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: Evergreen Post Acute LLC

DATE SURVEY COMPLETED: May 11, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual and Complaint Survey was conducted at this facility from May 4, 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 documents, as indicated. The facility census on the day of the survey was one hundred thirty-seven (137). The sample totaled forty-one (41) residents. Abbreviations/definitions used in this report are as follows: DON - Director of Nursing; NHA – Nursing Home Administrator;	1. Resident involved in the incident was immediately assessed upon identification of injury. Neurological checks were initiated per facility protocol. The physician and responsible party were notified. Documentation was completed to reflect resident condition and ongoing monitoring. No adverse outcome was noted, appropriate interventions were implemented. 2. All residents are at risk of being affected by this deficient practice. No steps can be taken to retroactively address risk to other residents.	6/25/26
3201	**Regulations for Skilled and Intermediate Care Facilities**	3. A root cause analysis was completed, it was found that staff had a misunderstanding of reporting requirements and upon review of the incident the nurse management team failed to report based on regulatory guidance.	
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 completed May 4, 2026: cross refer: F550, F605, F609,	Staff Development RN will re educate licensed nurses on facility policy for reporting injuries. Standardized incident reporting checklist updated to include when neurochecks are initiated. Director of nursing responsible for implementing this corrective action and reviewing incidents to ensure that state reportables are completed when indicated. 4. All falls will be reviewed by DON to ensure that reporting criteria is met. 5 daily audits will be completed for 5	

Provider's Signature OR Roth, RNA Title Administrator Date 6.15.26

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	F657, F677, F684, F686, F689, F692, F695, F755 and F812.	days or until 100% compliance. Audits will then be completed for 4 weeks or until 100% compliance. Audits will then be completed monthly for 3 months. Findings will be reported to QAPI committee.	
3201.9.8	**Reportable incidents are as follows:**		
3201. 9.8.4	**Significant injuries.**		
3201. 9.8.4.2	**Injury which results in transfer to an acute care facility for treatment or evaluation or**	Cross reference EPOC for FTags	
S/S – D	**which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.**		
	This requirement was not met as evidenced by:		
	Based on interview, record review and review of other facility documentation, it was determined for one (R157) out of five residents sampled for reportable incidents, the facility failed to report to the State Agency. Findings include:		
	Review of R157's clinical record revealed:		
	12/3/25 – R157 was admitted to the facility.		
	3/5/26 3:34 PM – A nursing note documented that R157 was observed sitting on the floor behind her wheelchair. An assessment revealed R157 had a small abrasion to the mid-back, was able to move all extremities, and had no discomfort.		
	3/6/26 7:00 AM – A new nursing order for R157 to document alert charting post fall every shift for 3 days.		
	5/8/26 - A record review revealed a neurological assessment document that R157 neurological assessments began on 3/5/26 at 1:20 PM, then every 15 minutes for 4 times, then every 30 minutes for 4 times, then every hour		

Provider's Signature [illegible], RNA Title Administrator Date 6/15/26

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	for 4 times, and then every 4 hours for 4 times. These assessments totaled 24 hours. 5/8/26 1:20 PM – During an interview, E2 (DON) confirmed that after R157's fall, an initial neurological assessment was completed beginning 3/5/26 at 1:20 PM. Afterward, a neurological assessment was performed every 15 minutes for 4 times, then every 30 minutes for 4 times, then every hour for 4 times, and then every 4 hours for 4 times. These assessments totaled 24 hours. 5/11/26 2:50 PM – During an interview, E1 (NHA) reviewed the information that R157 had an unwitnessed fall, had neurological assessments over a 24-hour period, and that this incident was not reported to the state agency. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 and E2.		

Provider's Signature A.R. Rocks, NHA Title Administrator Date 6/15/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085020	(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
EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD , SMYRNA, Delaware, 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		06/04/2026
F0000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from May 4, 2026, through May 11, 2026. The deficiencies contained in this report are based on observations, interviews, review of resident clinical records and review of other facility documents, as indicated. The facility census of the first day of the survey was one-hundred thirty-seven (137). The survey sample totaled forty-one (41) residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA – Nursing Home Administrator; RN - Registered Nurse; Acute kidney injury (AKI) - Acute kidney injury (AKI) refers to an abrupt decrease in kidney function, resulting in the retention of urea and other nitrogenous waste products and in the dysregulation of extracellular volume and electrolytes; Acute Respiratory Distress - a life-threatening lung injury where the tiny air sacs in the lungs fill with fluid, preventing oxygen from entering the blood; Albuterol sulfate - a prescription medication used to instantly open up airways in the lungs to make breathing easier;	F0000		06/25/2026

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

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

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F0000	Continued from page 1 BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best; Braden Scale - An assessment tool for measuring risk of pressure ulcer development using the following scale :AT RISK 15-18 MODERATE RISK 13-14 HIGH RISK 10-12 VERY HIGH RISK 9 or below. BUN (blood urea nitrogen) - lab measures the amount of urea nitrogen in the blood; Cerebral Vascular Accident (CVA) – (Stroke) a condition involving reduced blood supply to the brain from intracerebral hemorrhage, thrombosis, embolism, or vascular insufficiency; Complete Blood Count (CBC) - blood test used to evaluate your overall health and detect a wide range of disorders, including anemia, infection and leukemia; Complete Metabolic Panel (CMP) - set of tests that measure blood sugar, calcium levels, kidney function, and chemical and fluid balance; Creatinine – increased quantities found with renal/kidney disease; Dehydration - a condition in which the body has less than normal fluid; EMR - (Electronic Medical Record) - a systematized collection of patient and population electronically stored health information in a digital format; Endocarditis - infection and inflammation of the heart valves and inner lining of the heart; Hemiparesis - unilateral weakness of the entire left or right side of the body; Hemiplegia – half of body paralyzed; Hypernatremia - high salt or sodium blood level due to a decrease in total body water; Hypokalemia - low potassium;	F0000		06/25/2026

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F0000	Continued from page 2 Hyponatremia - low sodium; Minimum Data Set (MDS) - standardized assessment used in nursing homes; Nebulizer - a small, electric machine that turns liquid medicine into a fine mist; Nebulizer mask - device worn to deliver aerosolized liquid medication; Pneumonia - lung inflammation caused by bacterial or viral infection; Pressure Ulcer - sore area of skin that develops when the blood supply to it is cut off due to pressure; r/t - related to; Stage 2 - blister or shallow open sore with red/pink color.	F0000		06/25/2026
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 interview, record review and review of other facility documentation, it was determined that for one (R109) out of seven residents reviewed for accidents, the facility failed to provide adequate supervision and implement safe bed mobility practices to prevent a fall. As a result, R109 fell from the bed, sustained a head laceration, required hospital transfer, and received six sutures causing harm to the resident. Findings include: Review of R109 clinical record revealed: 6/9/25 – R109 was admitted to the facility with diagnoses including seizures, gastrostomy tube, tracheostomy, anxiety, and muscle spasms.	F0689	1. R109 returned to facility. Post fall safety measures were reassessed including mobility, cognition, nutrition, medication review and environmental factors, a perimeter overlay mattress was added to Low air loss mattress. 2. The facility has determined that dependent residents who require two-person bed mobility have the potential to be affected by the issue. The Director of Nursing conducted an audit of other residents who are dependent for bed mobility to ensure safety interventions are in place to address fall prevention including but not limited to correct transfer status, specialty mattresses and fall mats. 3. A root cause analysis determined that the dependent resident on a LAL mattress would benefit from a perimeter overlay mattress to establish bed boundaries and potential accident prevention. While lowering bed even further to the ground would not have prevented fall, it is good practice for bed to be in lowest position prior to any staff members stepping away or turning away from resident and this was not done. It was determined that mattress was in static mode during period of time that resident rolled out of bed, however when resident had involuntary movement it caused her to thrust	06/25/2026

