29/25 6:00 PM – A progress note by P3 (Physician) documented "History of Present Illness [R14] …will continue to be monitored and encouraged for oral hydration… Follow-up – Review CBC and CMP results when available." 1/6/26 8:32 PM – A progress note by P4 (Nurse Practitioner) documented "…[R14] was noted to be lethargic this morning. CBC and CMP will be checked to monitor patient. The note further documented the plan was to "continue to promote good p.o. [by mouth] intake with patient today and encourage fluids." 1/6/26 – CBC and CMP orders were listed with a status of completed in R14's EHR (Electronic Health Record). However, review of the clinical record lacked evidence of laboratory results between 10/15/25 and 1/9/26.	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 17 1/8/26 11:30 AM - A progress note by P3 documented "...acute decline, altered mentation...[R14] ... Staff report [R14] has not been participating well and appears more altered than at baseline...patient appears slightly altered... was noted to be lethargic the day prior...Exam – Frail, Lethargic, Altered, Declining status...No signs of distress or acute illness... Skin turgor normal." It should be noted that the lab results listed in the progress note were from 10/15/25, and vital signs were from 1/2/26. "Assessment and Plan -...Altered mental status...Ordered CBC...BMP...urinalysis today... Follow up-Review CBC, BMP, and urinalysis when available." 1/8/26 – CBC and CMP orders were again listed as completed on 1/8/26 in R14's EHR; however, review of R14's clinical record lacked evidence of lab results between 10/15/25 and 1/9/26. 1/8/26 9:44 PM – A Nursing SBAR [Situation, Background, Assessment, Recommendation] Communication Form documented R14's mental status was "better" after encouraging fluids and assisting with meals. However, the note also documented that R14 required more assistance with ADL's, had "decreased alertness, somnolence," and was spending "a lot of time in bed." 1/9/26 8:39 AM – A nurse's progress note documented night shift nurse was unable to obtain the UA [urinalysis] specimen due to consistency. [P3] was made aware. 1/9/26 10:11 AM – A nurse's progress note documented – "Specimen [urine] collected and labeled." 1/9/26 1:39 PM - A nurse's progress note documented – "Resident assisted with ADLs and transfers, stayed in bed most of the shift, drowsy but easily arousable, decreased mobility and poor appetite noted, awaiting lab results." 1/9/26 1:51 PM – A Communication with Physician note documented critical laboratory findings, including WBC 22.0, were reported to P3. Recommendations: Ciprofloxacin (antibiotic), increase fluids, and repeat labs. 1/9/26 4:30 PM – The Facility's investigation records documented "...[P3] was in the facility and was provided with a copy of the most recent lab results received today..." 1/9/26 – [8:00 PM] A progress note by P3	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 18 documented "...persistent confusion and marked lethargy... severe hypernatremia, and acute renal dysfunction..." The following lab values from 1/9/26 are noted: WBC 22.0 BUN 100, creatinine 1.8, sodium 171. It should be noted that creatinine on 10/15/25 was 0.8 and BUN was 22. P3 further documented "...severe hypernatremia on labs: sodium 171... with associated confusion and lethargy. Encourage oral hydration and monitor closely in facility.... Repeat labs in 2 days if there is no improvement in white blood cell count or if vital signs/mental status worsen. Transfer for further evaluation if patient becomes hypotensive, febrile, has worsening vital signs, worsening mental status, or worsening white blood cell count..... Electronically signed 1/9/26 10:54 PM." It should be noted that although the note reflected a visit time of 8:00 AM, facility investigation records indicated the provider inadvertently entered the incorrect time, and the visit occurred at 2000 (8:00 PM). On 1/9/26, critical laboratory findings included sodium 171 (normal 135–145), BUN 100 (normal 10–26), creatinine 1.8 (previously 0.8), and WBC 22.0 (normal 4.8–10.8), reflecting severe hypernatremia, acute renal dysfunction, dehydration, and significant leukocytosis 1/9/26 10:20 PM – E16 initiated a telehealth visit due to concern regarding R14's sodium level. A note from P4 (contracted telehealth NP) documented that R14 was "...lethargic, responds to name but will not open eyes and move head from side to side. May be a sign of fatigue/restlessness. Appears dehydrated... Diagnosis...Hyperosmolality and hypernatremia...Condition is critical. Patient noted with acute hypernatremia 171 [sodium level], with lethargy and restlessness." At 10:47 PM, P4 ordered R14 to be transferred to the Emergency Department for "acute change in mental status with sodium level of 171." 1/9/26 11:13 PM – A nurse's progress note by E50 (LPN)documented "resident remained in bed the entire shift, alert, oriented to self, easily breathing, no s/s [signs/symptoms] pain noted, appetite remained poor, fluid encouraged and tolerated VS 107/61[BP], 72 [HR], 17 [RR], 97.3 [temp], spO2 98 on room air, assisted with adl's [activities of daily living], no s/s distress noted" 1/9/26 11:22 PM – A nurse's progress note by E16 documented "Upon shift change, patient noted to be in no distress, VS: 106/70 [BP], 88 [HR], 18 [RR], 98.2 [temp], 95% R/AIR [room air]. [P4] made aware,	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 19 will continue to monitor." Review of the clinical record lacked evidence that the transfer order was followed or that a provider authorized cancellation of the transfer order. 1/10/26 12:37 AM – A nurse's progress note by E32 (RN Shift Supervisor) documented that R14 was resting calmly in bed, "no signs of dehydration." The note documented oral fluids were tolerated and resident would be continue to be monitored. 1/10/26 6:03 AM – A nurse's progress note documented that P3 "reviewed labs 1/9/26 and recommended that they be repeated on 1/12/26 and encourage PO [by mouth] fluids." At that time, R14 was responding to "tactile stimuli" [touching]. Despite severe laboratory abnormalities, worsening lethargy, poor oral intake, altered mental status, and a telehealth provider documenting the resident's condition as "critical" with an order for Emergency Department transfer, R14 remained in the facility overnight. 1/10/26 7:55 AM – A nurse's progress note by E32 documented, "[R14] evaluated this morning V/S WNL (vital signs within normal limits), afebrile, consulted with [P3] and agreed to send patient to the hospital for high Na (sodium) levels management. Unit nurse updated, 911 called." 1/10/26 8:00 AM - A progress note by P3 documented ongoing lethargy and hypernatremia. P3 documented, "The nurse called this morning reporting that the patient is still very lethargic. Labs from yesterday were reviewed and revealed sodium of 171, creatinine 1.8 and white blood cell count of 22. [R14] is still not having good po intake despite encouraging…will send the patient to the hospital for further evaluation...[R14] was noted to be lethargic starting 1/7/26, with concerns of worsening status and decline noted 1/8/26 when staff reported she had not been participating well and appeared more altered than at baseline. On 1/9/26, she remained very lethargic and confused with labs showing significantly elevated white blood cell count at 22.0 and elevated creatinine at 1.8… Severe hypernatremia with ongoing lethargy and poor PO intake…Due to persistent lethargy and severity of hypernatremia...[R14] will be sent to the hospital today for further evaluation and management of hypernatremia…" 1/10/26 8:06 AM – A nurse's progress note documented "[FM2] (Family member) notified about	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 20 patient's health status and transfer to the hospital." 1/10/26 1:18 PM – A hospital Emergency Department progress note documented dry mucus membranes. The note further documented laboratory results including sodium level 170 and creatinine 2.0. R14 was admitted to the Intensive Care Unit with a diagnosis of hypernatremia. 1/10/26 3:43 PM - Hospital History and Physical note documented that R14 had dry mucus membranes and a dry tongue. The note further documented that R14 was diagnosed with hypernatremia and AKI (acute kidney injury). 1/10/26 5:03 PM – A Nephrology (Kidney specialist) progress note documented that R14 had "very dry mucus membranes." The note further documented that R14's hypernatremia and acute kidney injury were most likely related to "severe volume depletion due to poor oral intake." Review of the clinical record, provider documentation, laboratory orders/results, hospital records, and staff interviews revealed delays and inconsistencies related to the recognition, assessment, communication, and response to R14's worsening condition. 1/15/2026 – R14 returned to the facility. 4/30/26 approximately 2:00 PM – Interview with E7 (CNA) revealed water pitchers are not kept at the bedside due to potential of residents wandering into other residents' rooms and drinking it. CNAs are responsible for providing two hydration opportunities each shift, in addition to what the resident drinks with meals. CNAs document the amount of fluid consumed during meals in the Meal Intake section of the CAN Documentation Report; the additional fluids consumed are documented under PRN Fluid Intake. 5/4/26 10:14 AM Telephone interview with FM2 [R14's family member] who reported she met [R14] at the Emergency Department on 1/10/26. She stated, "I couldn't believe when I saw her, her mouth was so dry, it looked like no oral care had been done, her hair was unkempt... They called me a few days before, but all they told me was she had had a change in behavior over those 2 days. They told me at the hospital that "this level of dehydration doesn't just happen overnight…her mouth was just so dry and her lips were so cracked. I should have been notified, I would have come in." 5/4/26 4:26 PM – An interview with P4 (Telehealth	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 21 Nurse Practitioner) revealed P4 was contacted the evening of 1/9/26 due to E16's [LPN] concern regarding R14's sodium level and lethargy. Resident was lethargic on exam; P4 confirmed sodium level of 171 and gave an order to transfer R14 to the emergency department. Surveyor asked P4 if she was aware that R14 had not been transferred; P4 replied "No." Surveyor asked if P4 had received any additional calls after the telehealth visit at 10:20 PM. P4 replied "No", telling the surveyor she was looking at her notes from that day and the only entry for R14 was the telehealth visit initiated at 10:20 PM. P4 stated "[Company name] is very strict about documentation, we must document every conversation, every call, I have nothing documented for R14 after the telehealth visit, I am very sure they did not call me back." Surveyor asked P4 if the expectation is to receive a call back if the order was not followed; P4 replied "Yes." P4 explained "with a sodium of 171, I'm not keeping that patient inhouse, they need to go to the hospital." 5/5/26 8:05 AM – An interview with E16 revealed that E16 was the nurse caring for R14 the evening of 1/9/26 into 1/10/26. When reviewing the resident's record, she noted the resident's sodium level of 171 and BUN of 100. She stated there were orders to "push fluids, but how much fluid can you push to effect a BUN of 100 and a sodium that high – especially when the resident is lethargic…I was afraid she [R14] wouldn't be here if we waited 2 more days to repeat labs." E16 initiated the telehealth consult and received the order to transfer the resident to the emergency room. E16 stated "I had to print out the paperwork; because we are a locked unit, I couldn't leave to get the papers, we don't have a printer on the unit. I called the supervisor and asked him to bring them down to me. They [the 3-11 supervisor and 11-7 supervisor] came down and said that the resident had been seen by the doctor earlier in the day and knew about the labs…." E16 stated that "he [E32] said he called the doctor" and then instructed her that R14 was not be transferred. Surveyor asked E16 which doctor the supervisor called; she replied she wasn't sure, but "it was a female." E16 stated "I was very concerned, it's not possible to give enough fluids by mouth for a BUN of 100 and a sodium of 171, especially to a resident who is lethargic. I spent the night trying to get her to take sips – sometimes she would, sometimes she wouldn't. I asked the supervisor to keep assessing her too because I was so worried about her." 5/5/26 9:40 AM – During a phone interview with P3, P3 reported that she had been "on the unit upstairs, the nurse verbally told me what the white count,	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 22 creat [creatinine] and BUN were. I asked if the resident was hemodynamically stable and they said yes. I went down to see [R14], she was resting, her vital signs were stable. That's when I ordered repeat labs and to push fluids. I also wrote that if anything happened or changed, she should be sent out. I don't know why they waited to call me in the morning with the labs, especially when the telehealth NP had already given the order to transfer her out…I was shocked when they called me with that sodium and they hadn't sent her out." The surveyor asked P3 if she was aware of the sodium level of 171 at the time of her visit on 1/9/26. P3 replied, "No, when the nurse upstairs told me the labs, she didn't tell me the sodium. I'm a nephrologist, I wouldn't have kept a patient with a sodium of 171, I would have sent them out. I went and examined the resident but did not check the labs in the computer. That's for me, something I should have done…If I had seen that sodium, I would have sent her out." The surveyor asked P3 if she had received communication from the facility the evening of 1/9/26 through the night of 1/10/26. P3 stated "No, absolutely not, the first call I received was the morning of the 10th. I 'm not on call after 5pm so they [the facility] would not have been able to reach me." It should be noted that this interview contradicted what was documented in P3's progress note on 1/9/26. 5/5/25 – Review of R14's chart revealed a lack of evidence of documentation of a conversation between E32 and a provider regarding the cancellation of transfer, or an order to cancel the transfer. Review of the facility's incident follow-up documentation lacked evidence of a statement from E32. Beginning on 1/6/26, R14 was documented as lethargic, and laboratory testing was ordered; however, review of the clinical record lacked evidence of laboratory results or documented provider follow-up prior to 1/9/26 despite continued decline in the resident's condition. On 1/8/26, P3 documented an acute decline and worsening condition; however, the assessment referenced laboratory values from 10/15/25 and vital signs from 1/2/26. On 1/9/26, critical laboratory findings included sodium 171, BUN 100, creatinine 1.8, and WBC 22.0. Although P3 later documented severe hypernatremia, acute renal dysfunction, dehydration concerns, and worsening mental status, the plan remained to encourage oral hydration, repeat labs in two days, and continue monitoring the resident in the facility unless the condition worsened further. At	F0684		06/16/2026

