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: Polaris Healthcare & Rehab Center LLC **DATE SURVEY COMPLETED:** February 11, 2026

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 02/08/26 to 02/11/26 Survey Census: 88 Sample Size: 32 Supplemental Residents: 16		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 11, 2026: F552, F582, F610, F656, F689, F695, and F880.	Please cross-refer to ePOC for completed and accepted plans of Correction for Citations: F552 F582 F610 F656 F689 F695 F880	03/17/2026

Provider's Signature [signature] Title NHA Date 3/17/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085058	A. BUILDING B. WING	02/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS HEALTHCARE AND REHABILITATION CENTER	21 W CLARKE AVENUE , MILFORD, Delaware, 19963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality on 02/08/26 – 02/11/26. The facility was found to be in compliance with 42 CFR 483.73.	E0000		03/17/2026
F0000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health & Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 02/08/26 to 02/11/26 Survey Census: 88 Sample Size: 32 Supplemental Residents: 16	F0000		03/17/2026
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: An unannounced Follow-up Survey was conducted on March 26, 2026, for the Annual and Complaint Survey ending February 11, 2026, by the State of	F0689	"Past Noncompliance - no plan of correction required"	

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

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

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F0689 SS = G	Continued from page 1 Delaware Division of Health Care Quality, Office of Long-Term Care Residents Protection. The facility census on the first day of the survey was ninety-two (92). The sample size was twenty (20) residents. The facility was found to be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care as of March 17, 2026. An informal dispute resolution (IDR) was conducted for this citation. It was determined that the citation was past non-compliance and corrected by the facility 8/24/25. No additional correction on part of the facility was necessary as a result of the survey. Based on record review, interview, and policy review, the facility failed to ensure resident safety for one of two residents (Resident (R) 108) reviewed for elopement and one of six residents (R83) reviewed for accidents. As a result, R108, who had been assessed as an elopement and fall risk with cognitive impairment and an unsteady gait, exited the facility without staff knowledge. R108 remained outside the facility for approximately one hour before being located by staff in the back employee parking lot. This had the potential to result in serious injury or death. On 02/10/26 at 7:09 PM, the Administrator was notified that Immediate Jeopardy (IJ), which also constituted Substandard Quality of Care (SQC), was identified at F689 at a Scope and Severity (S/S) of "J" related to the facility's failure to ensure a resident's safety after R108 eloped. The IJ began on 08/24/25 when R8, who had been assessed as an elopement and fall risk with cognitive impairment and an unsteady gait, exited the facility without staff knowledge. On 02/11/26 the facility provided a Removal Plan that was accepted at 3:34 PM. The survey team validated the implementation of the removal plan through observations, staff interviews, and record reviews on 02/11/26 at 6:57 PM, and the scope and severity was lowered to "D," isolated, potential for more than minimal harm Findings include: 1. Review of R108's "Face Sheet," located in resident's electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on 08/21/25 with diagnoses which included history of falling, muscle weakness, and abnormalities of gait and mobility.	F0689		

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F0689 SS = G	Continued from page 2 Review of R108's "Elopement Evaluation," dated 08/21/25 and located in the EMR under the "Assessments" tab, revealed a score of three indicating the resident was at risk of elopement. Review of R108's "Care Plan," dated 08/21/25 and located in the EMR under the "Care Plan" tab, revealed that it did not include his elopement risk or any interventions. Review of a "Nurses Note," dated 08/24/25 at 11:50 AM and located in the EMR under the "Progress Notes" tab, revealed, "Pt [patient] was wandering around unit this morning. After multiple redirections, he was placed in front of the fish tanks. Pt was content. CNA [Certified Nurse Aide] stated she saw him recently prior to incident and he was still sitting on the couch. Pt was found in back employee parking lot tending to the flowers. Patient unharmed and checked out ok. Wander guard to be placed asap [as soon as possible]." Review of R108's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/28/25, located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of three out of 15, which indicated severe cognitive impairment. During an interview on 02/09/26 at 1:27 PM, Licensed Practical Nurse (LPN) 1 reported she was the nurse on duty on 08/24/25 that was assigned to the unit R108 was on. LPN1 said on the morning of 08/24/25, R108 kept coming out of his room and walking around the unit. She was concerned about him falling, since he was unsteady on his feet. She made numerous attempts to redirect him back to his room unsuccessfully, but he did sit down in the visiting area by the fish tanks. She told the CNA staff to pass by that area every time they went anywhere on the unit to check on him. She was charting at the nurse's station that was out of view of the resident. A little while later one of the CNA staff asked her, "Where did [R108] go?" She, along with the two CNA staff and LPN2, immediately started to look for him. They alerted staff on the other unit and security. One of the CNA staff observed R108 through the window from room 212 and saw him outside by the street sign. She went out and immediately assessed him and brought him back into the facility. She was unsure of how long R108 was outside but thought it may have been about 20 minutes. She stated staff did hear a faint alarm sound that morning, but then it stopped so they were unaware that the emergency door had	F0689		

