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: The Center at Eden Hill

DATE SURVEY COMPLETED: May 22, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual Survey was conducted at this facility from May 18, 2026, through May 22, 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 seventy-five (75). The survey sample totaled twenty-eight (28) 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 22, 2026: F656, F684, F692, F755, F757 and F880.		

Provider's Signature _____ Title NHA/ED Date 6/16/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085057	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTER AT EDEN HILL, LLC	**300 BANNING STREET , DOVER, Delaware, 19904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from May 18, 2026 through May 22, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		07/01/2026
F0000	INITIAL COMMENTS An unannounced Annual and Survey was conducted at this facility from May 18, 2026, through May 22, 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 seventy-five (75). The survey sample totaled twenty-eight (28) 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; ADL - Activities of Daily Living - description for daily care including bathing, dressing, toileting, eating and mobility; Cardiac rhythm disturbance - an abnormal rhythm of the heartbeat caused by irregularities in the conduction, generation or timing of the electrical impulses that normally control heart rate and rhythm; C. diff (Clostridioides difficile) - a highly contagious bacterium that infects the large intestine (colon); Doff - to take off;	F0000		07/01/2026

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

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

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F0000	Continued from page 1 Don - to put on; Gastroenteritis - inflammation of the stomach and intestines; Isopropyl alcohol - a common chemical used as an antiseptic to clean the skin. It is also found in hand sanitizers and is used in hospitals to sterilize tools; Laxative - a medicine, or substance that prevents or treats constipation by loosening the stool and promoting bowel movements; MAR - Medication Administration Record - documentation of medications given to each resident; PPE (Personal Protective Equipment) - is the specialized gear worn to create a physical barrier between a person and dangerous germs, chemicals, or hazards; POC - Point of Care - responses that document ADL care given to each resident usually by the CNA; Stool - the solid waste matter that your body expels after it digests food; TLSO brace -Thoracic-lumbar-sacral orthosis, is a spinal brace designed to support and stabilize the thoracic, lumbar, and sacral regions of the spine.	F0000		07/01/2026
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F0880	A. Infection Preventionist (IP) educated E6 on the single use, disposable equipment in R63's room on 5/19/26. IP also placed appropriate C.diff disinfectant bleach wipes on the isolation cart outside R63's room on 5/19/26. B. All residents on transmission-based precautions, including strict isolation for C. diff, have the potential to be affected by this deficient practice. Infection Preventionist or designee will complete a facility wide audit by 6/26/26 to ensure residents on transmission-based precautions have appropriate single patient use equipment available and that appropriate disinfectant wipes are available when reusable equipment must be used. C. A root cause analysis, completed on 6/15/26, determined that facility staff required additional education regarding single patient use equipment and the appropriate cleaning/disinfection process for	07/01/2026

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F0880 SS = E	Continued from page 2 and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (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.	F0880	Continued from page 2 reusable equipment used for residents on strict isolation for C. diff. Moving forward, the Infection Preventionist or designee will ensure that all residents placed on strict isolation for C. diff have single patient use equipment available and, when not available, appropriate bleach wipes are available for disinfection of reusable equipment prior to use by another resident. Director of Nursing or designee will educate all facility staff regarding single patient use equipment, appropriate use of shared equipment, PPE, hand hygiene, and disinfectant requirements for residents on C. diff precautions by 7/1/26. Director of Nursing or designee will also provide education to newly hired nursing staff as part of the orientation and onboarding process. D. Director of Nursing, Infection Preventionist, or designee will complete daily audits of residents on transmission-based precautions to ensure single patient use equipment is available and/or appropriate disinfectant wipes are available and used when reusable equipment is necessary. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	07/01/2026