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F0684 SS = SQC-K	Continued from page 23 10:47 PM on 1/9/26, P4 documented the resident's condition was "critical" and ordered transfer to the Emergency Department due to an acute change in mental status and a sodium level of 171. Review of the clinical record lacked evidence that the transfer order was followed or that a provider authorized cancellation of the transfer order. Interviews with P3 and P4 confirmed neither provider was aware that the resident remained in the facility overnight. Despite documented worsening lethargy, poor oral intake, altered mental status, acute renal dysfunction, and critical laboratory findings, R14 remained in the facility until the morning of 1/10/26, when the resident was transferred to the hospital and subsequently required ICU admission for hypernatremia and acute kidney injury. Top of Form Findings were reviewed with E1 (NHA), E2 (DON), and E4 (CRN) during the Exit Conference.	F0684		06/16/2026
F0760 SS = SQC-J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of other documentation as indicated, it was determined that for one (R11) out of four residents sampled for medication administration review, the facility failed to ensure that R11 was free from significant medication errors as evidenced by failing to check and monitor R11's blood sugars before meals, failing to administer ordered insulin and heparin injections. The facility's multiple failures to administer critical medications had the potential to cause a serious adverse outcome or death to R11. Due to the failures, an Immediate Jeopardy (IJ) was called on 5/8/26 at 1:24 PM. The IJ was abated on 5/9/26 at 11:59 PM. Findings include: The facility's policy titled, "Medication Unavailability", effective 1/29/24, documented, "... Procedure ... 1. A licensed nurse will notify the provider of the unavailability of medication ... 2. ... the licensed nurse will activate the backup pharmacy process and procedures. 3. A licensed nurse will document notification to the provider of the unavailability in the medical record ...". The facility's policy titled, "Refusal of	F0760	F760 Residents free of Significant Medication Error (Cross Reference 685) A. R11 no longer resides in the facility; the facility is unable to correct the deficient practice for R11. B. Residents currently residing in the facility with orders for monitoring blood sugars, insulin and/or anti-coagulants including heparin have the potential to be affected. An initial audit of current residents was completed on 5/9/2026 to identify residents with orders for insulin, anti-coagulants including heparin and blood sugar monitoring to ensure completion of medication administration and documentation, blood sugar checks and identify any presence of any omitted doses and treatments. Identified concerns were corrected, provider notified as indicated, no residents had adverse outcomes. C. Root cause analysis is related to licensed nurses' failure to complete documentation in the electronic medication administration record related to results of glucose monitoring, failure to document administration, refusal or unavailable insulin and heparin injections and failure to follow proper reporting procedures to provider. Root Cause is also related to the licensed nurses' failure to follow the Blood Glucose Monitoring Policy, the Medication Administration Policy and the Medication Unavailability Policy. The Staff Development Coordinator/Director of Nursing provided 1:1 education with licensed nurses that failed to complete documentation in the electronic Medication Administration Record. Education included the process of medication administration completion and documentation, completion of blood sugar	06/16/2026

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F0760 SS = SQC-J	Continued from page 24 Medication/Treatment/Care", effective 1/29/24, documented that a licensed nurse is to document and notify the provider and responsible party when a patient refuses medication(s), treatment(s), and / or care. The facility's policy titled, "Blood Glucose Monitoring", dated 3/17/25, documented, "...Licensed nurses will complete blood glucose monitoring as ordered by the provider ... Procedure...4. Blood glucose (sugar) checks will be documented in the medical record ...". Cross refer F865 Review of R11's clinical record revealed: 1/17/26 – R11 was admitted to the facility with diagnoses including diabetes and stroke. 1/17/26 – R11 had a physician's order for heparin sodium injection 1 mL subcutaneously every eight hours for blood clot prevention. 1/19/26 – R11 had a physician's order for insulin Lispro injection subcutaneously for diabetes. Inject as per sliding scale: If 0-69 = 0 unit; call provider (physician) for BS (blood sugar) less than 70; 70 – 100 = 0 unit; 101 – 150 = 2 units; 151 – 200 = 4 units; 201 – 250 = 6 units; 251 – 300 = 8 units; 301 – 350 = 10 units; 351 – 400 = 12 units Call provider for BS greater than 400. 1/23/26 – R11 had a physician's order to check and record blood sugars before meals. A review of R11's insulin lispro administration from 2/1/26 through 2/14/26 revealed that R11 was administered insulin lispro coverages based of FSBS (finger stick blood sugar) on the following times: 7:30 AM - 12 of 14 opportunities (86%); 2/1/26 went on LOA (leave of absence) and 2/2/26 refused	F0760	Continued from page 24 monitoring as ordered, proper follow-up related to refusal or unavailability of medications, proper procedure of notifying provider and procedure to activate back-up pharmacy and documentation accuracy. Other licensed nurses were educated by the Staff Development Coordinator/designee. Education was completed by 5/9/2026 at 11:59 pm. The Director of Nursing/Assistant Director of Nursing/Unit Managers /Nursing Supervisors and/or designee are responsible for the clinical oversight of medication administration practices to verify that the deficient practices do not recur. The Unit Managers/Supervisors/designee will review the electronic medication administration record on the clinical dashboard prior to the end of each shift to ensure documentation has been completed. The system change will be that the unit managers will bring the findings of the review of the electronic medication administration record through the scheduled clinical meetings. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D. Supervisors/Nursing Leadership will audit medication administration compliance daily prior to end of each shift. Results of audits will be reviewed by DON/Administrator weekly x 4 weeks until 100% compliance, then monthly x 2 months until 100% compliance. Results of audits will be brought through Monthly in QAPI for ongoing compliance and identification of trends. Any identified concerns will result in immediate action, re-education, and follow-up auditing. E. Date of compliance: 6/16/2026	06/16/2026