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F0689 SS = G	Continued from page 3 been opened. During an interview on 02/09/26 at 2:27 PM, LPN2 stated that on 08/24/25 she was not assigned to R108 but was made aware by staff that he could not be located, and she assisted in looking for him. When she went outside, she observed him and LPN1 together, and a CNA came with a wheelchair. He was in the back of the building in an employee parking lot on the sidewalk and messing with the flowers in the flower bed. He had a tote bag with him. She said the time of 11:48 AM that she wrote down on her statement for the facility's investigation was the time she found him. During an observation and interview on 02/10/26 at 10:30 AM, the Maintenance Director (MD) stated he was told R108 got out of the emergency/egress door located on the 2nd floor unit. He said the door alarm would sound when the emergency bar was pushed, and it would release the door lock after fifteen seconds, but the alarm would stop sounding once the door was pushed open. He stated he installed fire alarms on the door after the incident that required a key to stop the alarm and were louder. He stated they checked the door locks daily, but they never checked the alarm function prior to this incident or since. The MD demonstrated holding down on the bar on the emergency/egress door and the door unlocked. He also opened the door that showed the two flights of steps going down that led to the door that R108 exited through. During review of the facility's video surveillance on 02/10/26 at 11:30 AM, R108 was observed on the video standing in front of the fish tank and there were no staff visible in the camera view. At 10:48 AM on 08/24/25, R108 walked away from his walker, carrying a tote bag, and went straight to the emergency door and pressed down on the emergency bar. After about 15 seconds, the door opened, and R108 walked through the door. Staff were still not observed in the camera view. During an interview on 02/10/26 at 2:05 PM, the Administrator stated surveyors were not allowed to see the facility's Quality Assurance and Performance Improvement (QAPI) meeting minutes, agenda, or any current Performance Improvement Projects (PIPs) the facility was working on. She reported what PIPs were in place and what was being followed in QAPI, and elopement was not being monitored. During an interview on 02/11/26 at 3:42 PM, The Administrator said the nurse who completed R108's	F0689		

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F0689 SS = G	Continued from page 4 admission elopement assessment should have put an immediate intervention in place, and the Interdisciplinary Team (IDT) would have met the following day to see what else, if anything, needed to be put in place. There also should have been a review of his admission records. The unit manager or shift supervisor should have checked to ensure that based on the findings of the elopement assessment that everything was put in place. That process did not happen in this situation. She said when R108 was wandering around the unit and could not be redirected, staff should have tried other things to keep him safe. The staff did not make good use of their resources. They could have gotten other disciplines involved to see what could have been done to supervise him, but they failed in this situation. She said the time of 11:05 AM on 08/24/25 listed in the facility's investigation reflected the moment on the video when staff were seen walking around and appeared to realize the resident was unaccounted for. The time of 11:16 AM that was indicated as the time R108 was found in the facility's investigation was when staff found him. She said she probably wrote that down somewhere, but she did not have anything that documented that time, and she did not preserve the video of the time R108 was returned to the facility. She said she did not think about it because she was more concerned with how he got out. She also stated she was unaware that the alarm system and the wander guard system were not being tested, but she would have expected that to have been completed. Review of the facility's policy titled "Wandering and Elopements," revised April 2024, revealed, "The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified as at risk on admission for wandering/elopement, or other safety issues, a wandering/elopement assessment is completed as well as an obtained wandering/elopement history if able. A wanderguard is placed on resident. A care plan is initiated that will include the wanderguard and strategies and interventions to maintain the resident's safety." 2. Review of R83's "Face Sheet," located in resident's EMR under the "Profile" tab, revealed the resident was admitted to the facility on 11/17/22 with diagnoses which included difficulty in walking and muscle weakness. Review of R83's "Care Plan," dated 11/17/22 and located in the residents' EMR under the "Care Plan"	F0689		