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F0880 SS = E	Continued from page 3 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for one (R63) out of six residents reviewed for infection control, the facility failed to use appropriate infection control practices. For R63 when cleaning/disinfecting reusable resident medical equipment. Findings include: Review of the facility's policy and procedure titled, "C. diff Infection Precautions," last updated 4/15/26, documented, "... equipment should be cleaned and disinfected according to facility policy using an appropriate disinfectant for C. diff...". 1. 4/17/26 – R63 was admitted to the facility. 5/16/26 6:42 PM – A physician ordered to collect blood and stool to rule out Clostridioides difficile (C. difficile) for low-grade temperature for one day for R63. 5/18/26 10:35 AM – A physician ordered diarrhea isolation precautions for R63 following three episodes of diarrhea. The order included 24-hour strict isolation with services provided in a single room, holding laxatives, notifying the physician, obtaining stool specimens, and monitoring each shift to rule out C. difficile. The preliminary diagnosis was acute infectious viral gastroenteritis. 5/18/26 5:18 PM – The stool test results for R63 were that C. difficile was detected.5/18/26 5:59 PM – A physician ordered strict contact transmission-based precautions for R63 due to C. difficile, requiring all care and services to be provided in the resident's room each shift through 6/2/26 at 11:59 PM. 5/19/26 12:05 PM – During a medication pass, E5 (LPN) and E6 (LPN orienting) revealed that a blood pressure was needed to determine if a medication was to be given to R63. E5 asked E6 to get the blood pressure for R63. An observation was made in which E6 took the vital-sign machine, which is used on all residents, donned appropriate PPE, and entered R63's room. E6 proceeded to take the blood pressure for R63, doffed the PPE, performed hand hygiene, put on clean gloves, and cleaned the vital sign machine and all equipment with a cleaning agent containing isopropyl alcohol. E6 returned the vital-sign machine to the hallway for use by other	F0880		07/01/2026

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F0880 SS = E	Continued from page 4 residents. During an interview, E5 stated that R63 is on contact precautions for confirmed C. difficile. 5/19/26 3:01 PM – During an interview, E5 stated the shared vital sign machine should have been disinfected with bleach wipes after use for R63. E5 reported disposable equipment was available in R63's room and indicated there was no need for the shared vital sign machine to enter the room.	F0880		07/01/2026
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.	F0656	A. R108 did not reside in the facility at time of survey, therefore facility was unable to correct the deficient practice. B. The Nursing Supervisor completed a facility wide audit on 5/21/26 of all current residents with TLSO braces, orthopedic braces, splints, or other ordered assistive/supportive devices to ensure each resident has an individualized care plan and corresponding order addressing use, application, positioning, skin monitoring, and resident-specific instructions. C. A root cause analysis, completed on 6/15/26, determined that the facility did not have a standardized process to ensure residents admitted with TLSO braces or other braces had corresponding individualized care plans with interventions for application, positioning, and tightness. Moving forward, upon identifying the resident has a TLSO, or other ordered brace, the assessing therapist or designee will place an order and initiate the care plan. All TLSO brace care plans and orders will be reviewed every Wednesday during UR by the IDT team to ensure accuracy. Director of Nursing or designee will educate all nursing and therapy staff regarding TLSO brace application, positioning, tightness, documentation, and care plan requirements by 7/1/26. Education for the patient specific TLSO brace will be based on provider orders and manufacturer's instructions. Director of Nursing or designee will also provide education to newly hired nursing and therapy staff as part of the orientation and onboarding process. D. The MDS Coordinator or designee will complete daily audits in morning clinical meeting to review all new admissions with braces to ensure a corresponding order and individualized care plan are in place. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed until	07/01/2026

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F0656 SS = D	Continued from page 5 (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R108) out of twenty-eight sampled residents the facility failed to create an individualized care plan to address R108's use of a specialized TLSO brace. Findings include: 7/18/25 - R108 was admitted to the facility with multiple diagnoses including a broken bone in her back [lumbar]. 7/21/25 - Care plans were initiated for R108. Review of the care plans lacked evidence of a care plan created for R108's TLSO brace. 7/22/25 - An admission MDS assessment documented that R108 had fractures as active diagnoses and required partial moderate assistance with upper body dressing. 8/20/25 8:52 PM - A neurologist consultant appointment note in R108's clinical record documented, "continue to wear brace, must be supporting of her lumbar spine." 8/25/25 - A physician's progress note in R108's clinical record documented, "Patient had L1 compression fracture. Patient was evaluated at bedside, stating that she is feeling weak. She has a (TLSO) brace, seems to be very wide as it is going to her chest. Also, she is not strong enough to able to apply a very tightly, which may be impeding her healing of the fracture." July 2025 - POC documentation attested to application of the TLSO brace at all times. August 2025 - POC documentation attested to application of the TLSO brace at all times.	F0656	Continued from page 5 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	07/01/2026