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F0760 SS = SQC-J	Continued from page 25 12:00 PM - 13 of 14 opportunities (93%); 2/12/26 refused 4:30 PM - 12 of 14 opportunities (86%); 2/1/26 went on LOA and 2/4/26 not given for blood sugar 79 mg/dl It was noted that from 2/1/26 through 2/14/26, R11 was administered her insulin lispro coverages based on the results of her blood sugar checks 86% during breakfast and dinner times and 93% during lunch time. 2/15/26 – Review of R11's eMAR revealed that E40 (LPN) administered R11's medications scheduled at 12:00 PM and 2:00 PM. Further review of R11's eMAR revealed that E40: - lacked evidence that R11's 12:00 PM blood sugar check was monitored; - lacked evidence that R11's 12:00 PM sliding scale insulin injection was administered nor did E40 document if insulin was not indicated; - lacked evidence that R11's 2:00 PM heparin injection was administered. 2/16/26 – Review of R11's eMAR revealed that E40 (LPN) administered R11's medications scheduled at 7:30 AM, 12:00 PM and 2:00 PM. Further review of R11's eMAR revealed: - lacked evidence that R11's 7:30 AM blood sugar check was monitored; - lacked evidence that R11's 7:30 AM sliding scale insulin injection was administered nor did E40 document if insulin was not indicated; - lacked evidence that R11's 12:00 PM blood sugar check was monitored. - lacked evidence that R11's 12:00 PM sliding scale insulin injection was administered nor did E40 document if insulin was not indicated; - lacked evidence that R11's 2:00 PM heparin injection was administered. 2/25/26 - Review of R11's eMAR revealed that E41 (LPN) administered R11's medications scheduled at 10:00 PM. E41 lacked that R11's 10:00 PM heparin injection was administered.	F0760		06/16/2026

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F0760 SS = SQC-J	Continued from page 26 3/11/26 - Review of R11's eMAR revealed that E42 (RN) administered R11's medications scheduled at 10:00 PM. E42 lacked evidence that R11's 10:00 PM heparin injection was administered. 3/18/26 - Review of R11's eMAR revealed that E43 (LPN) administered R11's medications scheduled at 10:00 PM. E43 lacked evidence that R11's 10:00 PM heparin injection was administered. 5/5/26 3:30 PM – In an interview, E4 (CRN) stated that she had another nurse review the missing entries in R11's February and March 2026 eMAR. E4 further stated and confirmed that the facility lacked evidence and documentation that R11's blood sugar checks were monitored and the insulin and heparin injections were administered on those dates in question. 5/8/26 9:00 AM – In an interview, P2 (PA) stated, "I don't think I remember receiving a call about [R11's] missing meds or unavailable meds particularly". 5/8/26 10:20 AM – During an interview, E40 (LPN) stated, "I don't remember what happened back then, I can't remember why I did not document on R11's eMAR on all those doses left blank." 5/8/26 10:30 AM – In a telephone interview, E41 (LPN) stated, "I don't remember anymore. I must have given the heparin but I forgot to sign in the eMAR." 5/8/26 10:49 AM – In a telephone interview, E42 (RN) stated, "If the heparin injection was not signed, I don't know… it must be held for a reason…for unavailable meds, we have a back up in our Omnicell machine (computer – controlled systems used to manage and dispense medications and supplies) … if it was not documented, I don't know". 5/8/26 11:25 AM – In an interview, E49 (LPN) stated that when meds are not available, she would call the pharmacy, notify the physician and document in the progress notes. E49 further stated that most medication back up supplies including insulin lispro and heparin injections are found in the Omnicell machine. 5/8/26 1:24 PM – During a meeting with facility management, the Survey Team notified E1 (NHA) and E4 (RDCS) of an Immediate Jeopardy for R11's significant medication errors that occurred from 2/15/26 through 3/18/26. 5/8/26 3:30 PM – E1 (NHA) submitted a signed,	F0760		06/16/2026

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F0760 SS = SQC-J	Continued from page 27 dated and timed written abatement plan to the State Agency. The facility's abatement included: Immediate Corrective Action for Identified Resident Nurses involved were identified and one on one education is in progress and with a scheduled completion date of 5/9/26 at 11:59 pm. Education for licensed nurses was initiated with a scheduled completion date of 5/9/26 at 11:59 pm. Identification of Other Residents at Risk On 5/8/26, the facility initiated a 100% audit of: All residents receiving insulin All residents ordered blood sugar monitoring All residents receiving anticoagulants including Heparin The audit will include verification of: Medication administration completion and documentation Completion of blood sugar checks as ordered Presence of any omitted doses and treatments Any identified concerns will be corrected, physician(s) notified as indicated, and residents assessed for adverse outcomes. Systemic Corrective Actions The facility immediately implemented the following systemic interventions to remove the likelihood of serious harm: Medication Administration Process Changes A licensed nurse/designee will perform end – of – shift reconciliation of Insulin administration Anticoagulant administration Ordered blood sugar checks Any omissions identified will be immediately	F0760		06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

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F0760 SS = SQC-J	Continued from page 28 escalated to the supervisor and Administrator/DON. Clinical Oversight Enhancements DON/ADON, Unit Managers, and or/Clinical Consultants will initiate daily medication administration audits. Review of daily clinical meeting will include review if: Missed medications Blood sugar omissions High – risk medication variances Follow – up actions as required Education Education of licensed nursing staff was initiated with a scheduled completion date of 5/9/26 at 11:59 PM: Medication administration requirements Blood sugar monitoring requirements Documentation accuracy Proper follow – up for held/refused medications Notification expectations Ensure all documentation completed in medical record Monitoring to Ensure Ongoing Compliance Nursing Leadership/Supervisors will audit medication administration compliance daily prior to end of each shift. Daily medication administration audits will be completed by Nursing Leadership in the scheduled Daily Clinical Meeting. Results of audits will be reviewed weekly by DON/Administrator Results of audits will be reviewed Monthly in QAPI for ongoing compliance and identification of trends Any identified concerns will result in immediate corrective action, re-education, and follow – up auditing.	F0760		06/16/2026

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F0760 SS = SQC-J	Continued from page 29 5/11/26 - Verification of facility's abatement plan included review of nursing staff education signed attestation. Interviews with nursing staff confirmed the facility's IJ was abated on 5/9/26 at 11:59 PM. 5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.	F0760		06/16/2026
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 observation, interview, record review and review of other facility documentation, it was determined that for one (R2) out of three residents sampled for accidents, the facility failed to ensure that R2 received adequate supervision and assistive devices to prevent accidents to the extent possible. Findings include: 1. R2's clinical record revealed: 9/26/25 – R2 was admitted to the facility with diagnoses including but not limited to right hip pain and heart failure. 9/26/25 – R2's fall care plan documented, "At risk for falls related to cognitive impairment, poor memory and muscle weakness." 9/28/25 – R2's admission MDS assessment documented a BIMS score of "00" indicating an inability to complete a cognitive assessment and required partial to moderate assistance from staff for wheelchair mobility. 10/11/25 2:30 PM – R2's clinical record included, "At 14:30 [2:30 PM], patient fell forward out of the wheelchair while staff member was wheeling her in the wheelchair in her room… Patient noted laceration	F0689	F689 Free of Accident Hazards/Supervision/Devices A. R2 currently resides in the facility and has no lasting ill effects related to the incident. B. Residents currently residing in the facility have the potential to be affected by this deficient practice. At the time of the incident the facility staff were educated that only nursing and therapy staff should assist with pushing residents' in wheelchairs, staff was also educated to ensure that wheelchairs have foot pedals when they are wheeling the residents. C. Root cause analysis is related to staff member pushing the resident in the wheelchair without leg rests in place, related to not following the facility process of and education needs related to the use of wheelchair leg rests when transporting residents. The Staff Development Coordinator/designee will educate facility staff regarding the need for foot pedals to be in place on the wheelchair when pushing residents; this education will be included in new hire orientation for all staff. The education clarified that any staff member can push the resident in a wheelchair. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D. The Rehab Director/Unit Managers/designee will monitor visually that when residents are being pushed in a wheelchair by staff, foot pedals are in place and in use on the wheelchair, 20% of the residents will be included in the audit. This audit will be conducted daily x 5 days until 100% compliance, then weekly x 2 weeks until 100% compliance, then monthly x2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 6/16/2026	06/16/2026