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F0689 SS = G	Continued from page 5 tab, revealed "The resident has potential for falls related to decreased weakness." Interventions in place were Hoyer lift [non-weight bearing mechanical lift] for transfers. Further review revealed two staff were to be present to provide care at all times. Review of R83's quarterly "MDS" with an ARD of 06/06/25, located in the EMR under the "MDS" tab, revealed a "BIMS" score of 14 out of 15, which indicated no cognitive impairment. Review of a "Nurses Note," dated 08/12/26 at 4:05 PM and located under "Progress Notes" tab, revealed, "Patient was received in bed awake. Patient complained of foot pain. Patient was given Tylenol with positive results. Physician made aware and ordered to be sent out for X-ray." Review of "Facility 5-day Follow Up," dated 08/21/25 at 5:50 PM and provided by the facility, revealed the allegation of improper transfer was confirmed. They found that staff transferred the resident using a stand-pivot but not a Hoyer lift. X-rays were completed with no findings of injury. During an interview on 02/08/2026 at 1:38 PM, R83 stated on 08/11/25 a new CNA (CNA3) came into her room to provide care. After CNA3 bathed and dressed her, CNA3 told her she was going to get her up out of the bed and place her in the chair. CNA3 placed the wheelchair next to the bed. CNA3 wrapped her arms around R83's waist, lifted her up out of the bed, and R83 stood on her feet. R83 said she yelled, "It's painful" then CNA3 placed her in the chair. R83 told the nurse what happened. During an interview on 02/10/26 at 12:45 PM, CNA3 said she was unfamiliar with R83 when she provided care to her on 08/11/25. She also stated she was unaware that she could go into the computer and access the resident's plan of care. She went into R83's room by herself, spoke with the resident, cleaned her, provided care, and got her dressed. CNA3 told R83 that she was going to put her in the chair. CNA3 placed the wheelchair next to the bed, had R83 on the side of the bed, put her arms around R83, and had R83 place her arms around her. CNA3 placed her in the wheelchair next to the bed. She said after R83 was in the wheelchair, R83 pointed to the corner of the room at the blue sling that was placed in the chair under some items and told CNA3 that she was supposed to use that to put R83 in the chair. She was unaware that R83 required a Hoyer left for transfers and that two staff were always required to provide care to R83.	F0689		

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F0689 SS = G	Continued from page 6 During an interview on 02/11/26 at 3:42 PM, the Administrator said that during the facility's investigation, they did find that R83 was transferred inappropriately. The CNA transferred R83 by herself without the use of a Hoyer lift. She stated that places both the resident and staff at risk of being hurt.	F0689		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to provide evidence that residents or their representatives were informed of the risks, potential side effects, and available treatment options for two of five residents (Resident (R) 12, and R66) reviewed for unnecessary medications who received antipsychotic and/or psychotropic medications This deficient practice resulted in residents receiving medications that may not have been clinically necessary. Findings include: 1. Review of R12's "Admission Record," located under the "Profile" tab in the electronic medical record (EMR), revealed an admission date of 11/03/25 with diagnoses of major depressive disorder, other recurrent depressive disorders, and dementia.	F0552	A. Resident R12 and representative were informed of the risks, potential side effects and available treatment options on 2/18/26 by RN. Representative of Resident R66 was informed of the risks, potential side effects and available treatment options on 2/18/26 by RN. B. Residents receiving psychoactive medications were identified. The identified residents and/or their representatives were informed of the risks, potential side effects and available treatment options by RN. C. Root cause analysis revealed that the facility's admission agreement clause in Section 2, Consent for Treatment, b. "The resident acknowledges that he/she is under the medical care of a personal attending physician and the Facility provides services based on the general and specific instructions of this physician. This includes any services necessary to manage the Resident's psychotropic medication....I understand that such...treatment may consist of a variety of services and other modes of treatment tailored to meet my needs." was deemed to be insufficient notice by the survey team. Review of the TeamHealth (provider of behavioral health services to residents) policy for Psychotropic Medication Consent Protocol, the Behavioral Health Clinician will obtain consent during the evaluation or consent will be obtained from the POA or responsible party and documented by the Clinician when submitting medication orders. It was discovered during the inspection that the consent was not being documented by the Behavioral Health Clinician. A change in practice was initiated to verify that consent is received for psychoactive medications. Education was provided to RNs by DON, RN regarding the requirement to obtain consent and document same. A psychoactive medication consent note template was provided to demonstrate the required components of risks, benefits and other options available. This education is included in the new hire orientation of Licensed Nurses which is	03/17/2026

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F0552 SS = D	Continued from page 7 Review of R12's "Physician Orders," located in the EMR under the "Orders" tab, revealed orders dated 11/03/25 for Rexulti (an antipsychotic medication) 0.5 milligrams (mg) at bedtime for agitation associated with dementia and Cymbalta (an antidepressant medication) 60mg one time a day for depression. Also ordered on 11/03/25 was "Side Effect Assessment: Does resident have any noted side effects from Depression medication? Y or N. Then indicate Type by letter: [A=voluntary movements, B=tremors, C=dry mouth, D=urinary retention, E=seizures, F=blurred vision, G=rashes, H=sedation, I=dystonia or rigidity, or J=other side effects, please note in progress note] IF YES CALL PHYSICIAN. every shift." Review of R12's admission "Minimum Data Set (MDS)" assessment, located in the EMR under the "MDS" tab with an Assessment Reference Date (ARD) of 11/10/25, revealed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15, which indicated intact cognition. The "MDS" also indicated antipsychotic and antidepressant medications were received during the assessment period. During an interview on 02/10/26 at 4:57 PM, The Director of Nursing (DON) was asked about consents or any evidence that the resident received education of the risks, benefits, or other options available for treatment with antipsychotic and psychotropic medications. The DON replied that the resident came into the facility already on those medications and confirmed there was no evidence that education was provided to the resident. 2. Review of R66's "Admission Record," located under the "Profile" tab in the EMR, revealed an admission date of 03/06/25 with diagnoses of major depressive disorder, dementia, and metabolic encephalopathy. Review of R12's "Physician Orders," located in the EMR under the "Orders" tab, revealed an order dated 03/06/25, "Side Effect Assessment: Does resident have any noted side effects from Depression medication? Y or N. Then indicate Type by letter: [A=voluntary movements, B=tremors, C=dry mouth, D=urinary retention, E=seizures, F=blurred vision, G=rashes, H=sedation, I=dystonia or rigidity, or J=other side effects, please note in progress note] IF YES CALL PHYSICIAN. every shift." On 07/10/25, sertraline (an antidepressant medication) 50mg by mouth one time a day for depression and anxiety	F0552	Continued from page 7 conducted by the Staff Development RN. D. 100% of Physician orders for new or changed psychoactive medications will be reviewed weekly for 4 weeks to verify that consents are completed with 100% compliance, then 10% random sample of new or changed orders will be reviewed monthly for 2 months until 100% compliance is maintained.	03/17/2026