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F0689 SS = G	Continued from page 3 A care plan last updated 6/10/25 documented ADL self-care deficit related to physical limitations. Interventions included assistance with daily hygiene, grooming, dressing, oral care, and eating as needed. The care plan further documented R109 required a two-person assist for transfers and bed mobility. Additionally, the care plan documented R109 was at risk for falls related to poor safety awareness, seizure and adjustment to a new environment. Interventions included assessing for fall risk on admission, quarterly, and as needed. 10/1/25 - The medical record was updated to include a diagnosis of multiple sclerosis. 12/13/25 – A quarterly Minimum Data Set (MDS) assessment documented in GG0120 Functional Abilities that R109 was dependent, with helper doing all of the effort and the resident doing none of the effort to complete the activity, or the assistance of two or more helpers was required for the resident to complete the activity. The assessment documented R109 was dependent for eating, oral hygiene, toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The assessment further documented in GG0170 Mobility that R109 was dependent for roll left and right, sit to lying, lying to sitting on side of bed, bed-to-chair transfers, and tub/shower transfers. 1/5/26 – A facility collected statement written by E23 (CNA) documented "during the 0615 check and change [R109] was noted to have a large liquid bowel movement. [E10 (CNA)] and I began to assist [R109]. [E10] pulled [R109] towards her (to the left side) and then rolled her onto her right side (towards me) to position her in the middle of the bed. [E10] removed the soiled brief and cleaned [R109] off, then walked the soiled brief to the linen/trash cart which was located at the entrance of the door to toss it away. [R109] continued to have diarrhea, I turned to grab a new brief and gown off the chair, which was located right behind me. As I turned back around, I noticed [R109] falling from the bed, hitting her head on the drawer of the nightstand. While falling, [R109] continued to actively pass a large amount of liquid stool, I called out for help and [E10] turned around to assist me. The supervisor was notified." 1/5/26 at 6:49 AM – A progress note documented "this nurse was called to the room it was noted that [R109] was laying on the floor on her back... [R109] is not able to verbalize what happen. In the process of doing personal care there were two aids present.	F0689	Continued from page 3 forward and roll out of bed and because there was no perimeter mattress, resident rolled onto floor. All residents that are dependent for bed mobility will be assessed by Admission Nurse for appropriateness to have a perimeter mattress placed on bed. Unit Managers will conduct observational rounds to verify compliance with residents ordered fall interventions. RN Staff Educator/designee will provide training of licensed nurses and CNAs on Bed mobility, accident prevention, and safety related to Low Air Loss Mattress upon hire and annually. 4. Residents who are dependent and require two-person staff assistance for bed mobility will be reviewed to ensure safety interventions are in place to address fall prevention. 5 audits will be conducted by Director of Nursing/Designee daily x 5 days or until 100% compliance, then weekly for a minimum of 4 weeks or until 100% compliance, then monthly for 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee.	06/25/2026

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F0689 SS = G	Continued from page 4 One aid stated that she turned to place dirty laundry in the basket and the other aid turned to get her night gown off the chair. The bed was at waist level and R109 was lying on her right side when [R109] fell off the bed onto the floor… She had a deep laceration to her left temple. There was minimal red drainage. [R109] did not display [signs and symptoms] of pain. The On-call doctor was notified, and resident was sent out to get sutures to the open wound. [R109's] family member was also notified. 1/5/26 – A facility collected statement by E10 documented "After providing care for [R109] I stepped away to put the dirty linen in the linen basket located at the threshold of the room door. When I turned back into the room, I did not see the resident in the bed. She was on the floor. I called for help." 1/5/26 – The facility reported incident documented that "at approximately 6:30 AM resident rolled out of bed. RN assessment completed a laceration to the left forehead was noted first aid applied, neuro checks initiated. Family and NP notified. Resident sent to ED for evaluation and treatment." A care plan was revised on 1/6/26 that included interventions provide adequate lighting; and fall mats on floor at bedside while in bed perimeter mattress to bed, Date Initiated: 1/6/26. 1/7/26 - A progress note in R109's clinical record written by E19 (NP) documented in a follow up visit that "Patient was sent to the ED s/p fall out of bed with left forehead laceration. Per ED notes Reportedly, patient was being changed in bed by nursing home staff and somehow slipped out of bed hitting her forehead." 1/9/26 – A 5 day follow up from the facility documented that R109 "Loss of balance r/t underlying medical condition - COVID causing increased weakness and inability to hold side lying position further compromised by dx of muscle spasms and multiple sclerosis. The staff interview revealed that, the resident rolled out of bed to the floor. RN assessment completed, and the resident was noted with a laceration to the left side of her forehead. First aid was rendered, and the resident was transferred to the ER for further evaluation. NP and family were notified. The resident was seen and examined at the ER, and all tests completed were negative for any additional injury related to the fall. The resident is an assist of x2 for bed mobility, and per the investigation findings, the resident was	F0689		06/25/2026

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F0689 SS = G	Continued from page 5 provided care utilizing two staff members prior to resident rolling OOB. After care provided, the resident was placed on her side in secure position. Staff was still present in the room although was unable to physically prevent the resident from rolling from bed to the floor. Both CNAs are familiar with the resident as they were her routine caregivers. The resident returned from the hospital post evaluation with sutures to laceration on forehead. Therapy was consulted to evaluate post return. Safety measures were reassessed. Interventions: Perimeter mattress, Fall mats, PT eval." 5/8/26 9:20 AM - During an interview with E10 (CNA), E10 revealed staff were providing incontinent care to R109 when additional linen was needed due to continued loose stool and the linen cart was positioned near the doorway. E10 stated R109 was positioned in the bed at approximately waist height and was unable to reposition herself or assist with movement. E10 further stated R109 required two-person assistance for care and positioning. E10 stated one CNA was positioned on the opposite side of the bed while care was being provided and additional linen was obtained due to continued diarrhea. E10 stated staff attempt to gather needed supplies prior to beginning care; however, additional linen was needed during the care activity due to the resident's condition. E10 stated staff try not to leave bedside during care activities. E10 stated the incident "happened suddenly" and E10 did not directly observe the fall; however, the other CNA observed R109 fall from the bed. E10 stated precautions for R109 included two-person assistance and maintaining the resident in an upright position related to the tracheostomy. E10 further stated staff had discussed the mattress following the incident, including a control button related to mattress inflation and deflation, and stated there had not been prior in-service education regarding the mattress function. E10 stated staff immediately notified the nurse and supervisor following the incident. Despite the facility's investigation indicating R109 had been placed in a "safe position" and centered in the bed, record review and staff interviews confirmed R109 continued to receive incontinent care related to ongoing diarrhea at the time of the incident. Staff interviews revealed R109 had not yet been dressed and incontinent care activities were ongoing when the fall occurred. Additionally, interview statements contained varying accounts regarding the resident's positioning immediately prior to the fall, including documentation that R109 was positioned side-lying as well as statements that the resident had been centered in the bed. Regardless of the exact	F0689		06/25/2026