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F0689 SS = G	Continued from page 30 to left eyebrow 2cm x 0.2 cm…Complained of pain to right hip…At 1535 [3:35 PM], patient heard yelling for help and found lying on the floor on her left side by her room…noted with hematoma below left eye…Send to the ER for evaluation." 10/11/25 11:29 PM – A facility incident report submitted to the Division included, "… At 1430 [2:30 PM] patient [R2] fell forward out of the wheelchair while staff member was wheeling her in the wheelchair in her room… Noted with a laceration to left eyebrow 2cm X 0.2 cm… Approximately 1530 [3:30 PM] resident was heard calling for help and was discovered on the left side of her room entrance. Noted with a hematoma below her left eye. Sent to the ER [emergency room] for evaluation…" 10/12/26 1:00 AM – R2's emergency room record included, "… Laceration on left side of face … repaired with three stitches and steristrips…" 4/30/26 2:00 PM – A review of the facility's investigative document revealed that R2 asked E9 (Houskeeper) to wheel her to her room. E9 wheeled R2 and she fell forward to the floor. During an interview, the Surveyor asked E9 about the fall. E9 stated, "[R2] asked me to push her into the room, and her feet got stuck and she fell out of the wheelchair." 4/30/26 3:30 PM – During an interview, E2 (DON) stated, "We provided education to [E9] that only nursing staff should push the wheelchair when the resident is in it. The nursing staff should be told if the resident asked to be pushed when they are in the wheelchair. We also educated the rest of the staff to ensure that the wheelchairs have foot pedals when they are wheeling the residents." 4/30/26 4:00 PM – The facility's education and training entitled, "Footrests on wheelchair", and dated 10/12/25 included, "Before ambulating a resident on the wheelchair ensure footrests are attached to it. Footrests should be on all wcs [wheelchairs] during transport. Housekeeping staff should not transport residents in wheelchairs." The facility failed to ensure that R2 was free from accidents when she fell while she was transported in the wheelchair without footrests resulting in the injury. 5/6/26 4:10 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.	F0689		06/16/2026

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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 record review, interview, and review of other facility documentation, it was determined for four (R1, R18, R27 and R28) out of five residents sampled for reporting of injuries, injuries of unknown origin, abuse and activities of daily living, the facility failed to ensure that all injuries, including injuries of unknown source were reported to the State Survey Agency within the guidelines. R1, a dependent resident was observed with visible head injury on 4/22/26 at 6:00 AM and was not reported to the State Survey Agency until 4/23/26 at 8:30 AM, more than 26 hours later. For R18, R27, and R28, the facility failed to report incidents of abuse and alleged neglect and to submit a follow-up report within the required timeframe. Findings include: 1. R1's clinical record revealed: 12/26/25 – R1 was admitted to the facility with diagnoses including, but not limited to, a stroke,	F0609	F609 Reporting of Alleged Violations A1. R1 no longer resides in the facility; the facility is unable to correct the deficient practice for R1. B1. Residents currently residing in the facility on the secured dementia unit have the potential to be affected by this deficient practice. An initial audit of any injuries of unknown origin was completed on the secure unit from 4/24/2026 through 4/29/2026 and no further injuries of unknown origin were identified. C1. Root cause analysis is related to assigned C.N.A.s failure to report injury to assigned licensed nurses, failure of assigned nurses to identify injury, and the assigned nurse who identified the injury failure to follow reporting requirements for an injury of unknown origin. The facility failed to follow the Reporting Requirements Policy related to reporting Abused/Neglect/Misappropriation/Crime to include injuries of unknown origin, which requires reporting no later than 2 hours after the allegation. Grievances and Risk Management reports will be reviewed in the daily scheduled clinical meeting to ensure allegations are identified and reported as required. The Regional Director of Clinical Services educated the Administrator and the Director of Nursing regarding reporting requirements for an injury of unknown origin and abuse and neglect. The Director of Nursing/Administrator educated Nursing Leadership regarding reporting requirements for an injury of unknown origin and abuse and neglect. The Staff Development Coordinator educated the facility staff regarding reporting requirements for an injury of unknown origin and abuse and neglect. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D1. The Administrator and/or Director of Nursing will audit risk management reports for injuries and any injury of unknown origin to ensure reporting requirements are followed. This audit will be conducted daily x 5 days until 100% compliance, then weekly x 2 weeks until 100% compliance then monthly x2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. A2. R12 and R18 currently reside in the facility and have no ill effects related to deficient practice. B2. Residents currently residing in the facility have the potential to be affected by this deficient practice.	06/16/2026

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F0609 SS = E	Continued from page 32 deep vein thrombosis, heart failure, and dementia. 3/13/26 – R1's quarterly MDS assessment documented a BIMS score of 5, indicating a severe cognitive impairment. R1 required substantial to maximum assistance from staff for bed mobility and was totally dependent for all transfers between surfaces. 4/23/26 9:36 AM – E12 (LPN) documented in R1's nursing clinical record, "Resident discovered in bed sleeping not easily aroused in deep sleep not able to explain what happen. Observation hematoma to right [forehead] and right eye bruising. Fully dressed… [Name of doctor] assessed resident and ordered to send resident out to the hospital for further evaluation." 4/23/26 12:24 PM – A facility reported incident report submitted to the Division documented, "On 4/23/26 at approximately 0830 [8:30 AM], CNA reported to the Unit Manager that resident [R1] has a hematoma to the right side of her forehead and a right periorbital bruising." 4/29/26 9:00 AM – During a telephone interview, E8 (CNA) stated, "My shift started on 4/21/26 at 11:00 PM and ended at 4/22/26 at 7:00 AM. I provided care to the resident [R1] two or three times during the night. Around 6:00 AM, I saw a discoloration on the right side of her forehead, but I forgot to tell the nurse." The Surveyor asked E8 if R1 showed any signs of pain when care was provided was provided to her. E8 stated, "No." The Surveyor then asked E8 about R1's status during the 11-7 shift of 4/22/26 to 4/23/26. E8 stated, "I saw the bruise around 5:00 AM but I did not see any additional injuries. The resident was responsive when I provided care to her during the shift." The Surveyor asked E8 if he reported the bruise to the nurse on duty or the oncoming aide. R8 stated, "No." E8 failed to notify the nurse despite observing the bruise on R1's face on two separate occasions. 4/29/26 9:15 AM – During a telephone interview, E16 (LPN) stated, "I worked the 11:00 PM to 7:00 AM shift on 4/21/26 into 4/22/26. I did an initial round when I came on the shift, and the resident [R1] was in her bed. I did not observe anything unusual with her. I gave her the morning medication between 5:30 AM to 5:45 AM, but I did not turn on the light in the room." The Surveyor asked E16 how she was able to see to give the resident her medication and if the resident was awake enough to take the medication. E16 stated, "There was some	F0609	Continued from page 32 An initial audit of risk management and grievances was completed from 5/1/2026 through 5/31/2026 to ensure reporting requirements were met related to reporting of injuries, injuries of unknown origin, abuse/neglect of activities of daily living. Injuries of unknown origin were identified on two residents, one on 5/21/2026 that was reported to the state agency within 2 hours, 5-day follow-up was submitted to the state agency in the required timeframe. The other area identified on 5/5/2026 by the NP noted on exam to have ecchymosis and edema of the left breast; resident denied any injury or trauma. On 5/11/2026 at 5:30 pm patient was noted with a large dark bruise on the left abdomen and left breast area, it was reported to the state agency within 2 hours, 5-day follow-up was submitted to the state agency in the required time frame, there were no allegations of abuse or neglect identified in the audit period. C2. Root cause analysis is related to RN Supervisor not following reporting requirements of abuse and neglect allegations. The facility failed to follow the Reporting Requirements Policy related to reporting Abused/Neglect/Misappropriation/Crime, which requires reporting no later than 2 hours after the allegation. Grievances and Risk Management reports will be reviewed in the daily scheduled clinical meeting to ensure allegations are identified and reported as required. The Regional Director of Clinical Services educated the Administrator and the Director of Nursing regarding initial and 5-day follow-up reporting requirements to the State Agency related to injuries, injuries of unknown origin, abuse/neglect of activities of daily living and allegations of abuse and neglect. The Director of Nursing educated the RN Supervisor involved with the late reporting regarding reporting requirements. The Director of Nursing/Administrator educated Nursing Leadership reporting of injuries, injuries of unknown origin, abuse/neglect of activities of daily living. The Staff Development Coordinator/designee educated the facility staff regarding reporting requirements regarding allegations of abuse and neglect. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D2. The Administrator and/or Director of Nursing will audit risk management reports for resident-to-resident abuse allegations to ensure reporting requirements are followed. This audit will be conducted daily x 5 days until 100% compliance, then weekly x 2 weeks until 100% compliance, then monthly x2 months until 100% compliance. Results will be provided to the Quality Assurance and	06/16/2026