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F0552 SS = D	Continued from page 8 was ordered. On 11/19/25, buspirone (an anti-anxiety medication) 5mg one tablet by mouth two times a day for anxiety was ordered. Review of R66's quarterly "MDS" assessment, located in the EMR under the "MDS" tab with an ARD of 12/12/25, revealed a "BIMS" score of nine out of 15, which indicated moderate cognitive impairment. The "MDS" also indicated antidepressants and anxiety agents were received during the assessment period. During an interview on 02/10/26 at 4:57 PM, the DON was asked about consents or any evidence that the resident received education of the risks, benefits, or other options available for treatment with psychotropic medications. The DON replied there was no evidence that education was provided to the resident. During an interview on 02/11/26 at 9:46 AM, the Administrator was asked what the expectation was about evidence of education provided for antipsychotic and psychotropic medications. The Administrator stated there should be consents signed to confirm education. Review of the facility's policy titled "Antipsychotic Medication Use," with a revision date of 07/2022, revealed, "5. Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will . . . b. re-evaluate the use of the antipsychotic medication at the time of admission and/or within two weeks [at the initial MDS assessment] to consider whether or not the medication can be reduced, tapered, or discontinued . . . " Review of the facility's policy titled "Psychotropic Medication Use," with a revised date of 02/2025, revealed, "Policy Statement: Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical Record . . . informed Consent or Refusal: 1. Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: a. non-pharmacological alternatives;	F0552		03/17/2026

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F0552 SS = D	Continued from page 9 b. the indications and rationale for the recommendation; c. the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); and d. the resident's/representative's right to accept or decline the treatment . . . "	F0552		03/17/2026
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit	F0582	A. Unable to correct for Residents R109, R110 and R81. B. Facility identified 4 residents whose Part A Medicare stay ended and stayed in the facility from February 11 to present through the EMR action summary of payer change. These residents were reviewed to verify that an Advanced Beneficiary Notice was provided. C. Root cause analysis revealed that the Social Service staff was not consistently providing the required ABN notices to residents who completed a Part A stay and remained in the facility when a discharge was expected but did not occur. In weekly Utilization Review meetings, residents whose Medicare A coverage was discontinued and stayed in the facility since the previous UR meeting are reviewed to verify the provision of the ABN. Social Service staff and MDS Coordinator were educated by Corporate Director of Clinical Reimbursement regarding the requirements of F0582 and the facility's policy "Liability Notification Process and SNG Liability Notices". This education will be included in new hire Social Service staff orientation. D. 100% sample of residents whose Medicare A stay ended and remained in the facility will be audited weekly for 4 weeks by NHA or designee until 100% compliance is maintained then 50% random sample will be audited monthly for 2 months until 100% compliance is maintained. Audit results will be reviewed in monthly QAPI meetings.	03/17/2026

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F0582 SS = D	Continued from page 10 or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and policy review, the facility failed to provide the required Skilled Nursing Facility (SNF) Advance Beneficiary Notice of Non-coverage (ABN) notifications to three of three residents (Residents (R) 109, R81 and R110) reviewed for beneficiary notification. This failure had the potential to affect all residents who continued residing in the facility after the end of their Medicare Part A services by limiting their ability to make informed decisions regarding their financial responsibility. Findings include: 1. Review of R109's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed she was admitted to the facility on 08/08/25 with diagnoses including muscle weakness and difficulty in walking, and that she remained in the facility after her Medicare Part A covered services ended on 11/04/25. Review of R109's "SNF (Skilled Nursing Facility) Beneficiary Notification Review" form revealed Medicare Part A skilled services start date was 10/09/25 and the last day covered was 11/04/25. Further review revealed no SNF ABN notification was provided prior to the last date of services. 2. Review of R81's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed she was admitted to the facility on 06/28/25 with diagnoses including muscle wasting, difficulty in walking, and lack of coordination and that she remained in the facility after her Medicare Part A covered services ended on 08/02/25.	F0582		03/17/2026