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F0656 SS = D	Continued from page 6 5/22/26 12:11 PM - During an interview E4 (CNA) reported that in general instruction about TLSO braces is through verbal report. 5/22/26 2:54 PM - During an interview E2 (DON) confirmed that the facility failed to develop a care plan related to R108's use of the TLSO brace and interventions for its application, positioning and tightness for desired outcome. 5/22/26 3:40 PM - Findings were reviewed at the exit conference with E1 (NHA) and E2 (DON).	F0656		07/01/2026
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 (R108) out of four residents reviewed for hospitalization the facility failed to ensure that the residents discharge medication orders were correctly transcribed. The incorrect transcription resulted in the administration of a decreased dosage of R108's antidepressant medication. Findings include: Review of R108's clinical record revealed: 7/14/25 – 7/18/25 – R108 was hospitalized. Discharge instructions dated 7/18/25 directed that R108 continue prescribed medications, including fluoxetine 20 mg daily for depression. 7/18/25 - R108 was admitted to the facility with multiple diagnoses including depression. 7/19/25 - A physician's order was written for R108	F0684	A. R108's Fluoxtine was increased to the correct dose on 8/4/25 by the Attending Physician. R108 was not a resident during the time of the survey. B. Director of Nursing or designee will complete a facility wide audit by 6/19/26 of current residents admitted or readmitted from the hospital within the past 30 days to ensure discharge medication orders were accurately transcribed into PCC and that any discrepancies were clarified with the provider. C. A root cause analysis, completed on 6/15/26, determined that nursing staff required additional education and that the facility needed a strengthened process for new admission order transcription and verification for accuracy. Moving forward, the admitting RN will enter admission orders into PCC. Two nurses will then verify that orders were transcribed correctly against the hospital discharge paperwork/AVS and will sign on the MAR to validate completion of the order verification process. Two nurse managers will audit the AVS against the active orders in PCC on the next business day to ensure accuracy and timely correction of any discrepancy. The Director of Nursing or designee will educate all nursing staff regarding new admission order transcription, two nurse verification, MAR validation, and nurse manager next-business-day audit requirements by 7/1/26. Director of Nursing or designee will also provide education to newly hired nursing staff as part of the orientation and onboarding process. D. Director of Nursing or designee will complete daily audits of new admissions/readmissions to ensure admission orders were accurately	07/01/2026

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F0684 SS = D	Continued from page 7 to receive fluoxetine 10 mg daily for depression. The clinical record was unclear why the antidepressant medication dosage was reduced from the order on the discharge documentation. 7/22/25 - An Admission MDS assessment documented that R108 had a diagnosis of depression and received antidepressant medication. 7/24/25 - An initial psychology visit note documented that R108 had "mild depression". 7/26/25 - A care plan for depression was created for R108 with the intervention to administer medication according to physician's order. July 2025 - Review of R108's MAR revealed thirteen doses of fluoxetine 10 mg given. August 2025 - Review of R108's MAR revealed four doses of fluoxetine 10 mg given. 8/4/25 - A psychiatry progress note in R108's clinical record documented "Depression/Anxiety. Change fluoxetine to 20 mg to target mood." 8/4/25 - A physician's order was written to increase R108's fluoxetine from 10 mg daily to 20 mg daily for depression. 8/4/25 - 4:11 PM - A progress note in R108's clinical record documented, "Per daughter the patient is on 20 mg of [fluoxetine], records review noted a transcription error and daughter was made aware of this and attending physicians as well as Psych NP was notified and the medication was updated to the home does of 20 mg daily." 5/22/26 2:54 PM - E2 (DON) confirmed that the facility failed to correctly transcribe the initial order for R108's antidepressant medication resulting in seventeen undermedicated doses. 5/22/26 3:40 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0684	Continued from page 7 transcribed, verified by two nurses, and reviewed by two nurse managers on the next business day. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	07/01/2026