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F0609 SS = E	Continued from page 33 light in the room, so I was able to see. And the resident took the medication fine." The Surveyor asked E16 if E8 informed her about any bruising or other concerns with R1. E16 stated, "No." 4/29/26 9:30 AM – During an interview, E7 (CNA) stated, "I was helping to feed the residents breakfast in the dining/activity room around 8:30 AM on 4/22/26. I saw the bruising and swelling on the resident's [R1] right-side temple and forehead area. I asked if anyone saw this. I told E6 (UM) and she told me to tell the resident's nurse. I told the nurse [E15 LPN] and she stated, "I will take a look at it." 4/29/26 9:45 AM – During an interview, the Surveyor asked E6 (UM) whether she was informed of the discoloration and swelling on R1's head. E6 stated, "The aide told me, and I told him to tell her nurse." The Surveyor asked E6 whether she assessed R1, informed the ADON, DON, updated the provider or documented the change in the resident's status. E6 stated, "No." 4/29/26 10:00 AM – During a telephone interview, E13 (AA) stated, "[E7] and I were in the dining room around 8:30 AM to 9:00 AM on 4/22/26. We saw the bruise on the resident's face and the CNA went to tell the nurses. I stayed in the dining room to watch the residents." 4/29/26 10:30 AM – During a telephone interview, E14 (CNA) stated, "This was my assignment on 4/22/26 on the 7-3 shift. I gave morning care to the resident and saw the bruise when I was washing her face. I dressed her and brought her into the hallway, and I asked her nurse [E15], "Did you see this? What happened to her?" The nurse replied, "It happened overnight," and remained at the medication cart. I took the resident into the dining room for breakfast." 4/29/26 11:00 AM – During a telephone interview, E15 stated, "The night nurse did not tell me anything about a bruise on this resident. It was around 8:30 AM to 9:00 AM on 4/22/26 when the aide [E7] told me that [R1] had a "knot" on her head. I was passing medications, and I stopped and checked on the resident. I took her vital signs and checked her neuros [neurological status]. I saw a mildly raised area on the right side of her forehead, but there was no discoloration and her eyes were clear". The Surveyor asked E15 if she reported her observations to the supervisor or the medical provider. E15 stated, "No, I did not report it to anyone. I don't work with this resident very often and I thought it was an old bruise that was already addressed and did not need to be reported again." The Surveyor asked E15 if	F0609	Continued from page 33 Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. A3. R27 no longer resides in the facility; the facility is unable to correct the deficient practice for R27. B3. Residents currently residing in the facility have the potential to be affected by this deficient practice (R27). An initial audit of grievances was completed from 5/1/2026 through 5/31/2026; no other allegations were identified. C3. Root cause is related to the RN and LPN not being aware of the need to report the allegation of neglect due to the LPN completing care to the residents. The facility failed to follow the Reporting Requirements Policy related to reporting Abused/Neglect/Misappropriation/Crime, which requires reporting no later than 2 hours after the allegation. Grievances and Risk Management reports will be reviewed in the daily scheduled clinical meeting to ensure allegations are identified and reported as required. The Director of Nursing educated E22 and E23 related to reporting requirements of suspected neglect. The Staff Development Coordinator educated facility staff related to reporting requirements of suspected neglect. The Regional Director of Clinical Services educated the Administrator and the Director of Nursing regarding initial and 5-day follow-up reporting requirements to the State Agency regarding allegations of abuse and neglect. E24 was suspended pending investigation and has subsequently been terminated related to customer service issues. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D3. The Administrator and/or Director of Nursing will audit grievances for any allegations of neglect to ensure reporting requirements are followed. This audit will be conducted daily x 5 days until 100% compliance, then weekly x 2 weeks until 100% compliance, then monthly x2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. A4. R28 no longer resides in the facility; the facility is unable to correct the deficient practice for R28.	06/16/2026

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F0609 SS = E	Continued from page 34 she documented the results of R1's neurological check and updated the 3-11 shift nurse about the bruise. E15 stated, "No, I did not tell the 3-11 nurse, and I forgot to document the neuros." R1's medication administration record revealed that E15 administered oral medications to R1 at 9:00 AM and oral supplements at 1:00 PM on 4/22/26 but failed to identify, assess or report the visible bruise on the right side of her head. 4/29/26 11:30 AM – During a telephone interview, E19 (CNA) stated, "I was in the hallway around 8:30 AM or 9:00 AM on 4/22/26 when I heard the aide [E14] tell the nurse [E15] that the resident had a "knot" on her forehead. The nurse replied, "It was not reported to me from the previous shift," and "I saw the injury already." 4/29/26 1:30 PM – During a telephone interview, E17 (LPN) stated, "I worked on the 3-11 shift on 4/22/26 but I did not see any bruising or swelling on the resident." R1's medication administration record revealed that E17 gave her oral medications at 4:00 PM and 8:00 PM but failed to identify the obvious bruise on the right side of her head. 4/29/26 2:00 PM – During a telephone interview, E21 (CNA) stated, "I worked with the resident [R1] on the 3:00 PM to 11:00 PM shift of 2/22/26. I saw the bruise on the right side of her head. I don't usually work with her. When I saw the fall mat near her bed, I thought that she had a previous fall, and the nurses already knew about it. That is why I did not think the bruise was new and did not report it." E21 failed to report the bruise on R1's face despite the lack of a report of an injury from the previous shift. 4/30/26 9:00 AM – During a telephone interview, E20 (RN) stated, "I worked with the resident [R1] on the 1:00 PM to 7:00 AM shift on 4/22/26 to 4/23/26. I checked on all the residents at the start of the shift. I did not turn on the lights because I didn't want them to wake up. [R1] slept all night and took her medication in the morning around 5:45 AM." The Surveyor asked R20 if R1 was awake and alert when she gave her the medication. R20 replied, "I did not turn on the light when I gave her the medication with some applesauce. I did not give her water or anything else to drink." 4/30/2026 9:30 AM – During a telephone interview,	F0609	Continued from page 34 B4. Residents currently residing in the facility have the potential to be affected by this deficient practice (R28). An initial audit of grievances was completed from 5/1/2026 through 5/31/2026; no other allegations were identified. C4. Root cause is related to the RN and LPN not being aware of the need to report the allegation of neglect due to the LPN completing care to the residents, failing to identify alleged neglect by C.N.A. assigned to care for the resident. The facility failed to follow the Reporting Requirements Policy related to reporting Abused/Neglect/Misappropriation/Crime, which requires reporting no later than 2 hours after the allegation. The Director of Nursing educated E22 and E23 related to reporting requirements of suspected neglect. The Staff Development Coordinator educated facility staff related to reporting requirements of suspected neglect. The Regional Director of Clinical Services educated the Administrator and the Director of Nursing regarding initial and 5-day follow-up reporting requirements to the State Agency regarding allegations of abuse and neglect. The Staff Development Coordinator educated facility staff related to reporting requirements of suspected neglect. E24 was suspended pending investigation and has subsequently been terminated related to customer service issues. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D4. The Administrator and/or Director of Nursing will audit grievances for any allegations of neglect to ensure reporting requirements are followed. This audit will be conducted daily x 5 days until 100% compliance, then weekly x 2 weeks until 100% compliance, then monthly x2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. 5. Date of compliance: 6/16/2026	06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/C_IA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	**700 FOULK ROAD , WILMINGTON, Delaware, 19803**

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F0609 SS = E	Continued from page 35 E11 (CNA) stated, "The resident [R1] was on my assignment on the 7:00 AM to 3:00 PM shift. I did a quick round when I came on the shift to check that none of the residents had fallen out of bed. [R1] appeared to be sleeping so I went and got a couple of other residents up and then went to get her up. She was breathing in and out but I could not wake her up. And I saw bruises on her forehead and right eye. I told the unit manager who was outside of the room." The facility failed to ensure that R1's injury of unknown origin was reported to the State Survey Agency for more than 26 hours after the injury was identified by the staff. 2. 4/3/26 2:30 PM – A facility report documented an incident of resident-to-resident abuse between R18 and R12. 4/3/26 11:06 PM- The facility submitted an incident report to the State Agency over six hours after the two-hour reporting requirement for alleged resident abuse. 4/13/26 – A facility 5 Day Follow-Up Report was submitted to the State Agency. The 5 Day Follow-Up Report was submitted three days after the required due date. 3. 4/22/26 – A facility investigation statement signed by E22 (RN Supervisor, UM) and E23 (LPN) documented, "[E24] was scheduled to work on [unit] 4/21/26 for 3-11 PM shift. [R27] complained that [E24] assisted him in using the toilet at approximately 3:45 PM. [R27] stated that [E24] did not return to assist him with care for the rest of the shift. [E22] called [E24] on the staffing phone, but [E24] did not pick up. This was approximately 10:30 PM. [E22] did not see [E24] for the rest of the shift…". 4/22/26 - A facility investigation statement signed by E22 and E23 documented, "[R27] had his call bell on, but [E24] never went back to assist him with care…[E24] was not on the floor at this time and did not return to the floor. [R27] was finally assisted by the overnight nurse when she came on duty at 11PM…". 4/23/26 3:41 PM – A facility incident report submitted to the State Agency documented that R27 and R28 reported to E22 an allegation of neglect by E24 on 4/21/26 during the 3:00 PM to 11:00 PM shift. The incident report also documented that E23 reported to E22 that she completed care for	F0609		06/16/2026