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F0689 SS = G	Continued from page 6 positioning, the resident remained dependent on staff and continued to require two-person assistance and supervision during the care activity. 5/8/26 at 1:08 PM - During an interview on E4 (CNA) stated that residents requiring two-person bed mobility require one staff member on each side of the bed during care. E4 further stated that if one staff member needed to step away, the resident should first be returned to a safe position in the bed and the bed lowered prior to staff leaving bedside. E4 stated staff received education regarding fall prevention through demonstrations and in-person training. 5/8/26 at approximately 1:15 PM – During an interview with E24 (Nurse Educator) confirmed the above and E24 provided state agency with documentation of a training on 12/3/25 that documented Education for all staff that transfer/care status must be followed at all times if a resident requires a 2 person assist, they must not provide care/transfer alone. When asked what you would do if you had to step away during a two-person activity E24 confirmed that you would return the resident to a safe position move to the center of the bed, by lowering the bed to the floor. Additionally, E24 provided documentation on an Inservice initiated on 1/5/26. "When providing care for resident on low air loss mattress, ensure in STATIC mode prior to providing care and resident is in the middle of the bed." 5/11/26 at 9:38 AM - During an interview on E2 (Director of Nursing) stated that one aide stepped away from the bedside to place soiled linen in the linen cart outside the room while the second aide turned away from the resident to retrieve clothing. E2 confirmed the bed remained waist high during the care activity. E2 stated the facility believed R109's diagnoses, including multiple sclerosis with spasticity and COVID diagnosis, contributed to the fall. 5/11/26 - During interviews conducted on E11, E12, and E13 (CNAs) stated that residents requiring two-person bed mobility require two staff members at bedside during care. Staff further stated that if one caregiver needed to leave or step away from the bedside, the resident should first be repositioned safely in the center of the bed and the bed lowered prior to staff stepping away. 5/8/26 and 5/11/26 - Attempts were made during the survey to interview E23 (CNA); however, those attempts were unsuccessful.	F0689		06/25/2026

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F0689 SS = G	Continued from page 7 5/11/26 3:20 PM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0689		06/25/2026
F0692 SS = G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R155) out of one resident reviewed for hydration, the facility failed to ensure that R155 was offered sufficient fluids to maintain proper hydration. This failure resulted in harm with R155 being transferred to the hospital on 10/21/25 with diagnoses of dehydration and AKI (acute kidney injury). Findings include: The BUN (blood urea nitrogen) lab measures the amount of urea nitrogen in the blood. The BUN is directly related to the metabolic function of the liver and the excretory function of the kidney ... BUN levels also may vary according to the state of hydration, with increased levels seen in dehydration and decreased levels seen in overhydration. Mosby's Diagnostic and Laboratory Test Reference 2023. Review of R155's clinical record revealed:	F0692	1. R155 was no longer in the facility unable to correct. 2. The facility has determined that all residents have the potential to be affected. Audit of all current residents was initiated to identify those at risk for decreased fluid intake including those with cognitive impairment, limited mobility and history of limited fluid intake, to ensure that care plans were reviewed and appropriate and that hydration interventions including hydration carts and scheduled rounds were implemented. Residents decreased meal intake less than 50 % in the last 3 days will be reviewed by dietician /designee to ensure that interventions are implemented to maintain nutrition/hydration status 3. Root cause analysis was conducted, and it was identified that resident's decreased PO intake, medical diagnosis and ineffective fluid resuscitation further compromised by electrolyte imbalance contributed to transfer to acute care setting. Nurse leadership should closely monitor intake documentation to ensure accuracy and alignment with intake orders. Although resident is care planned for refusals of po intake, CNAs should alert Unit Manager on a daily basis of continued refusals to ensure that action is taken accordingly. Actions taken/systems put into place to reduce the risk of future occurrence include: Unit managers closely overseeing the process of fresh water at bedside every shift, this will be done by conducting daily rounds. CNAs and Nurses will be responsible for notifying Unit Manager daily of fluid refusals or decreased fluid intake for residents on their assignment. Any residents identified by care staff for decreased fluid intake will be reviewed at daily clinical meeting with Nurse Leadership (DON, ADON) to ensure all appropriate monitoring and interventions are in place. CNA and nursing orientation will be revised to	06/25/2026

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F0692 SS = G	Continued from page 8 6/12/25 - R155 was admitted to the facility. 6/17/25 - A care plan documented that R155 was at risk for nutrition/hydration risk related to dementia, hypokalemia, hyponatremia, aphasia, hemiparesis, hemiplegia, and cerebral vascular accident (CVA) with the following interventions: honor food and beverage preferences as able; provide and serve diet, snacks and fluids as ordered; provide assistance with meal tray set up and/or feeding assistance; provide nutrient-relevant medications and supplements as ordered; and Registered Dietician (RD) to make dietary recommendations as needed. 6/17/25 11:12 AM - A nutrition assessment documented the recommended fluid intake for R155 was 2050 mL/day. The nutrition assessment further identified R155 was at risk for malnutrition and dehydration related to diagnoses of dementia, hemiplegia, and hemiparesis. The assessment additionally referenced laboratory results obtained on 6/16/25 which documented the following values: Sodium 148 (high) and Potassium 3.1 (low). The assessment further documented the provider ordered additional oral fluids for two weeks related to the electrolyte imbalance. 9/18/25 - A quarterly MDS documented that R115 had a BIMs score of 3 indicating severe cognitive impairment and required supervision or touching assistance for eating/drinking. 9/18/25 1:35 PM - A quarterly nutritional assessment documented that R155 had maintained stable weight since admission, had good oral food and fluid intake and remains on mechanical soft diet with no chewing or swallowing difficulty. No other nutrition concerns at this time and continue to monitor R155's nutritional status. The daily totals obtained from CNA task flow sheet for R155's fluid intake: 10/1/25 - 1360 mL. 10/2/25 - 720 mL. 10/3/25 - 960 mL. 10/4/25 - 1360 mL. 10/5/25 - 1360 mL. 10/6/25 - 960 mL.	F0692	Continued from page 8 include education related to residents with hydration needs who do not meet their daily recommended hydration/fluid intake goals. An in-service education was conducted by the Staff educator /designee with licensed nursing staff CNAs and dietician on the importance of reviewing PO intake, identifying change in PO intake to ensure that appropriate interventions are implemented. education to CNAs will include that they should report to Unit Manager when a resident did not meet their fluid goals for the shift during which they cared for that resident. 4. Review of residents with decreased meal intake less than 50% and those with cognitive impairment, limited mobility and history of limited fluid intake will be conducted by Dietician/designee to ensure that appropriate interventions are implemented to maintain nutrition/hydration status. Audits will be done daily x 5 days or until 100% compliance then weekly for 4 weeks or until 100 % compliance, then monthly for 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee.	06/25/2026