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F0582 SS = D	Continued from page 11 Review of R81's "SNF Beneficiary Notification Review" form revealed Medicare Part A skilled services start date was 06/28/25 and the last day covered was 08/02/25. Further review revealed no SNF ABN notification was provided prior to the last date of services. 3. Review of R110's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed she was admitted to the facility on 08/08/25 with diagnoses including muscle wasting and lack of coordination and that she remained in the facility after her Medicare Part A covered services ended on 09/22/25. Review of R110's "SNF Beneficiary Notification Review" form revealed Medicare Part A skilled services start date was 08/08/25 and the last day covered was 09/22/25. Further review revealed no ABN notification was provided prior to the last date of services. During an interview on 02/11/26 at 6:09 PM, the Social Worker (SW) said she was unaware that she was supposed to issue the SNF ABN form when a resident's Medicare Part A benefits were ended and they remained in the facility. During an interview on 02/11/26 at 6:57 PM, the Administrator stated she was unaware that SNF ABN notices were not being provided. She said she expected that the policy would be followed and that beneficiaries would be notified timely. Review of the facility's policy titled "Beneficiary Notice – NOMNC [Notice of Medicare Non-Coverage] and SNF ABN – Policy and Procedure," dated 2025, revealed, " . . . to ensure that the Facility fulfils its responsibility to inform its residents about potential Medicaid and Medicare noncoverage and the option to continue services with the resident accepting financial liability for those services. Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage [SNF ABN] The Facility will only issue the SNF ABN, CMS-10055 if the resident intends to continue services and the Facility believes the services may not be covered under Medicare. The Facility will inform the resident about potential non-coverage and the option to continue services with the resident accepting financial liability for those services. The SNF ABN provides information to residents so that they can decide if they wish to continue receiving the skilled services that may not be paid for by Medicare and assume financial	F0582		03/17/2026

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F0582 SS = D	Continued from page 12 responsibility. If the Facility provides the resident with the SNF ABN, the Facility has met its obligation to inform the resident of his or her potential financial liability and related standard claim appeal rights."	F0582		03/17/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, facility document review, and policy review, the facility failed to follow its abuse policy and did not conduct a thorough investigation into allegations of abuse involving two of five residents (Resident (R) 59 and R72) reviewed for abuse out of 32 sampled residents. This failure had the potential to result in unrecognized or ongoing abuse that puts other residents in the facility at risk. Findings include: 1. Review of R59's "Face Sheet," located in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted on 08/03/22 with diagnoses of cerebrovascular accident (stroke), seizure disorder, and depression. Review of R59's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/31/25, located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R59 was	F0610	A. Residents R59 and R72 were notified of the results of the investigation on August 31, 2025, and were satisfied. Unable to correct the investigation that occurred in August 2025. B. Abuse allegations reported in the last 30 days were reviewed by the Regional Clinical RN and confirmed that the investigations were thorough. According to facility policy "Abuse, Neglect, Exploitation and Misappropriation Prevention Program," a thorough investigation includes: review of completed documentation forms, review of resident's medical record to determine events leading up to the incident, interview of person(s) reporting the incident, interview witnesses to the incident, interview the resident (as medically appropriate), interview the resident's attending physician as needed to determine the resident's current level of cognitive function an medical condition, interview staff members who have had contact with the resident during the period of the alleged incident, interview the resident's roommate, family members and visitors, interview other residents to whom the accused employee provides care or services, and review all events leading up to the alleged incident. C. Root cause analysis revealed that allegations was made by two male residents on the same hall who both choose to remain in their rooms and who both exhibit behaviors of verbal abuse and aggression toward female CNAs. There were no like residents identified (verbally abusive toward female CNAs), as the alleged perpetrator spoke with these two residents, with the stated intent of protecting the female CNAs. Because the alleged perpetrator was addressing specific residents who had exhibited these behaviors, no other residents were interviewed. Abuse investigations are conducted by DON, ADON and NHA. One of these individuals other than the individual completing the investigation will complete the abuse investigation checklist, which includes: Name of resident, name of investigator, date of abuse allegation, date investigation initiated, date concluded, date of initial report, date of 5 day report,	03/17/2026