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F0609 SS = E	Continued from page 36 residents assigned to E24 and that E22 was not aware of the need to report the allegation of neglect. The incident report was submitted to the State Agency forty (40) hours after the required timeframe for reporting alleged neglect. 5/5/26 1:09 PM – During a telephone interview, E23 stated, "I saw the call lights on in the hallway. I went in [R27]'s room…[R27] was very upset…I told him I would get someone to help him...[E24] did not pass hydration or get any snacks during the shift. I took care of the residents. At 8:00 PM or 8:30 PM, I helped [R27] change into his night clothes. I reported it to [E22]…". 4. 4/22/26 – A facility investigation document signed by E22 and E23 documented, "…[R28] complained [E24] assisted her with a shower and then to bed around 4:30 PM…Care was given by the nurse when called…[R28] stated that [E24] did not return to her room the remainder of the shift.". 4/22/26 – A facility investigation document signed by E22 and E23 documented, "…[R28] also stated [E24] did not assist with her care for the rest of the shift despite [R28] calling for help…Most of the patients on [R28]'s assignment complained to the night nurse that they did not get care on the evening shift.". 4/23/26 3:41 PM – A facility incident report was submitted to the State Agency documenting an allegation of neglect when E24 assisted R28 to bed at 4:30 PM on 4/21/26 and did not assist R28 again for the rest of the shift. The incident report was submitted to the State Agency forty hours after required timeframe for reporting alleged neglect. 5/5/26 - During a telephone interview, E23 stated, "...I saw [E24] in [R28]'s room around dinner time. I did not see [E24] after that." 5/5/26 3:30 PM – Findings were reviewed with E1 (NHA) and E4 (CRN). 5/11/26 12:30 PM – Findings were reviewed with E1, E2 (DON) and E4 during the exit conference.	F0609		06/16/2026
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination	F0561	F561 Self-Determination R10 currently resides in the facility; the resident was given a bag lunch prior to leaving for his appointment. The resident had no ill effects from the deficient practice.	06/16/2026

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F0561 SS = D	Continued from page 37 through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to ensure that one (R10) of 31 sampled residents, was given the right to self-determination when the resident was not provided an early lunch tray or a bagged lunch prior to his afternoon neurosurgeon appointment until the surveyor intervened. Findings include: Review of R10's clinical record revealed: 12/5/25 - R10 was re-admitted to the facility with diagnoses including neck fracture. 4/14/26 - R10's quarterly MDS assessment documented a BIMS score of 5 indicating a severe cognition impairment, had adequate hearing and vision, usually makes self understood and understands others with clear speech. R10 ambulates with a wheelchair and is independent of eating. 4/22/26 10:23 - A nurse progress noted documented, " ... [R10's] appt (appointment) is 4/29/26 @ (at) 130pm...."	F0561	Continued from page 37 Residents currently residing in the facility have the potential to be affected. Root cause is related to facilities lack of process in place to ensure residents with appointments around mealtimes receive an early tray or a bagged meal prior to their appointment. The Administrator and Director of Nursing developed the process going forward to be for the unit clerk and/or Unit Managers to inform the kitchen using the appointment notification slip of residents requiring an early meal tray or bagged meal related to appointments around mealtimes. The Staff Development Coordinator will educate Unit Clerk, Receptionist, Food Service Director and Unit Managers related to the new process using the appointment notification slip of residents requiring an early meal tray or bagged meal and will also educate nurses and C.N.A.s regarding the need to ensure residents have an early meal tray or bagged meal prior to going out for appointments. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. The Unit Clerk/Unit Manager/designee will audit appointments for residents around mealtimes to ensure the kitchen has been notified of a need for an early meal tray or bagged meal prior to appointments around mealtimes. This audit will be completed daily x 5 days until 100% compliance, then weekly x 3 weeks until 100% compliance, then monthly x 2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. Date of compliance: 6/16/2026	06/16/2026

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F0561 SS = D	Continued from page 38 4/29/26 12:00 PM - During an observation in (unit dining room), R10, sitting on his wheelchair, was looking at the nursing staff taking out food trays from the food truck and passing the trays to the residents seated in the dining room. 4/29/26 12:20 PM - E50 (CNA) was heard talking to R10 and told him, "Your food tray is not in here, it's on the next truck. Since you will be going out now for your appointment, you will just have your lunch later when you come back." R11 and his companion, FM3 (father) both nodded in agreement. 4/29/26 12:25 PM – E27 (LPN) was heard instructing R11 and FM3 to go up to the 2nd (second) floor lobby and wait for the transportation to come and pick them up for R11's neurosurgeon appointment. 4/29/26 12:30 PM – As instructed, FM3 was observed wheeling R11 out of the dining room heading up to the lobby on the 2nd floor. 4/29/26 12:32 PM – When asked if R10 had his early lunch? E27 stated that R10 would eat his lunch when he returns from his 1:30 PM appointment. When asked if R11 brought a bagged lunch with him, E27 stated, "No". When surveyor told E27 that it would be way past lunch time when E27 would return from the appointment. E27 replied to the surveyor that she will try to ask for bagged lunch from the kitchen. 4/29/26 12:40 PM – During an observation, E27 was heard asking R10 if he wanted to take a quick lunch in the dining room or bring a bagged lunch with him to the appointment. R10 was heard saying, "a bagged lunch is good, make sure you have soda in it." 4/29/26 12:42 PM – In an interview, FM3 stated that he was appreciative that E27 offered to send a bagged lunch for R10. FM3 further stated, "There's nothing much we can do. We don't want to miss this appointment even if lunch will be served late." 5/4/26 4:00 PM – Findings were reviewed with E2 (DON) and E4(CRN). 5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.	F0561		06/16/2026

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F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656	F656 Develop/Implement Comprehensive Care Plan R10 currently resides in the facility, and had no ill effects related to the deficient practice. Residents currently residing in the facility with neck braces/braces/splints have the potential to be affected by this deficient practice. The root cause analysis is related to the facilities failure to update the resident's care plan when the behavior of the resident removing the neck brace was identified and the licensed nurses' failure to follow the Care Planning Policy which includes updating care plans on an ongoing basis as changes in the patient occur, changes to the care plan will be discussed in the clinical meeting and reviewed and updated by a licensed nurse as needed. R10's care plan was updated to include refusal/removal to wear the neck brace and then was subsequently resolved as a physician order was received to discontinue the neck brace. An initial audit was completed to ensure care plans were in place related to residents' removal or refusal to wear neck brace. There were no residents identified with a current order for a neck brace. Root cause was related to facility failure to follow the process of care planning needs to address residents' removal or refusal of wearing a neck brace. The Staff Development Coordinator will educate licensed nursing staff regarding care planning requirements related to residents' removal/refusal of neck brace. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. The MDS Nurses/designee will audit resident care plans related to removal/refusals of a neck brace. These audits will be completed daily x 5 days until 100% compliance, then weekly x 3 weeks until 100% compliance, then monthly x 2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. Date of compliance: 6/16/2026	06/16/2026

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F0656 SS = D	Continued from page 40 Based on observations, interviews and record reviews, it was determined that in one (R10) out of 31 sampled residents, the facility failed to develop a person centered care plan to address an identified need when R10 refused to wear his neck brace when out of bed. Findings include: Review of R10's clinical record revealed: 12/5/25 - R10 was re-admitted to the facility with diagnoses including neck fracture. 4/14/26 - R10's quarterly MDS assessment documented a BIMS score of 5 indicating a severe cognition impairment, had adequate hearing and vision, usually makes self understood and understands others with clear speech. R10 ambulates with a wheelchair and is independent of eating. 4/21/26 – R10 had a physician's order for neck collar to be worn when out of bed every shift and for monitoring. 4/25/26 10:49 AM - A nurse progress notes documented "Neck collar … frequently remove". 4/27/26 12:53 PM - A nurse progress notes documented, "Neck collar … removes". 4/28/26 2:57 PM – A nurse progress notes documented, "Neck collar … removes". 4/29/26 11:50 AM – R10 was observed out of bed and sitting on his wheelchair watching TV in his room. R10's neck collar was not in use. 4/29/26 11:55 AM – In an interview, E50 (CNA) stated that R10 was supposed to wear his neck collar when not in bed but "he likes to take it off". 4/29/26 11:58 AM – E27 (LPN) entered the room and asked R10 if he wanted to put the neck collar on. R10 stated, "It's uncomfortable." E27 was looking at this surveyor and said, "Sometimes [R10] likes to put it on, sometimes he likes it off him." 4/29/26 1:53 PM – A nurse progress notes documented, "… resident frequently removes neck brace…encouraged not to remove leave on when OOB (out of bed)". 4/30/26 12:43 PM – R10 was observed sitting in the dining room. R10's neck collar was not in use.	F0656		06/16/2026

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F0656 SS = D	Continued from page 41 4/30/25 12:45 PM – In an interview, E28 (LPN) confirmed that multiple nurse progress notes documented that R10 refused to wear his neck collar. E28 further stated that it was not documented in the care plan as an identified behavior problem of refusal. 5/4/26 4:00 PM – Finding was discussed with E3 (DON) and E4 (CRN) 5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.	F0656		06/16/2026
F0770 SS = D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of other facility documentation, it was determined that for one (R11) out of 31 sampled residents, the facility failed to provide laboratory services to R11 when lab work ordered was not followed up after a failed specimen collection. In addition, the facility failed to ensure that a stat (at once) ordered lab draw result was reported to the physician in a timely manner. Findings include: Cross refer F684 example 2 Review of R11's clinical record revealed: a. 3/18/26 - R11 had a physician's order for CBC and CMP for hyponatremia. 3/23/26 - A labs result report from C6 (contracted laboratory vendor) with a specimen collection date of 3/19/26 documented "... albumin ... please reschedule ... difficult draw specimen not obtained ... WBC ... please reschedule ... difficult draw ... specimen not obtained ..." a handwritten note also documented, "CBC, CMP difficult stick".	F0770	F770 Laboratory Services (Cross Reference 684) A. R11 no longer resides in the facility, the facility is unable to correct the deficient practice for R11. B. Residents currently residing in the facility have the potential to be affected by this deficient practice. Initial audit from 5/1/2026 to 5/31/2026 has been completed to ensure lab draws were completed, results received and communicated to physicians. C. Root cause analysis was related to an unplanned change in the facilities laboratory Vendor (Brookside Laboratory Services), that was not communicated to the facility in a timely manner another laboratory vendor (Atlantic Laboratory), was supposed to take over the operation but do to miscommunication from the vendor, labs were not completed, resulted, nor were results reported in a timely manner to the facility or to the physician. This change caused a delay in collecting laboratory specimens, receiving laboratory results, and reporting results. The new laboratory vendor, Accu Labs started providing lab services in the facility on March 30, 2026, as well as the new vendor was not initially integrated into the electronic medical record. Additional root cause analysis was related to difficult venous access, required rescheduling as well as not following the facility lab tracking process including rescheduling and communication with providers in the event labs are not collected, follow-up regarding pending lab results and abnormal lab results to ensure timely physician notification. The contracted laboratory (AccuLabs) is now electronically integrated into the electronic medical record. Root cause is also related to Unit Managers' failure to follow the facility Laboratory/Diagnostic Testing Policy which includes but is not limited to ensuring that tests are completed as ordered and communication of results to the provider and utilizing the Lab Tracking Form. The Lab Tracking Tool was not being utilized due to the facilities failure to follow the process that was in	06/16/2026