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F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interview it was determined that for one (R94) out of two residents reviewed for urinary tract infections the facility failed to ensure that a resident with a urinary catheter remained free of infection. Findings include: John Hopkins medical center guidelines regarding antibiotic stewardship for UTI indicated, "Enterococcus [bacteria] can be a contaminant or colonizer, particularly in patients with urinary catheters or multiple organisms growing in urine culture. https://www.hopkinsmedicine.org/-/media/antimic	F0690	A. R94 was provided catheter care by the Licensed Practical Nurse on 5/22/26. Licensed Practical Nurse replaced the patient's catheter bag and ensured proper positioning of the catheter bag and privacy cover on 5/21/26. B. Director of Nursing, Infection Preventionist, or designee will complete a facility wide audit of all residents with indwelling catheters by 6/26/26 to ensure catheter care is ordered, completed, and documented as ordered; the catheter drainage bag is maintained below bladder level; the drainage bag is not placed on the floor; and catheter-related signs and symptoms are monitored and reported as clinically indicated. C. A root cause analysis, completed on 6/15/26, determined that nursing staff required additional education regarding catheter care, catheter drainage bag positioning, documentation of catheter care, and CAUTI prevention practices. The RCA also determined that providers required additional education regarding colonization versus active infection and treatment criteria for urinary tract infections. Director of Nursing or designee will provide education to nursing staff by 7/1/26 in regards to providing catheter care every shift and as needed, maintaining the drainage bag below bladder level and off the floor, maintaining dignity/privacy bag positioning, documenting catheter care as ordered, and reporting abnormal findings. The Medical Director or designee will provide education to providers regarding colonization versus active infection and treatment criteria by 7/1/26. Director of Nursing or designee will also provide catheter care education to newly hired nursing staff and provider education to newly credentialed providers as part of the orientation and onboarding process. D. Director of Nursing, Infection Preventionist, or designee will complete daily audits of residents with indwelling catheters to ensure catheter care is completed and documented, the catheter drainage bag is below bladder level and off the floor, and abnormal findings are reported and addressed. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	07/01/2026

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F0690 SS = D	Continued from page 9 robial-stewardship/bacterial_uti_guidelines.pdf. 3/28/25 - The facility policy on Foley catheter care indicated, "Foley catheter care will be provided routinely and as needed according to facility practice, infection control standards, and applicable clinical guidance...The drainage bag will be kept below the level of the bladder when feasible and will not be placed on the floor. " Review of R94's clinical record revealed; 4/15/26 - R94 was admitted to the facility. 4/15/26 - A physician order was written for R94 to receive Foley catheter care each shift and as needed for foley catheter maintenance. 5/11/26 - A progress note in R94's clinical record written by E13 (NP) documented, "Chief Complaint / Nature of Presenting Problem: altered mental status, back pain. Patient seen today resting in bed, noted with some confusion. Advised patient will order urinalysis culture and sensitivity." 5/12/26 - A progress note in R94's clinical record written by E13 (NP) documented, "Urinalysis showed some markers of infection. Will send urine culture and empirically start on Vantin (antibiotic)." 5/13/26 - A physician's order was written for R94 to receive Vantin an antibiotic for treatment of a UTI twice a day for seven days. 5/14/26 - Urinalysis culture and sensitivity test reported enterococcus faecalis (bacteria) in R94's urine in an amount that indicated an infection with a sensitivity to Penicillin. 5/15/26 - A physician's order was written for R94 to receive penicillin an antibiotic for treatment of a UTI four times a day for seven days. April 2025 - Review of R94's TAR lacked evidence that catheter care was completed the following shifts below:	F0690		07/01/2026

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F0690 SS = D	Continued from page 10 4/15 night 4/16 evening 4/19 evening 4/23 evening 4/24 night 4/29 night. May 2025 - Review of R94's TAR lacked evidence that catheter care was completed the following shifts below: 5/2 evening 5/4 night 5/6 day 5/6 evening 5/9 evening 5/9 night 5/11 night 5/18 night. 5/19/26 11:19 AM - During a random observation R94's foley catheter bag was observed directly on the floor, privacy bag was askew allowing bag to be directly on the floor. Observation immediately confirmed by E12 (RN). 5/19/26 2:35 PM - During an interview E3 (ICP and ADON) confirmed that R94's foley catheter should not have been on the floor and that catheter care is to be completed as ordered. 5/22/26 3:40 PM -Findings were reviewed the exit conference with E1 (NHA) and E2 (DON).	F0690		07/01/2026
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	F0755	A. R77 received Clonazepam as ordered starting on 4/6/26. R77 was assessed by Psychiatric Nurse Practitioner on 4/13/26 to ensure the deficient practice did not negatively impact the patient. R2 received the Quetiapine as ordered starting on 4/10/26 and was assessed by the Psychiatric Nurse Practitioner on 4/13/26.	07/01/2026