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F0692 SS = G	Continued from page 9 10/7/25 - 840 mL. 10/8/25 - 480 mL. 10/9/25 - 2000 mL. 10/10/25 - 480 mL. 10/11/25 - 1200 mL. 10/12/25 - 920 mL. 10/13/25 - 240 mL. 10/14/25 - 1120 mL. 10/15/25 - 1440 mL. 10/16/25 - 720 mL. 10/17/25 - 240 mL. 10/18/25 - 960 mL. 10/19/25 - 1680 mL. 10/20/25 - 480 mL. 10/20/25 1:00 AM - A provider's progress note documented that R155 was seen due to nursing reported R155 was noted with increased fatigue and slow to respond. The provider plan documented to check CBC, CMP, Vit D and B12 lab levels and encourage fluids. Despite provider recommending encouraging fluids, the facility failed to implement provider recommendation and lacked the evidence of increased monitoring and implementing approaches to increase hydration. The daily totals obtained from CNA task flow sheet for R155's fluid intake: 10/21/25 - 0 mL. 10/21/25 10:39 AM - A laboratory results report documented that R155 had the following lab values: BUN level 42 mg/dL, creatinine 1.50 mg/dL, and sodium 159 mmol/L. 10/21/25 2:22 PM - A progress note documented that labs were reviewed by provider and indicative of hypernatremia and AKI, fluid resuscitation was unsuccessful and initiated a new order to send R155 to the hospital.	F0692		06/25/2026

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F0692 SS = G	Continued from page 10 10/21/25 2:44 PM - A progress note documented that R155 was sent to the hospital via ambulance. 10/21/25 4:49 PM - A hospital progress note documented that R155 had lab values of BUN of 40 mg/dL and creatinine 1.5 mg/dL upon arrival to emergency department. The progress note further documented that R155 was being admitted with diagnosis of AKI, hypernatremia, hypokalemia and dehydration. The progress note documented the plan to correct was IV fluid resuscitation during admission. 10/21/25 1:00 AM - A provider progress note documented that R155 was seen for increased fatigue, lab review, and slow to respond. The progress note documented that R155's lab values were as follows: BUN 42 mg/dL, creatinine 1.50 mg/dL and Sodium 159 mmol/L. The provider recommended IV (intravenous) fluid resuscitation and to send R155 to hospital if unable to establish an IV line. 5/11/26 1:02 PM - During an interview, E14 (CNA) stated the expectation is for staff to record any fluids provided during meals and hydration rounds in the electronic system. E14 stated that staff was to report any changes noted in intake by residents to the nurse when observed. 5/11/26 1:07 PM - During an interview, E15 (CNA) stated the expectation is for staff to record all fluid intake and report any changes to the nurse. 5/11/26 1:10 PM - During an interview, E16 (LPN) stated that R155 required assistance from staff with eating and drinking and had a good appetite. E16 further stated that nurses were expected to monitor resident's intake and report any changes to the Unit Manager or dietician. 5/11/26 1:15 PM - During an interview, E17 (RN) stated that resident's not meeting fluid volume goals are to be reported to the Unit Manager who will notify the provider and/or dietician to evaluate resident. E17 stated that she was unable to recall who attempted to initiate the IV line on R155 and stated the orders were not placed in the system due to unsuccessful insertion of the IV. E17 stated typically the orders would be added to EMR after the IV line was established. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0692		06/25/2026

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F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that the facility failed to ensure sanitization of dishware to prevent food borne illness. Findings include: 2/26/26 - A Kitchen Service Report from contracted maintenance provider documented a dish washing machine rinse temperature of 158 degrees Fahrenheit, less than the minimum required temperature for sanitization of 180 degrees Fahrenheit. The maintenance provider documented the washer machine was "good". The facility lacked evidence of recognition of a failed temperature or response to this temperature. April 2026 - Dish washing machine temperature logs documented that the facility dishwasher failed to reach required temperatures for sanitization [washing minimum 150 degrees rinse minimum 180 degrees Fahrenheit] on the following dates: 4/2 - breakfast wash cycle140 degrees Fahrenheit. 4/3 - lunch wash cycle130 degrees Fahrenheit.	F0812	1. Dietary manager was educated on regulations surrounding storing, preparing, distributing and serving food in accordance with professional standards for food service safety esp. related to dishwashing machines and sanitation. Immediate action taken was to add chemical sanitization to dish machine to ensure proper sanitation of dishware to prevent food borne illness. 2. The facility has determined that all residents who consume food by mouth have the potential to be affected. 3. Root cause analysis was conducted, it was found that dish machine was taking too long to reach required temperature and attempts to repair were unsuccessful. When temperature checks are completed and do not fall within parameters this must be escalated to management immediately. Dietary staff did not escalate concern to Administrator timely. Actions taken to reduce the risk of future occurrence included purchasing a new dishwasher. Education of dietary staff will be conducted by NHA/designee on regulations surrounding store, prepare, distribute and serve food in accordance with professional standards for food service safety esp. related to dishwashing machines and sanitation. The new machine purchased and installed monitors temperatures and sends an alert to Food Services Director if any deviation from required temperature occurs. Hourly manually temperature checks will continue to be completed by Dietary Aide and logged, any deviation will be immediately reported to Food Services Director. New employee orientation for the Food Services Director will be revised to include education about required dishwashing machine temperature and sanitation and the significance of an alert received and required action taken if any deviation from required temperature occurs. 4. Food Services Director or Designee will conduct daily audits of dish washing machine temperature logs to ensure temperature meets recommendations for food safety. Audits will be conducted daily for 5 days or until 100% compliance then weekly for 4 weeks or until 100% compliance then monthly for 3 months or until 100& compliance is achieved. The	06/25/2026

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F0812 SS = F	Continued from page 12 4/4 - dinner wash cycle140 degrees Fahrenheit. 4/17/26 - A Kitchen Service Report from contracted maintenance provider documented a dish washing machine rinse temperature of 155 degrees Fahrenheit, less than the minimum required temperature for sanitization of 180 degrees Fahrenheit. The maintenance provider documented "Dish machine is working correctly". The facility lacked evidence of recognition of failed temperature requirements or a response to this temperature. 5/7/26 10:30 AM - During a follow-up kitchen tour observation the facility dish washing machine failed to reach the required minimum wash cycle temperature of 150 degrees Fahrenheit the thermometer dial was fixed on 130 degrees Fahrenheit and appeared to be broken and immobile. E7 (Kitchen Supervisor) was present and observed/confirmed the same finding. 5/7/26 10:36 AM - E7 (Kitchen Supervisor) ran a second dish washing cycle using an external thermometer; at the end of the cycle the thermometer read 140 degrees Fahrenheit failing to reach the minimum wash cycle temperature required to ensure sanitization of dishware. E7 then added chemical sanitization. 5/7/26 12:00 PM - During an interview E7 (Kitchen Supervisor) and E8 (Regional FSD) confirmed the findings that the facility experienced intermittent failure to ensure dish washer temperatures met minimum temperature for sanitization and reported that a repair company would be onsite the same day to repair the dish washer. 5/7/26 2:43 - During an interview E7 (Kitchen Supervisor) and E8 (Regional FSD) provided documentation of same date maintenance log of repaired dish washer with required temperatures for sanitization at wash cycle 160 degrees Fahrenheit and rinse cycle 180 degrees Fahrenheit. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0812	Continued from page 12 audit findings will be reported to the QAPI Committee.	06/25/2026