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F0770 SS = D	Continued from page 42 5/4/26 2:00 PM – A review of R11's nurse progress notes lacked evidence that the physician was notified of R11's lab draw for CBC and CMP was not completed due to difficulty in drawing R11's blood specimen. 5/4/26 3:00 PM – In an interview, E4 (CRN) stated, "That was approximately the time when we encountered change of service provider issues with between our laboratory [C6] and [C7, the lab vendor contracted by C6 to temporarily provide lab services to the facility while in transition]. A phlebotomist did come in on 3/19/26 and made an attempt to draw [R11's] blood specimen, but it was a hard stick and was not able to collect R11's specimen. Somebody else was supposed to follow up, come in and do [R11] again the next night (3/20/26) but nobody came. We did not know if it was supposed to come from [C6] or from [C7]. 5/5/26 4:00 PM Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN). b. 3/20/26 – R11 had a stat (at once) physician's order for CBC, CMP, magnesium, phosphate, B12, folate, Vitamin D for electrolyte derangements. 3/24/26 – A medical note by P1 (physician) documented "… I reviewed BMP 3/17/26 … BUN/creatinine 53/2.9 …" 3/25/26 – R11 had CBC, CMP, magnesium, phosphate, B12, folate, Vitamin D labs drawn. 3/26/26 – 7:11 AM (another fax transmittal time stamped 7:14 AM) - Transmitted via fax by C7, R11's calcium, magnesium phosphorus, CMP, Vit B12 folate, CBC with diff profile lab results report revealed the following: elevated phosphorous 4.7 (2.6 – 4.5) BUN 44 (5-20) creatinine 2.6 (0.5 – 1.3) WBC 15.20 (4.5 – 11.00) and low hemoglobin 8.2 (11.7 – 16.1). 3/26/26 9:35 AM – Transmitted via fax by C7, R11's magnesium, phosphorus, CMP and CBC profile lab results report revealed the following: elevated phosphorous 5.8 (2.6 – 4.5) BUN 56 (5-20) creatinine 4.6 (0.5 – 1.3) WBC 16.30 (4.5 – 11.00) low sodium 130 (133- 145) and low hemoglobin 7.6 (11.7 – 16.1). 5/4/26 4:10 PM – A review of R11's progress notes lacked evidence that results of R11's 3/20/26 stat lab draw order for CBC, CMP, magnesium, phosphate, B12, folate, Vitamin D for electrolyte derangements was followed up by the nursing staff.	F0770	Continued from page 42 place. The Staff Development Coordinator/designee will educate licensed nurses regarding the facilities' laboratory ordering, collection, result follow-up and reporting process, including physician notification, utilizing the Lab Tracking Form. New hire orientation includes the education utilizing the Lab and radiology education tool which addresses the lab process as well as the Lab Tracking Tool. The Unit Managers, LPN or RN, or designee will be responsible for ongoing oversight of ensuring completion of labs ordered and results reported utilizing the Lab Tracking Form. The Lab Tracking Form will be brought through the daily scheduled clinical meetings for review. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. The Lab Tracking Form will be brought through the daily scheduled clinical meetings by the Unit Managers for review. D. The Unit Managers/designee will follow the lab tracking process utilizing the Lab Tracking Form as part of the scheduled daily clinical meeting. The Director of Nursing/designee will audit the lab tracking logs daily x5 days until 100% compliance, then weekly x 3 weeks until 100% compliance, then monthly x 2 months until 100% compliance to ensure the lab tracking process is completed. E. Date of compliance: 6/16/2026	06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/C_IA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

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F0770 SS = D	Continued from page 43 5/5/26 10:40 AM – In an interview, E4 (CRN) stated that C7's reporting system was not connected to the facility's EHR (electronic health record system). E4 further stated, "Unlike [EHR], we could not access the lab results from [C7]. They didn't call us, they only sent the results by fax. In the case of [R11], her lab results were only faxed on 3/26/26 in the morning. We had a contract with another laboratory vendor [C8] starting April 2026." 5/8/26 9:05 AM – In an interview, P2 (PA) stated that he was not immediately notified of the results of R11's stat lab draw order. "I think it was that weekend. We had a third-party lab issue that time. We didn't know whom to call for follow up results". 5/8/26 9:10 AM – During an interview, E47 (LPN) stated, "… When there's a stat lab order, the nurses should call and follow up with the lab and notify the physician, especially if the results are critical and the resident is going through a change in condition." 5/8/26 4:00 PM – Findings were discussed with E1 (NHA), E2 (DON) and E3 (CRN). 5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.	F0770		06/16/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F0842	F842 Resident Records R11 no longer resides in the facility, the facility is unable to correct the deficient practice for R11. Residents currently residing in the facility have the potential to be affected by this deficient practice. An initial audit of current residents was completed on 5/14/2026 to ensure required assessments were present and reflective of residents' needs. There were no omissions identified. The root cause was related to C1 (contracted dietician) not completing a nutrition assessment when indicated due to not following the facilities Weight Monitoring and Tracking Policy but then was completed by (C5) contracted dietician after R11's discharge from the facility. The Staff Development Coordinator/Director of Nursing educated the contracted dieticians related to the required nutritional assessments in accordance with the facility policy and/or regulatory requirements and to not document a nutrition assessment after resident	06/16/2026

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F0842 SS = D	Continued from page 44 (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F0842	Continued from page 44 discharge. The dietitian will bring weight variances through the daily scheduled clinical meeting for review. The system change will be that the Director of Clinical Informatics has been in contact with Point Click Care (Electronic Medical Record) to inquire if an alert can be added when a closed chart is opened to prevent documentation in the electronic clinical record. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. The Director of Nursing and/or designee will audit residents to ensure nutritional assessments are completed per facility policy and/or regulatory requirements. These audits will be completed daily x 5 days until 100% compliance, then weekly x3 weeks until 100% compliance, then monthly x 2 months until 100% compliance to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. Date of compliance: 6/16/2026	06/16/2026

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F0842 SS = D	Continued from page 45 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record reviews, it was determined that for one (R11) out of 4 residents reviewed for nutrition, the facility failed to maintain clinical records that meet professional standards of practice when R11's missing nutrition assessments were completed and signed by another Registered Dietitian on 5/5/26, one month after R11 was discharged from the facility on 3/26/26. Findings include: Review of R11's clinical record revealed: 1/17/26 – R11 was admitted to the facility. 1/19/26 – R11's nutrition assessment was completed by C1 (contract RD/ Registered Dietitian). 3/26/26 2:00 PM - A nurse progress note documented that R11 was transferred to the hospital. 5/4/26 – A review of R11's electronic health record under the evaluation/assessment tab revealed only one nutrition assessment completed by C1 on 1/19/26. 5/4/26 3:00 PM - In an interview, E2 (DON) confirmed that R11 was discharged from the facility on 3/26/27. E2 further stated that R11 did not return to the facility after she was transferred to the hospital on 3/26/26. 5/5/26 3:25 PM - E2 presented to the surveyor copies of R11's nutrition assessment for 2/19/26 and 3/17/26 completed by another RD (C5) and signed on the same day, 5/5/26. 5/5/26 3:30 PM – E2 informed this surveyor that C1 was on leave and they have an interim RD (C2) who fills in and sees patients in C1's absence. E2 provided C2's contact information. 5/5/26 3:38 PM – During an interview, C2 told this surveyor that she has never met R11 and never completed a nutritional assessment for R11. When	F0842		06/16/2026