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F0610 SS = D	Continued from page 13 cognitively intact. 2. Review of R72's "Face Sheet," located in the EMR under the "Profile" tab, revealed the resident was admitted on 08/24/22 with diagnoses of diabetes mellitus, anxiety disorder, and depression. Review of R72's quarterly "MDS" with an ARD of 11/27/25, located in the EMR under the "MDS" tab, revealed a "BIMS" score of 15 out of 15 which indicated R72 was cognitively intact. Review of "Facility Reported Incident (FRI)," signed and dated 08/27/25 by the previous Director of Nursing (PDON) and provided by the facility, revealed the facility received allegations of verbal abuse by a housekeeper from R59 and R70. An investigation was initiated promptly in accordance with facility policy. Interviews were conducted with the involved housekeeper, one staff present on the unit, and the two alert and oriented residents who made the report. There were no indications of any other interviews conducted. During an interview on 02/11/26 at 1:40 PM, the Assistant Director of Nursing (ADON) stated that during an investigation the facility should interview the resident making the complaint, staff working with the resident at the time, and other residents from the floor where the allegation was made. The ADON verified, after reviewing the FRI, that only R59 and R70 were interviewed and stated the PDON should have completed additional resident interviews for a complete and thorough investigation. During an interview on 02/11/26 at 1:50PM, the DON stated that for a thorough investigation, similar residents should be interviewed. Review of the facility's policy titled "Abuse, Neglect, Exploitation and Misappropriation Prevention Program," with a revision date of 04/21, revealed "Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the residents' symptoms . . . The individual conducting the investigation will, as a minimum: Interview the person(s) reporting the incident . . . Interview staff members [on all shifts] who have had contact with the resident during the period of the alleged incident . . . interview other residents to whom the accused	F0610	Continued from page 13 review of medical record, interview reporter, interview witness(es), interview resident, interview attending physician, interview staff member(s) with contact with resident, interview roommate, interview family members and visitors, interview other residents to whom accused provided care or services and review events leading up to the alleged incident. DON, ADON and NHA were educated by Corporate Director of Clinical Services re: facility policy of Abuse Allegation Investigation. This education is included in the orientation education for these positions. D. NHA and DON are made aware of abuse allegations through reporting by Supervisors, Unit Managers, Department Managers and other staff members. Education which includes the necessity of timely reporting of abuse allegations is provided to all employees on hire and annually, and to Nursing staff after each allegation. 100% of allegations of abuse will be audited for thoroughness by NHA or designee weekly for 4 weeks until 100% compliance is achieved, then 100% of allegations will be audited for thoroughness for 2 months until 100% compliance is maintained. Audit results will be reviewed in monthly QAPI meetings.	03/17/2026

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F0610 SS = D	Continued from page 14 employee provides care or services."	F0610		03/17/2026
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. (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-	F0656	A. Unable to correct for Resident R108. Comprehensive care plans for Resident R6 and Resident R 52 were developed by description of services furnished to maintain the highest practicable well-being and include other services and specialized services in consultation with the residents and representatives and based on the residents' goals. The cardiac monitoring for Resident R6 was discontinued on 2/7/2026. Unable to revise care plan retrospectively. The isolation for resident R52 was discontinued on 2/11/2026, unable to retrospectively revise care plan. B. Care plans of residents with a CAA summary in the last 30 days were reviewed by DON to verify that care plan is person-centered and comprehensive. 1 resident was identified at risk for elopement and care plan interventions included wanderguard, reorient, redirect and engage in purposeful activities. No other residents were identified with orders for Holter monitor. 3 residents were identified with isolation precautions which have since been discontinued. Care plans did include monitoring for signs and symptoms of infection, use of PPE, resident and family education, and respiratory interventions. C. Root cause analysis determined that in one instances, Nursing staff did not identify Holter monitor as an item that required care plan revision, in one instance the nursing staff failed to revise the care plan for isolation precautions after return from physician appointment, and in one instance, the nurse completing the elopement assessment failed to implement interventions. Interdisciplinary care planning team was educated by DON regarding the care planning requirements and necessity of specifically including Holter monitors, isolation precautions and elopement interventions. Licensed Nursing orientation includes education regarding developing a person-centered comprehensive care plan and how the care plan is related to a MDS assessment. The comprehensive care plan is based on a Care Area Assessment (CAA) that triggered. The MDS RN initiates the care plan and revises post-assessment so that it reflects resident goals, desired outcomes, care/services provided, and specific services as	03/17/2026

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F0656 SS = D	Continued from page 15 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interviews, and facility policy review, the facility failed to ensure a person-centered comprehensive care plan was developed for three residents (Resident (R) 6, R52, and R108) out of a total of 32 sampled residents. This deficient practice placed the residents at risk for unmet care needs, ongoing assessment, and provider notification. Findings include: 1. Review of R6's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R6 was admitted to the facility on 11/21/25, with the most current re-entry on 12/22/25, with diagnoses that included essential (primary) hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, and transient cerebral ischemic attack (stroke symptoms that resolve). Review of R6's "Order Summary Report," located under the "Order" tab of the EMR, reflected an order dated 01/19/26 to "Check Holter monitor placement each shift every shift for Cardiac monitoring for 30 days." There were no other orders related to the Holter monitor. Review of R6's current "Care Plan," located in the EMR under the "Care Plan" tab did not address the Holter monitor or any specific, measurable, achievable, relevant, and time-bound goals and interventions to ensure effective, patient-centered, and actionable healthcare outcomes for R6's cardiac monitoring. During an interview on 02/11/26 at 2:16 PM, the Registered Nurse Unit Manager (RNUM) 1 said that any care, treatment, and services provided to a resident should be reflected in the care plan to ensure continuity of care. The interventions would ensure nursing staff assessed the resident's skin for potential reaction to the electrode contact adhesive and that the cardiac Holter monitor was in place and did not get wet. RNUM1 said that any nurse could update the care plan to address specific care needs and appropriate interventions. During an interview and record review on 02/11/26 at 3:42 PM, the Minimum Data Set (MDS) Coordinator (MDSC) said that she initiated the comprehensive care plan based on a Care Area Assessment (CAA)	F0656	Continued from page 15 reflected in the comprehensive assessment. D. Audits of care plans of 100% of residents identified with Holter monitors, at risk for elopement and with isolation precautions will be audited to verify that the care plan is comprehensive. Audits will be conducted by DON or designee weekly for 4 weeks until 100% compliance is achieved, then monthly for 2 months until 100% compliance is maintained. Results of audits will be reviewed by QAPI. In addition, 10% sample of care plans of residents with an MDS completed within that week will be audited by the RNAC to verify that the care plan is comprehensive. These audits will be conducted weekly for 4 weeks until 100% compliance is achieved, then monthly for 2 months until 100% compliance is maintained.	03/17/2026