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F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined for one (R63) out of three residents reviewed for dignity the facility failed to ensure R63's urostomy bag was covered. Findings include: R63's clinical record revealed:	F0550	F0550 1. R63 was immediately given a urostomy bag cover. 2. All other residents with urostomy bags were confirmed to have covers. 3. Root cause analysis was conducted, and it was found that upon admission resident was not offered a urostomy bag. Actions taken/systems put into place to reduce the risk of future occurrence include when completing admission assessments and identifying a urostomy bag is in place nurses will obtain and offer cover at that time. Admission RN responsible for corrective action. All nurses (including admission nurses) and caregiving staff will receive education on providing residents with urostomy bag covers by the Staff Development Nurse/Designee. 4. The Director of Nursing/designee, will conduct audits on all residents with urostomy bags to ensure a cover is in place or has been offered. 5 daily audits will be completed for a minimum of 5 days or until 100% compliance is achieved. Audits will then be completed weekly for a minimum of 4 weeks or until 100% compliance is achieved. Audits will then be completed monthly for 3 months. The audit findings will be reported to the QAPI Committee.	06/25/2026

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F0550 SS = D	Continued from page 14 3/6/26 – R63 was admitted to the facility. 5/4/26 12:25 PM – An observation revealed R63 had a urostomy bag that was not covered and visible from the hallway. Observation confirmed E2 (DON) stated, "Ok I will take care of that now." 5/4/26 12:39 PM – E2 stated, "I got a bag I'm changing it now and making sure that it's covered. 5/11/26 2:20 PM – Findings were reviewed at the exit conference with E1 (NHA) and E2 (DON).	F0550		06/25/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- . . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience	F0605	F605 1. R14 had no negative effect. R14 PRN psychotropic was reviewed to assure that 14-day limitations and non-pharmacological interventions were addressed. 2. The facility has determined that all residents with orders for PRN psychotropic medications have the potential to be affected. A review of all prn psychotropic medication orders and indication for use was completed to ensure compliance with 14 day duration and non pharmacological interventions. 3. Root cause analysis was conducted and identified that providers and licensed nurses lacked understanding of the regulations related to unnecessary medication order. Staff educator/Designee will educate all licensed Nursing staff and providers regarding the regulation surrounding unnecessary medications and the importance of 14 day stop date and non-pharmacological interventions. Director of Nursing/Designee will review all PRN psychotropic medication orders in daily morning meeting to ensure a 14 day stop date and non pharmacological interventions are present. 4. The Director of Nursing/designee will complete	06/25/2026

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F0605 SS = D	Continued from page 15 and that are not required to treat the resident's medical symptoms. . . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an	F0605	Continued from page 15 audits to ensure that 14 day stop dates, and non-pharmacological interventions are clearly documented in the medical record for PRN psychotropic medications will be completed daily times 5 days until 100 % compliance achieved, then weekly times 4 weeks until 100% compliance achieved, monthly times 3 until 100 % compliance achieved or until sustained compliance is achieved. The audit findings will be reported to the QAPI Committee.	06/25/2026

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F0605 SS = D	Continued from page 16 effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R14) of six residents sampled for medication review, the facility failed to ensure a PRN medication was limited to a 14-day duration and failed to ensure that R14 was free from unnecessary medication. Findings include: Review of R14's clinical record revealed: 4/10/26 - R14 was admitted to the facility. 4/16/26 - A physician's order documented Ativan 0.5 mg: Give one tablet by mouth every 12 hours as needed for agitation for 14 days. 4/2026 - A review of the April MAR documented Ativan 0.5 mg PRN was administered on the following dates: 4/17/26 7:41 AM - No behaviors documented. 4/19/26 8:27 PM - No behaviors documented. 4/29/26 7:12 PM - No behaviors documented. 4/30/26 8:00 AM - No behaviors documented. 4/2026 - A review of the Nursing progress notes	F0605		06/25/2026

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F0605 SS = D	Continued from page 17 lacked evidence of non-pharmacological interventions used related to behaviors prior to PRN administration of Ativan for the aforementioned dates. 5/5/26 - A physician's order documented Ativan 0.5 mg: Give one tablet by mouth every 12 hours as needed for agitation. The stop date was documented as indefinite in the EMR. 5/2026 - A review of the May MAR documented Ativan 0.5 mg PRN was administered on the following dates: 5/6/26 7:39 AM - No behaviors documented. 5/2026 - A review of the Nursing progress notes lacked evidence of non-pharmacological interventions used related to behaviors prior to PRN administration of Ativan on 5/5/26. 5/6/26 10:44 AM - During an interview, E21 (CNA) stated that R14 had behaviors that required redirection and the expectation was to document in the EMR and also in the behavior charting book. 5/6/26 11:00 AM - A review of the behavior charting book lacked evidence of R14's behavior tracking sheet for the month of May. 5/6/26 1:54 PM - During an interview, E16 (LPN) stated that expectation was for a PRN medication to have a 14 day stop date and if the resident was still needing the medication the provider would be notified to re-evaluate for use. E16 also stated that prior to giving a PRN medication staff is expected to attempt redirection with non-pharmacological interventions and document what interventions were used and the effectiveness. 5/6/26 2:06 PM - During an interview, E17 (RN) stated the expectation was to document any behaviors, interventions used, the effectiveness, and any medication if needed in a progress note. E17 stated that R14 did not have a behavior monitoring sheet due to being a short term stay resident and did confirm that R14 did have behaviors since admission. E17 confirmed that the PRN Ativan order written on 5/5/25 did not have a 14 day stop date. 5/6/26 2:07 PM - During an interview, E19 (NP) and E22 (NP) stated that the Psych Provider was responsible for ordering any medications, determining the diagnosis, and sets the stop date. E19 stated the expectation was a 14 day stop date and then re-evaluate for continuing use of	F0605		06/25/2026

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F0605 SS = D	Continued from page 18 medication. E22 confirmed that the aforementioned PRN Ativan order indicated an indefinite stop date when input into the EMR. The facility failed to implement and document non-pharmacological interventions prior to use of a PRN psychotropic medication and failed to implement a 14 day stop date for a PRN psychotropic medication. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0605		06/25/2026
F0609 SS = D	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 and interview, it was determined that for one (R30) out of five residents reviewed for abuse, the facility failed to report an injury of unknown source to the State Agency within the required timeframe. Findings include:	F0609	F609 1. The facility cannot retroactively correct this issue. 2. The facility has determined that all residents with an injury of unknown origin have the potential to be affected. 3. A root cause analysis was conducted and it was found that the facilities nursing leadership recognized the resident's symptoms as a potential significant injury requiring medical evaluation; however, there was a failure to classify the injury as an "injury of unknown source involving serious bodily injury" requiring immediate State Agency notification. The specific requirement to report injuries of unknown source involving serious bodily injury within 2 hours was not recognized and acted on by nursing supervisors or nursing leadership. Actions taken to reduce the risk of future occurrence include implementation of a reportable event checklist for all incidents involving injuries of unknown source. QAPI nurse is responsible for creating and implementing this corrective action. Nursing supervisors are responsible for notifying Nurse Leadership of any potential reportable events and Nursing Leadership (DON, ADON) are responsible for reviewing the information and submitting reportable events to the state where applicable within the required timeframe. Staff educator/Designee in-servicing all licensed nursing staff and nursing administration on the importance of following reporting timeframes for injuries of unknown origin. 4.	06/25/2026