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F0755 SS = D	Continued from page 11 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. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for two (R77 and R2) out of six residents reviewed for unnecessary medications the facility failed to ensure prompt pharmacy services were provided to newly admitted residents resulting in missed doses of medications. Findings include: 3/28/24 - The facility policy for admissions documented that persons will be accepted for admission only if the services and or care provided can reasonably be provided. 1. Review of R77s' clinical record revealed: 4/4/26 8:00 PM - R77 was admitted to the facility with multiple diagnoses including anxiety. 4/4/26 - A physician's order was written for R77 to receive clonazepam twice daily for anxiety.	F0755	Continued from page 11 B. Director of Nursing or designee will complete a facility wide audit of residents admitted within the past 30 days receiving controlled medications, antipsychotic medications, or other time-sensitive medications by 6/26/26 to ensure medications are available, valid prescriptions are on file when required, and any unavailable medication was escalated timely to the appropriate party. C. A root cause analysis, completed on 6/15/26, determined that the facility did not have a standardized process to ensure valid prescriptions and medication availability were confirmed timely for newly admitted residents. Moving forward, the provider reviewing admission medications will ensure that controlled medications have valid prescriptions sent to the pharmacy immediately. The two nurses verifying admission orders will confirm with the pharmacy that valid prescriptions have been received for all controlled substances. If the prescription is not valid, the nurse will contact the provider. If the provider cannot be reached within one hour, the DON or designee will be contacted to obtain the prescription either from the attending physician or the Medical Director. Nursing staff will be educated on medications available in the Cubex system on site, and the process to access available emergency medications. For antipsychotic medications such as quetiapine, and other time-sensitive medications as clinically indicated, the nurse entering the orders will communicate the order as STAT to pharmacy to prevent missed doses. Director of Nursing or designee will educate all nursing staff and providers regarding this process by 7/1/26. Director of Nursing or designee will also provide education to newly hired nursing staff and newly credentialed providers as part of the orientation and onboarding process. D. Director of Nursing or designee will complete daily audits of new admissions to ensure admission medications are available, controlled medication prescriptions are valid when required, unavailable medications are escalated timely, and no medication doses are missed due to pharmacy/prescription delay without appropriate follow up. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was	07/01/2026

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F0755 SS = D	Continued from page 12 4/4/26 11:24 PM - A progress note in R77's clinical record documented that the resident was not given their ordered clonazepam because staff was "waiting for pharmacy to clear order". 4/5/26 8:07 AM - A progress note in R77's clinical record documented that the resident was not given their ordered clonazepam because pharmacy was "awaiting signature." 4/5/26 10:48 PM - A progress note in R77's clinical record documented "Medication not available. Called pharmacy, prescription on file not valid. Called team health, spoke with NP and requested script to be sent to pharmacy. NP herself was unable to send prescription but will attempt to get peer to send script to pharmacy. Provided with pharmacy phone and fax numbers." April 2026 - Review of R77's MAR revealed missed doses of the resident's anxiety medication on the following dates/times: 4/4 - 10:00 PM 4/5 - 8:00 AM 4/5 - 10:00 PM. 4/6/26 - A pharmacy invoice of delivered medications documented arrival of R77's clonazepam. 5/18/26 9:45 AM - During an interview R77 stated, "They stopped my medication I have severe anxiety. They stopped my Klonopin/clonazepam for no reason when I came." 2. Review of the Medex Drug information website revealed, "Missing doses of quetiapine significantly increases the risk of relapse for conditions like schizophrenia and bipolar disorder. Understanding what happens if you miss doses of quetiapine is crucial for managing your mental health effectively and preventing complications. What Happens if you Miss Doses of Quetiapine?" medexdrg.com. Review of R2's clinical record revealed;	F0755	Continued from page 12 successfully addressed.	07/01/2026

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F0755 SS = D	Continued from page 13 4/8/26 3:24 PM - R2 was admitted to the facility with multiple diagnoses including Major Depressive and Mood disorder. 4/8/26 - A physician's order was written for R2 to receive quetiapine an antipsychotic medication daily at 9:00 PM for mood disorder. 4/9/26 3:22 AM - A progress note in R2's clinical record documented that R2 did not receive the quetiapine because it was not yet delivered from the pharmacy. 4/9/26 3:33 PM - A pharmacy invoice of delivered medications documented that R2's quetiapine was delivered. 4/9/26 - 11:49 PM - A progress note in R2's clinical record documented that R2 did not receive the quetiapine because it was not yet delivered from the pharmacy. 4/14/26 - An admission MDS assessment documented that R2 received antipsychotic medications. 4/14/26 - A care plan was created for R2's use of antipsychotic medications. April 2026 - Review of R2's MAR lacked evidence that R2 received the ordered quetiapine on 4/8 and 4/9. 5/20/26 10:51 AM - During an interview E15 (RNUM) confirmed that R2's medications were not administered for two doses. E15 stated if we call the pharmacy before 6:00 PM then they will deliver by the next day. During the same interview E15 (RN) and staff developer reported, "if it is a STAT medication than we can usually get it right away but most medications come the following morning. 5/20/26 10:56 AM - During an interview E8 (LPN) confirmed that at times newly admitted residents do not have all their medications. E8 stated, "We then	F0755		07/01/2026