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F0656 SS = D	Continued from page 16 that was triggered. The MDSC reviewed the comprehensive care plan and confirmed that the care plan did not reflect objectives and interventions for monitoring the cardiac Holter monitor to address the risk of actual wounds. The MDSC said that the care plan should reflect resident goals, desired outcomes, care/services provided, and specific services to be provided as reflected in the comprehensive assessment. The MDSC said that she was responsible for the admission, quarterly, annual, and change in condition MDS completion. The MDSC said that the Unit Managers reviewed the care plans for changes and updates. 2. Review of R52's "Admission Record," located under the "Profile" tab of the EMR, revealed R52 was admitted to the facility on 04/04/25, with the most current re-entry on 01/27/26, with diagnoses that included cellulitis (a common infection of the skin and the soft tissues underneath), unspecified dementia, carcinoma in situ (cancer that remains in the original cells where it started, without spreading to nearby tissues) of skin of scalp and neck and actinic keratosis (precancerous skin lesions that form on sun-exposed areas of the body). Review of R52's "Order Summary Report," located under the "Order" tab of the EMR, reflected an order dated 02/04/26 for "Contact Isolation: MRSA ([Methicillin-resistant Staphylococcus aureus] type of bacteria that is resistant to several antibiotics) Skin, nares every shift for MRSA." Review of an order written by R52's dermatologist, dated 02/04/26, located under the "Misc" tab of the EMR revealed, "Patient is MRSA positive, needs respiratory and contact isolation." Review of R52's "Care Plan," located in the EMR under the "Care Plan" tab, initiated on 02/09/26, revealed it did not reflect interventions specific and relevant to respiratory isolation precautions to ensure appropriate personal protective equipment was worn to prevent airborne and droplet transmission of MRSA. During an interview on 02/11/26 at 2:16 PM, RNUM1 said that she did not normally work on the unit where R52 currently resides and was notified that R52 was only on contact precautions for MRSA. RNUM1 said the risk of not wearing a mask and eye protection when entering an isolation room for respiratory precaution would be becoming infected with the pathogens transmitted by the resident when talking, coughing, or sneezing. RNUM1 said that any care, treatment, and services provided to a resident	F0656		03/17/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0656 SS = D	Continued from page 17 on a transmission-based precaution should be reflected in the care plan to ensure safety of the residents and staff. RNUM1 said that any nurse could update the care plan to address specific care needs and appropriate interventions. During an interview and record review on 02/11/26 at 3:42 PM, the MDSC said that she initiated the comprehensive care plan based on a CAA that was triggered. The MDSC reviewed the comprehensive care plan and confirmed that the care plan did not reflect objectives and interventions for respiratory isolation. The MDSC said that the care plan should reflect resident goals, desired outcomes, care/services provided, and specific services to be provided as reflected in the comprehensive assessment. The MDSC said that she was responsible for the admission, quarterly, annual, and change in condition MDS completion. The MDSC said that the Unit Managers reviewed the care plans for changes and updates. 3. Review of R108's "Admission Record," located in resident's electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on 08/21/25 with diagnoses which included history of falling, muscle weakness, and abnormalities of gait and mobility. Review of R108's "Elopement Evaluation," dated 08/21/25 and located in the EMR under the "Assessments" tab, revealed a score of three, indicating the resident was at risk of elopement. Review of R108's "Care Plan," dated 08/21/25 and located in EMR under the "Care Plan" tab, revealed that it did not include his elopement risk or any interventions. Review of R108's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 08/28/25, located in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of three out of 15 which indicated severe cognitive impairment. During an interview on 02/11/26 at 3:42 PM, The Administrator said the nurse who completed R108's admission elopement should have implemented a care plan and put in an immediate intervention, and the Interdisciplinary Team (IDT) should have met the following day to see what else if anything needed to be put in place. Review of the facility's policy titled "Wandering and Elopements," revised April 2024, revealed, "If	F0656		03/17/2026