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F0609 SS = D	Continued from page 19 Review of R30's clinical record revealed: 4/1/23 - R30 was admitted to the facility. 3/8/26 1:00 PM - A facility reported incident documented that R30 had an injury of unknown origin determined by a positive x-ray report of a fractured right hip. 3/8/26 8:35 PM - A Radiology Results Report documented an acute fracture to R30's right hip. 3/9/26 12:59 AM - A facility reported incident was submitted to the State Agency 12 hours after incident occurred. 5/8/26 12:28 PM - During an interview, E2 (DON) confirmed that the aforementioned report was not submitted to the State Agency within the appropriate timeframe. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0609	Continued from page 19 The Director of Nursing Services, or designee, will conduct an audit of all injuries of unknown origin to ensure that the State Agency is notified within the required timeframe. Audits will be completed daily x 5 days or until 100 % compliance then weekly x 4 weeks or until 100% compliance is reached then monthly for 3 months or until 100 % compliance is achieved. The audit findings will be reported to the QAPI Committee.	06/25/2026
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or	F0657	1. R139 had no negative effect. The care plan for R139 has been updated to reflect that he does not comply with incontinence care and behavior of taking off the nasal cannula on placing on the floor. 2. Care plans for residents with known refusals in plan of care have been reviewed by director of nursing/designee and updated to accurately reflect residents' non-compliance. 3. The facility conducted a root cause analysis and determined there was a breakdown in the process for identifying, communicating, and incorporating recurring resident behaviors into the interdisciplinary care planning process. Staff were managing the behaviors through daily care practices; however, the behaviors were not escalated to the care plan team for review and revision. As a result, the care plan did not accurately reflect the resident's current needs, risks, and interventions. The Unit Nursing Manager and/or designee will review behavior documentation, oxygen therapy records, and significant nursing notes during routine care plan reviews to ensure identified resident needs	06/25/2026

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

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F0657 SS = D	Continued from page 20 as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review it was determined for one (R139) out of forty-one residents sampled for care plans the facility failed to review and revise R139's care plan to reflect R139's refusal of incontinence care and putting the nasal cannula on the floor. Findings include: Cross Refer F677 3/17/26 – R139 was admitted to the facility. 3/23/26 3:05 PM – A physician's order for R139 documented "Continuous 02 2L/min via NC may titrate 02 to maintain Sp02 > 92%." 5/4/26 10:55 AM – During an observation E18 (LPN) confirmed [R139] has behaviors and refuses incontinence care and also removes the nasal cannula and places it on the floor. E18 stated, "This occurs often as you can see [R139] is like this." 5/4/26 11:00 AM – A review of R139's care plan lacked the evidence of an actual problem that the resident refuses incontinence care and places the nasal cannula on the floor. 5/11/26 3:20 PM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0657	Continued from page 20 and behaviors are incorporated into the care plan. Staff educator/Designee will conduct in-services for licensed nursing staff/MDS coordinators/Social work on the importance of revising care plans to accurately reflect noncompliance when residents choose to not adhere to plan of care. 4. The director of nursing/designee will audit 5 care plans a day for 5 days or until 100% compliance to ensure that care plan accurately reflects any resident non-compliance with plan of care. Audits will be completed weekly times 4 weeks and monthly for 3 months until sustained compliance is achieved. The audit findings will be reported to the QAPI Committee.	06/25/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, and record review, it was determined that for two residents (R7 and R38) out of thirteen residents reviewed for Activities of Daily Living (ADLs), the facility failed to ensure grooming and personal care needs were met. The facility failed to provide nail grooming for R7 and failed to provide shaving for R38. Findings include:	F0677	F677 1. R7 and R38 had no negative impact. Nail care for R7 has been provided. Shaving for R38 was done. 2. All residents have the potential to be affected by this deficient practice. A facility sweep has been conducted for residents requiring assistance with nail care and shaving to ensure grooming and personal hygiene has been completed. 3. Root cause analysis was conducted and determined that inconsistent documentation and communication	06/25/2026

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F0677 SS = D	Continued from page 21 1. R7's clinical record revealed: 2/13/26 – R7 was admitted to the facility. 5/4/26 10:17 AM – Initial observation revealed R7's fingernails were long in length with dark encrusted debris underneath the nails on both hands. 5/5/26 8:40 AM – An observation revealed R7's fingernails remained untrimmed with dark encrusted debris underneath the nails on both hands. 5/5/26 2:10 PM – An observation revealed R7's fingernails remained untrimmed and dirty. 5/6/26 8:52 AM – An observation revealed R7 still had not been provided nail care. 5/6/26 1:57 PM – Another observation revealed R7 had not been provided nail care. 5/6/26 2:05 PM – During an interview E25 (CNA) reported during R7's AM care "I just wiped [R7's] hands of with the washcloth and I just wiped underneath the nails with the washcloth." E25 was asked if R7's fingernails were dirty and needed to be trimmed. E25 stated, "Yes [R7's] nails need to be cut and cleaned." E2 (DON) confirmed observation and then stated, "Ok we will take care of it now, so it doesn't go any further." 2. Review of R38's clinical record revealed: 3/23/26 - R38 was admitted to the facility with a diagnosis of COPD and muscle weakness 3/25/26 - R 38's annual MDS assessment documented that the resident required moderate assistance for personal hygiene. 3/25/26 - A review of R38's care plan documented that the resident has a self-care deficit for ADLs. 4/2026 - The CNA task flow sheet documented that R38 required moderate assistance for personal hygiene. 5/4/26 9:57 AM - An observation of R38's beard revealed it was long and unkempt, indicating he had not been shaved recently. 5/5/26 11:15 AM – An observation of R38's beard revealed it was long and unkempt. 5/6/26 10:00 AM – During an interview, R38 stated	F0677	Continued from page 21 regarding resident grooming preferences. Failure of nursing staff to consistently complete routine grooming tasks during daily care. Lack of supervisory oversight to ensure grooming needs were assessed, provided and documented according to resident preferences and care plans. Insufficient auditing of personal care and grooming services to identify missed opportunities. Staff educator/Designee will in-service direct care staff on the importance of ensuring nail care and grooming for dependent residents. A standardized grooming review process will be implemented by the Director of Nursing during daily clinical rounds and resident care observations. Unit managers will review ADL documentation routinely to ensure grooming services are completed and documented as required. 4. Random observation of dependent residents' nails and grooming will be conducted by DON/designee to ensure resident needs are met. Audits will be completed on 5 dependent residents daily x 5 days or until 100% compliance, then weekly x 4 weeks or until 100 % compliance, then monthly for 3 months or until 100 % compliance the audit findings will be reported to the QAPI Committee.	06/25/2026