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F0755 SS = D	Continued from page 14 go to back up and tell the supervisor." 5/20/26 10:59 AM - During an interview E14 (LPN) confirmed that sometimes newly admitted residents do not have all their medications. E14 stated, "When they don't we check the emergency box to see if any of the medication is there. We call the doctor to see if we can get a hold." Review of the facilities emergency medication inventory list revealed that quetiapine is not a medication stored int he emergency box. 5/21/26 11:52 AM - During an interview E2 (DON) confirmed that pharmacy delivery for new residents can be "24 to 48 hours" resulting in missed dosages of medication for R2 and R77. E2 stated, "The delivery run is 11:00 AM and 3:00 AM and something in the afternoon. Our pharmacy is in Baltimore so it takes time." 5/22/25 3:40 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0755		07/01/2026
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F0757	A. R1 was evaluated by Physician Assistant on 5/20/26 to ensure the deficient practice did not have any negative impact. B. Director of Nursing or designee will complete a facility wide audit by 6/26/26 of all current residents with blood pressure medications having parameters to ensure medications are administered or held according to physician orders and that provider notification occurs when parameters are not met or when medications are consistently held. C. A root cause analysis, completed on 6/15/26, determined that nursing staff required re-education regarding following physician ordered medication parameters, accurately documenting medication administration/hold reasons, and notifying the provider when ordered parameters are not met or when medications are consistently held and require reassessment. Director of Nursing or designee will provide education to all nursing staff by 7/1/26 regarding medication administration parameters, following physician orders, holding medications when parameters are not met, documenting appropriately on the MAR, and notifying the provider for reassessment when indicated. Director of Nursing or designee will also provide education to newly hired nursing staff as part of the orientation	07/01/2026

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F0757 SS = D	Continued from page 15 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R1) out of five residents sampled for medication review, the facility failed to ensure that R1 received medication with adequate monitoring. Findings include: Review of R1's clinical record revealed: 2/27/26 - R1 was admitted to the facility. 3/7/26 - A care plan documented that R1 had high blood pressure with the following interventions: administer medications per physician orders; assess for signs and symptoms of high blood pressure; and monitor blood pressure as indicated. 4/7/26 - A physician's order documented Losartan Potassium 25 mg give one tablet by mouth one time a day for hypertension: hold is systolic blood pressure (SBP) is less than 120 mmHg. 5/2026 - A review of the May MAR documented losartan potassium 25mg was administered on the following dates: 5/2/26 - BP 113/63. 5/10/26 - BP 111/68. 5/11/26 - BP 107/62. 5/15/26 - BP 108/72. 5/17/26 - BP 110/60. 5/18/26 - BP 110/65. 5/19/26 1:31 PM - During an interview, E7 (LPN) stated that the expectation is to follow the physician's order and hold medication if the blood pressure does not fall within the parameters to give. E7 also stated if the resident's blood pressure medication was consistently being held it should be reported to the provider for reassessment.	F0757	Continued from page 15 and onboarding process. D. Director of Nursing or designee will complete daily audits on a 5 patient sample of residents with medication administration parameters to ensure medications are administered or held according to physician orders, parameters are documented, and provider notification occurs when clinically indicated. A daily audit will continue until 100% compliance is achieved for 3 consecutive audits. Then, a three times weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. Finally, a weekly audit will be completed for a 5 patient sample until 100% compliance is achieved for 3 consecutive audits. The QAPI committee will then complete a final audit in the following month's QAPI meeting to conclude that the problem was successfully addressed.	07/01/2026

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F0757 SS = D	Continued from page 16 5/19/26 3:18 PM - During an interview, E14 (LPN) stated the aforementioned blood pressure readings did not meet the parameters to administer the medication and confirmed per the MAR they were administered. 5/22/26 3:40 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F0757		07/01/2026