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F0842 SS = D	Continued from page 46 asked if C2 was familiar with C5, C2 stated, "Yes, she is my boss and the owner of our contract dietary agency. I can call her for you now to get clarification on why [R11's] nutrition assessments were dated back in 2/19/26 and 3/17/26 and she's only signing them with her name today." 5/5/26 3:46 PM – In an interview, C5 (Owner of contract RD company) stated that C1 (contract RD) was on leave and was not available to answer this surveyor's questions regarding R11's assessments. C5 further stated, "The facility called me today and asked about these nutrition assessments. I went over C1's risk management notes and since I can't find any assessments, I just typed the information in the template, signed it and dated it today." When asked if C5 had personally met R11 for a nutrition assessment in the past, C5 replied, "No". 5/4/26 4:00 PM – Findings were discussed with E1 (NHA), E2 (DON) and E4 (CRN). 5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.	F0842		06/16/2026
F0865 SS = D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities; §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation;	F0865	F865 QAPI Prgm/Plan Resident R11 no longer resides in the facility; the facility is unable to correct the deficient practice for R11. Residents currently residing in the facility have the potential to be affected by this deficient practice. When deficient practices are identified, the deficiency will be brought through QAPI and a plan will be initiated. The root cause was related to the facilities failure to identify the medication-related concerns as they were not consistently identified, investigated or brought forward to the QAPI committee for analysis and performance improvement activities, resulting in missed opportunities for risk reduction and quality improvement. The facility failed to consistently review the Medication Administration Record, MAR, at the end of each shift which would have identified any missing medication documentation. The facility is monitoring the completion on the Medication Administration record prior to the end of each shift to ensure all documentation is completed. The facility failed to follow the clinical meeting guidelines to review the completion of documentation in the	06/16/2026

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F0865 SS = D	Continued from page 47 §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides. §483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities.	F0865	Continued from page 47 electronic medication administration record during the scheduled daily clinical meeting. The Regional Director of Clinical Services will educate the Administrator and Director of Nursing regarding the facility QAPI process. The Staff Development Coordinator / designee will educate licensed nursing staff on the requirements of monitoring the MAR at the end of each shift. An initial audit was completed to identify residents with orders for insulin, anti-coagulants including heparin and blood sugar monitoring to ensure completion of medication administration and documentation, blood sugar checks and identify any presence of any omitted doses and treatments. Identified concerns were corrected, provider notified as indicated, no residents had adverse outcomes. The Unit Managers/Supervisors will review the electronic medication prior to the end of each shift to ensure completion of medication administration and documentation is complete. The system change will be that the unit managers will bring the findings of the review of the electronic medication administration record through the scheduled clinical meetings. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. Supervisors/Nursing Leadership will audit medication administration compliance daily prior to end of each shift. Results of audits will be reviewed by DON/Administrator weekly x 4 weeks until 100% compliance, then monthly x 2 months until 100% compliance. Results of audits will be brought through Monthly in QAPI for tracking and trending and ongoing compliance and identification of trends. Any identified concerns will result in immediate action, re-education, and follow-up auditing. Date of compliance: 6/16/2026	06/16/2026

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F0865 SS = D	Continued from page 48 §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of facility documents, it was determined that the facility failed to identify and correct R11's significant medication errors involving blood sugar checks, heparin and insulin injections. Findings include: Cross refer 760 5/8/26 3:15 PM – During QAPI interview, E1 (NHA) confirmed that the facility failed to identify and correct quality issues for R11's nutrition and hydration status requiring emergent hospitalization on 3/26/26. 5/8/26 3:50 AM – In a follow up interview, E1 further confirmed that facility failed to identify and correct	F0865		06/16/2026

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F0865 SS = D	Continued from page 49 R11's significant medication errors involving blood sugar checks, heparin and insulin injections from 2/15/26 to 3/18/26. 5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.	F0865		06/16/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify 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:	F0880	F880 Infection Prevention and Control A1. R29's treatment for MRSA has been completed, R29 has transitioned to Enhanced Barrier Precautions. The facility was unable to correct the deficient practice for R29. B1. Current residents with orders for contact precautions have the potential to be affected by this deficient practice. An initial audit of current residents with orders for contact precautions has been completed to ensure the policy for Transmission Bases Precautions was followed. C1. Root cause analysis was related to the facilities failure to follow the Policy Transmission Based Precautions related to staff's lack of knowledge related to following procedures for contact precautions. The Registered Nurse, E38, failed to ensure contact precautions were followed; E38 entered R29's room without applying all PPE. The Staff Development Coordinator provided one to one education to E38 regarding PPE requirements for Contact Isolation. The Staff Development Coordinator / designee will educate facility staff on the requirements for Transmission Based Precautions. The Infection Preventionist will complete rounds to ensure the facility is following Transmission Based Precautions as indicated. The system change is that the Infection Preventionist will bring findings through the scheduled clinical meeting for review. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D1. Infection Preventionist/ Staff Development/designee will observe staff including contracted staff for residents on Contact Precautions to ensure that the proper PPE is worn prior to entering the room. These audits will be completed daily x 5 days until 100% compliance, then weekly x3 weeks until 100% compliance, then monthly x 2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans.	06/16/2026

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F0880 SS = D	Continued from page 50 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and review of records and the facility's policy and procedure, it was determined that for two (R29 and R30) out of 31 residents sampled during the survey, the facility failed to ensure infection control and prevention practices were followed. Findings include: According to the Center for Disease Control's (CDC) website, the Infection Control Guidance: Preventing Methicillin-resistant Staphylococcus aureus (MRSA) in Healthcare Facilities, dated 6/27/25, stated, "... The prevention of MRSA infections is a priority for CDC... Based on the current evidence, CDC recommends the use of Contact Precautions for MRSA-colonized or infected patients...". The facility's policy and procedure entitled Transmission Based Precautions, effective 2/6/2020, stated, "... Transmission based precautions are	F0880	Continued from page 50 A2. R30's Contact Precautions for C. Diff were discontinued on 5/8/2026. B2. Current residents with orders for Contact Precautions have the potential to be affected by this deficient practice. An initial audit of current residents has been completed no current residents were identified. C2. Root cause analysis was related to the facility failing to follow the Policy related to Contact Precautions and staff's lack of knowledge related to following the policy for contact precautions. The contracted dietician (C2) failed to ensure contact precautions were followed for R30 the failure was related to when C2 asked E39 (LPN) if PPE was required, E39 provided inaccurate information regarding need for PPE , therefore, C2 entered the R30's room without donning PPE. The Director of Nursing provided one to one education regarding the Policy related to Contact Precautions with the contracted dietician and the nurse who told the dietician she did not need to wear PPE. The Staff Development Coordinator / designee will educate facility staff on the requirements regarding the Policy related to Transmission Based Precautions. The Infection Preventionist will complete rounds to ensure the facility is following Transmission Based Precautions as indicated. The Administrator and/or Director of Nursing or assigned designee are responsible for the corrective action. D2. Infection Preventionist/ Staff Development/designee will observe clinical and contracted staff for residents on Contact Precautions to ensure that the proper PPE is worn prior to entering the room. These audits will be completed daily x 5 days until 100% compliance, then weekly x3 weeks until 100% compliance, then monthly x 2 months until 100% compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E.Date of compliance: 6/16/2026	06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD , WILMINGTON, Delaware, 19803

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = D	Continued from page 51 designed for patients documented as suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens for which additional precautions beyond standard precautions are needed to interrupt transmission... 3. Contact precautions (e.g., MRSA... C. difficile...). In addition to standard precautions, for specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient-care activities that require touching the patient's dry skin) or indirect contact (touching) with environmental surfaces or patient care items in the patient's environment...". 1.Review of R29's clinical record revealed: 4/28/29 - An active physician's order for R29 documented, "CONTACT PRECAUTIONS every shift for MRSA...". 4/29/26 9:57 AM - Observation by the surveyor revealed a contact precautions sign and an isolation cart with personal protective equipment available outside R29's room. Further observation with the door opened revealed E38 (RN) only wearing gloves while in R29's room administering an injection in the resident's right arm. Interview upon exit of R29's room, E38 confirmed that that he should have applied a gown on before entering R29's room. 2. Review of R30's clinical record revealed: 5/2/26 - A physician's order for R30 documented contact precautions for diagnosis of C-Diff. 5/3/26 10:41 AM - A telehealth note documented that R30 was evaluated by C9 (contracted telehealth APN) with E39 (LPN) present for vomiting. 5/3/26 approximately 1:00 PM - Observation by the surveyor revealed C2 (contracted dietician) ask E39 (LPN) at the medication cart if she needed to apply personal protective equipment before entering R30's room if she was only going to be asking her questions. E39 replied no if only you are asking questions. Further observation revealed that outside of the R30's room there was a contact precautions	F0880		06/16/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

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F0880 SS = D	Continued from page 52 sign posted with instructions to apply gown and gloves before entering the room and an isolation cart was present with personal protective equipment (PPE) available. C2 entered the R30's room without applying PPE. 5/3/26 approximately 1:10 PM - Surveyor reported observation to E2 (DON) and E4 (CRN). 5/4/26 - An individual inservice record for C2 was provided to the surveyor by E2 (DON), which stated "Isolation Requirements - Before entering any room that has a posted isolation sign, stop, read the instructions before entering. The information on the signage will direct you to the proper PPE." 5/6/26 4:10 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E4 (CRN).	F0880		06/16/2026

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: Wilmington Nursing and Rehabilitation **DATE SURVEY COMPLETED:** May 11, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint and Extended survey was conducted at this facility from April 27, 2026 through May 11, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was (one hundred thirty-one) 131. The investigative sample totaled (thirty-one) 31 residents.		
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement was not met as evidenced by: Cross Refer to the CMS 2567 – L survey completed May 11, 2026: F561, F609, F656 F684, F689, F760, F770, F842, F865 and F880.		

Provider's Signature _____ Title _____ Date _____