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F0677 SS = D	Continued from page 22 he does not like having a beard and wanted to be shaved. 5/6/26 10:30 AM – During an interview with E4 (CNA) explained that when providing a bed bath, shower, or full bath, she always washes the residents' hair and checks their nails. She added that if the resident is male, she asks whether he needs to be shaved and provides shaving assistance if requested. 5/6/26 10:35 AM – During the interview, E5 (CNA) explained that she provides both showers and baths for residents, checks their nails, washes their hair when needed, and shaves male residents as part of her regular care routine. 5/6/26 10:35 - A confirming interview, E6 (RN) acknowledged R38 had not been shaved, and she would have him shaved immediately. 5/11/26 3:20 PM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0677		06/25/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R30) out of three residents reviewed for quality of care, the facility failed to ensure care/treatment in accordance with professional standards of practice. Review of R30's clinical record revealed: 4/1/23 - R30 was admitted to the facility. 3/8/26 10:48 AM - An SBAR (provider communication note) documented that R30 was observed with right hip discomfort and swelling noted. The SBAR also documented the provider was notified and awaiting a return call.	F0684	1. The facility cannot retroactively correct this issue. 2. All residents have the potential to be affected. An audit of all residents experiencing a significant change in condition, injury, fall, suspected fracture or emergency transfer within the previous 30 days was conducted to ensure appropriate assessment, physician notification, diagnostic follow up and timely transfer. 3. Root cause analysis was conducted, and it was determined that staff failed to follow the facility change in condition protocol when significant signs and symptoms of a possible fracture were identified. Staff inadequately communicated and escalated the resident's condition to Nurse Leadership ensuring that suspected fractures or acute injuries where clinically indicated require transfer to hospital. A process will be implemented requiring Nurse Supervisors to monitor diagnostic testing results in Electronic Health Records System every 2 hours	06/25/2026

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F0684 SS = D	Continued from page 23 3/8/26 3:22 PM - A telephone physician's order for R30 documented diagnostic imaging x-ray of bilateral hips with two views. 3/8/26 8:35 PM - A radiology results report documented that x-ray was obtained and completed at 5:03 PM on 3/8/26. The results indicated and acute fracture of R30's right hip. 3/8/26 11:09 PM - A nursing progress note documented that R30 had a positive fracture to the right hip and was sent to the hospital for further evaluation. 5/8/26 10:13 AM - At this time multiple attempts were made to contact E28 (LPN) to determine the time line of events regarding R30's change in status and were unsuccessful. 5/8/26 10:24 AM - During an interview, E14 (CNA) stated when providing care to R30 on 3/8/26 she noticed R30 was showing signs and symptoms of pain when turning during incontinence care. E14 stated that R30's right hip was not sitting evenly with the left hip when she was laying supine in the bed and that the resident was grimacing while receiving care. E14 stated she reported her observations to the nurse on duty after completing care. 5/8/26 10:51 AM - During an interview, C2 (Technician) confirmed they [mobile diagnostic imaging] received the physician's order for x-ray at 3:22 PM on 3/8/26, x-ray was completed at 5:03 PM, and the results were sent to the facility at 8:35 PM on 3/8/26. 5/8/26 12:28 PM - During an interview, E2 (DON) confirmed that R30 had a positive x-ray for right hip fracture and was sent to the hospital for treatment. It was unclear based on interview and record review why the facility sent R30 to the hospital 15 hours after change in condition was observed. This resulted in R30 not receiving care in a timely manner. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0684	Continued from page 23 ensuring a timely review of all STAT and urgent diagnostic results. Nurse supervisor will call physicians upon receipt of diagnostic test results for review of results and any new orders. Nursing supervisors will review all significant changes in condition during daily clinical meetings to verify appropriate interventions and follow up. Staff educator/Designee will educate licensed nurses on the importance of timely response to change in condition and follow up of diagnostic reports including transfer to hospital if needed. 4. Director of Nursing/Designee will audit 5 radiology results daily to ensure that timely response and follow up including transfer to hospital if needed are completed. Audits will be completed daily x 5 days or until 100 % compliance then weekly times 4 weeks or until 100 % compliance then monthly for 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee.	06/25/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F0686	1. Unit Manager/RN conducted new Braden scale for resident R58 on 5/12. The Physician Order for R58 was reviewed and revised to reflect the increased	06/25/2026

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F0686 SS = D	Continued from page 24 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R58) out of two residents reviewed for pressure ulcers the facility failed to ensure implementation of interventions to promote healing. Findings include: Undated - The facility policy on pressure ulcers indicated, "Interventions will be implemented in accordance with physician's orders. Interventions will be documented in the care plan and communicated to all relevant staff." Review of R58's clinical record revealed: 3/17/26 - R58 was admitted to the facility. 3/18/26 - A wound care assessment report documented that R58 was admitted to the facility with a Stage 2 pressure ulcer to the sacrum [tail bone]. measuring 4.5 cm x .3 cm x .1 cm. 3/19/26 - A care plan for impaired skin was created that included the intervention to reassess skin risk per protocol. Additionally, a care plan for risk of nutritional deficit was created that included the intervention to provide nutrition relevant medications and supplements as ordered. 3/19/26 - A physician's order was written for R58 to receive liquid protein supplements daily.	F0686	Continued from page 24 liquid protein need to promote wound healing. 2. Residents with pressure ulcers have the potential to be affected by this issue. An audit was conducted on all residents with existing pressure ulcers to ensure accuracy of Braden scale assessments, physician orders, care plan and implementation of interventions. 3. A root cause analysis was done, and it was determined that nursing staff failed to accurately complete Braden Scale assessments due to thorough skin check not being completed at time of form completion. Nurse leadership team failed to validate the accuracy of assessment. Breakdown occurred in communication and follow-through to ensure protein supplements were increased as recommended due to the wound report which includes Wound NP recommendations not being thoroughly reviewed by facility Wound Nurse and NP. Insufficient oversight by nurse leadership team to ensure all interventions were implemented timely. Facility will implement a wound recommendation tracking process requiring all wound care recommendations to be reviewed by the clinical team and reconciled with physician orders. This process will be managed by the Assistant Director of Nursing. The Wound NP written reports which include all recommendations will be brought to daily clinical meetings where dietician and other members of the Interdisciplinary Team during will review all recommendations with physician to obtain new orders where appropriate and implement. Director of Nursing/Designee will in-service Wound consultant and dietician on importance of communicating new interventions to promote wound healing and assuring physician orders reflects the interventions 4. The Director of Nursing/Designee will conduct audits for 5 residents with pressure ulcers to ensure recommended nourishment orders are implemented. Audits will be completed daily x 5 days until 100 % compliance then weekly x 4 weeks until 100 % compliance then monthly x 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee.	06/25/2026

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F0686 SS = D	Continued from page 25 3/23/26 - An admission MDS assessment documented that R58 was admitted to the facility with a stage 2 pressure ulcer to the sacrum. R58 was assessed as always incontinent of bowel and bladder and dependent for toileting. Substantial maximal assistance was needed for R58 to move in bed. 3/26/26 - A Braden scale assessment documented a score of 18 indicating at minimal risk for pressure ulcer development. The score was based on the assessment that R58's skin was only occasionally moist and had no limitation with mobility. 3/31/26 - A Braden scale assessment documented a score of 18 indicating at minimal risk for pressure ulcer development. The score was based on the assessment that R58's skin was only occasionally moist, had no limitation with mobility and had not apparent problem with friction or shear moved in bed independently. 4/7/26 - A Braden scale assessment documented that R58 was a score of 18 indicating at minimal risk for pressure ulcer development. The score was based on the assessment that R58's skin was rarely moist and had no limitation with mobility. 4/29/26 - A wound care assessment report and corresponding progress note documented a recommendation from E20 (NP) contracted to care for R58's pressure ulcer, to increase R58's physicians order for liquid protein to twice a day. Review of R58's physician's orders lacked evidence the order was written. 5/7/26 2:06 PM - During an interview with both E2 (DON) and E19 (NP), E2 confirmed the inaccuracy of the Braden scale skin assessments and the delay of implementing the recommended and nourishment orders to promote healing of R58's pressure ulcer. E2 stated, "yes we should have done this". E19 (NP) reported that R58's pressure ulcers "healing is stalled because of her age and other comorbidities", R58 is one hundred and one years old. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0686		06/25/2026

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EVERGREEN POST ACUTE	3034 SOUTH DUPONT BLVD , SMYRNA, Delaware, 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for two (R1 and R139) out of two residents reviewed for respiratory care, the facility failed to ensure R1's nebulizer tubing was changed as ordered and R139's nebulizer equipment was dated and placed in protective bagging when not in use. Findings include: 1. A review of R1's clinical record revealed: 1/21/26 – R1 was admitted to the facility. 4/30/26 – R1 was readmitted to the facility with new diagnoses of acute respiratory distress and pneumonia due to inhalation of food. 5/1/26 – A physician's order for R1 documented to inhale a respiratory treatment, albuterol sulfate, orally by nebulizer every 8 hours for shortness of breath. May 2026 – The medication administration record documented that R1 received the albuterol sulfate by nebulizer at 12:00 AM, 8:00 AM and 4:00 PM on 5/1/26, 5/2/26, 5/3/26 and 5/4/26. 5/4/26 10:13 AM – An observation of R1's room revealed that R1's nebulizer was sitting next to the bed with the mask in a protective bag. The nebulizer tubing was dated 3/29/26. 5/4/26 10:20 AM – During an interview, E17 (UM) stated that nurses administer respiratory treatments. She mentioned that tubing and masks are replaced weekly. She confirmed that R1's nebulizer tubing was dated 3/29/26 and stated that he had recently returned from the hospital. 2. R139's clinical record revealed:	F0695	1. R1 and R139 had no negative impact. The Director of Nursing/designee changed R1's nebulizer tubing as per facility protocol and the Director of Nursing ensured 139's nebulizer tubing was changed, dated and bagged. 2. The facility has determined that all residents with nebulizer treatment orders have the potential to be affected. The Director of Nursing reviewed each resident with physician ordered nebulizer treatment to ensure the tubing is changed and dated and bagged when not in use. 3. Root cause analysis identified that staff lacked understanding of the importance of following protocol with changing, dating and placing nebulizer in a bag when not in use. In service for licensed nursing staff will be conducted by Staff educator /Designee on the importance of following facility protocol related to nebulizer tubing change and dating and bagging when not in use. Daily Unit Manager rounding tool will include ensuring that all tubing is changed, dated and bagged. 4. The Director of Nursing Services (DON), or designee, will conduct observations of residents with orders for a nebulizer treatment to ensure tubing is changed, dated and bagged when not in use. 5 audits will be completed daily x 5 days weekly or until 100% compliance then weekly x 4 weeks or until 100 % compliance and then monthly x 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee.	06/25/2026

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F0695 SS = D	Continued from page 27 3/17/26 – R139 was admitted to the facility. 5/4/26 10:55 AM – An observation and interview, revealed R139's nebulizer tubing and mask were sitting on a chair next to the bed. The mask and tubing were not placed in a protective bag and was not dated. E18 (LPN) confirmed and stated, "Oh, yes no ok I will take care of that it should be in a bag and dated." In addition, R139's clinical record lacked evidence of an order to date and place the nebulizer mask and tubing in a bag when not in use. 5/11/26 3:20 PM – Findings were reviewed at the exit conference with E1 (NHA) and E2 (DON).	F0695		06/25/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F0755	1. The facility cannot retroactively correct this issue. 2. New admission residents with IV antibiotic orders have the potential to be affected by this practice. An audit of MARs of new admissions in the last 7 days was conducted to identify any medication unavailability. Any issues will be addressed with the physician. 3. A root cause analysis identified that pharmacy deliveries were delayed after order was placed for new medication to be administered to residents. When medication delivery was delayed staff did not escalate to Director of Nursing the pharmacy nor was pharmacy rep called to help expedite delivery of medication. Pharmacy now delivers from a closer distribution center to mitigate delays with delivering ordered medication. Director of Nursing will review medication administration report generated by our electronic medical record system daily to identify and address any delays in receiving ordered medication. Staff educator/Designee will educate licensed nurses on the importance of following medication ordering process for new admissions and notifying physicians of any unavailability. 4. The Director of Nursing Services (DON), or designee, will complete Medication Administration Record Audits for 5 new admissions to ensure medications	06/25/2026

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F0755 SS = D	Continued from page 28 This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R153) out of six residents reviewed for pharmacy services, the facility failed to provide pharmaceutical services to meet the needs of each resident. Findings include: Review of R153's clinical record revealed: 1/9/26 - R153 was admitted to the facility. 1/9/26 - A physician's order documented nafcillin sodium (antibiotic) in dextrose intravenous solution 2GM/100mL: Use 2 gram intravenously every 8 hours for pneumonia for 15 days. 1/10/26 - A review of the January MAR documented "H" on the aforementioned nafcillin order for 12:00 AM and 8:00 AM dose due to medication not available from pharmacy. The MAR lacked evidence of a hold order for the dose on 1/9/26 at 4:00 PM. 1/13/26 - A physician's order documented cefazolin sodium injection solution 2 GM: Use 2 gram intravenously three times a day for endocarditis and bacteremia prophylaxis. 1/13/26 11:41 PM - A progress note documented that cefazolin was on order from the pharmacy. The MAR documented "8" for the 10:00 PM dose with the aforementioned progress note. 5/8/26 12:10 PM - During an interview, C1 (Pharmacy) confirmed that the nafcillin was delivered on 1/10/26 and the cefazolin was delivered on 1/14/26 by the pharmacy currier. 5/8/26 1:36 PM - During an interview, E26 (LPN) stated the admitting nurse was responsible for calling pharmacy regarding any new medication orders from admission. E26 stated at times medications would have to be requested STAT (immediately) to receive them from pharmacy quickly. E26 stated she did not recall if there was a delay in receiving R153's IV medications. 5/8/26 1:49 PM - During an interview, E27 (LPN) stated she assisted in admitting R153 to the facility and cannot recall if there was any issue receiving R153's medications. E27 stated they do have medication on site in the back up pharmacy if its needed, but it has limited options of medications. 5/8/26 2:02 PM - During an interview, E2 (DON) stated the facility was having issues with the	F0755	Continued from page 28 are available from pharmacy. Audits will be completed daily x 5 days or until 100% compliance then weekly x 4 weeks or until 100% compliance then monthly x 3 months or until 100% compliance is achieved. The audit findings will be reported to the QAPI Committee.	06/25/2026

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F0755 SS = D	Continued from page 29 pharmacy and deliveries delayed for the medications. E2 confirmed that R153's delay in delivery was around the time the facility was experiencing delays, which resulted in the facility switching locations of pharmacy delivery. 5/11/26 1:30 PM - During an interview, E19 (NP) stated that the antibiotics R153 were ordered by the provider at the hospital and would have had to be ordered from pharmacy. E19 confirmed that he approved medications to be held due to the delay in delivery from pharmacy. 5/11/26 3:20 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0755		06/25/2026