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F0656 SS = D	Continued from page 18 identified as at risk on admission for wandering/elopement, or other safety issues, a wandering/elopement assessment is completed . . . A wanderguard is placed on resident. A care plan is initiated that will include the wanderguard and strategies and interventions to maintain the resident's safety." Review of the facility's policy titled, "Care Plans, Comprehensive Person-Centered," revised March 2022, revealed, "2. The comprehensive, person-centered care plan is developed within seven [7] days after the completion of the comprehensive MDS assessment [Admission, Annual, or Significant Change in Status]. All CAAs triggered by the MDS will be considered in developing the plan of care . . . 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being."	F0656		03/17/2026
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interviews, record reviews, and facility policy review, the facility failed to follow professional standards or its own established tracheostomy care procedures for cleaning the stoma site, replacing the inner cannula, and ensuring two staff members were present during care for one of six residents (Resident (R) 93) reviewed for respiratory care out of a total of 32 sampled residents. This deficient practice placed the residents at risk for respiratory distress or infection. Findings include: Review of R93's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R93 was admitted to the facility on 04/02/25 with diagnoses that included chronic	F0695	A. Resident R93 was assessed by Provider, trach is in place, VS were stable and no work of breathing was noted and no concerns were noted. Nursing was instructed to continue with trach care and to continue to monitor oxygenation. LPN1 was counselled and re-educated on appropriate tracheostomy care with return demonstration. B. Physician orders were reviewed by physician and DON and required no updates for the 16 current residents with tracheostomies. Tracheostomy competency assessments were completed for all residents with tracheostomies in facility on 2/27/26 by DON/RN Designee to verify optimal care. Competency assessments included: procurement of appropriate equipment and supplies, use of aseptic technique, use of PPE, proper procedure, 2 staff members present during changing of neck ties. C. Root cause analysis indicated that the nurse lacked knowledge. Licensed nurses and Respiratory Therapists were educated by DON/RN designee regarding professional standards and facility policy of tracheostomy care. Clinical Competency validation was completed by competency assessment which includes: procurement of necessary equipment and supplies, use of aseptic technique and PPE, check physicians	03/17/2026

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F0695 SS = D	Continued from page 19 respiratory failure with hypoxia (not enough oxygen in blood), tracheostomy status, and hemorrhage from tracheostomy stoma (bleeding from a tracheostomy site). Review of R93's "Order Summary Report," located under the "Order" tab of the EMR, reflected an order dated 09/23/25 to "Change inner cannula" . . . "Tracheostomy Care – trach ties – change every Monday and Thursday one time a day every Mon, Thu" . . . "Tracheostomy Care – pulse ox [pulse oximetry- a measure of the oxygen saturation in the blood] every shift and prn [as needed] every shift" . . . "Tracheostomy Care – trach care/Shiley disposable inner cannula 5IC70every shift" . . . "Tracheostomy Care – trach care every shift" . . . "Change Inner Cannula every 24 hours trach care." Review of R93's "Treatment Administration Record (TAR)," located under the "Order" tab of the EMR, on 02/09/26 at 2:10 PM, revealed Licensed Practical Nurse (LPN) 1 initialed the TAR for "tracheostomy care – pulse ox every shift, tracheostomy care – trach care/Shiley disposable inner cannula 5IC70every shift, and Tracheostomy Care – tach care every shift" on 02/09/26 for the "7a-3p" shift. During an interview and record review on Monday, 02/09/26, at 2:10 PM, LPN1 said that she had not performed tracheostomy (trach) care yet. LPN1 said that she was responsible for trach care every Monday and Thursday only. LPN1 could not verbalize the procedure for trach care. LPN1 said that the respiratory therapist (RT) performed trach care that included changing ties and she (LPN1) was only responsible for cleaning the inner cannula. LPN1 reviewed R93's "TAR" and said that she probably clicked on the orders by accident and pointed out that the order for "Tracheostomy Care – trach ties – change every Monday and Thursday one time a day" was to be performed on Mondays and Thursdays. LPN1 was informed that it was currently Monday. LPN1 said that she did not realize that it was Monday and agreed to be observed performing trach care. During an observation and interview on 02/09/26 at 2:33 PM, LPN1 obtained a package containing a Shiley 5IC70 disposable inner cannula and a package containing split gauze. LPN1 opened the gauze package and placed it as well as the inner cannula package, on R93's blanket, which covered the resident, without setting up a sterile field. LPN1 did not ensure the procedure area was clean and did not use an antiseptic (liquid that kills germs) solution to clean R93's skin at the stoma site when	F0695	Continued from page 19 orders, explain procedure to resident, step-by-step procedure for removing inner cannula, site and stoma care and replacing neck ties; and will continue until 100% compliance achieved. Clinical care of residents with tracheostomies is overseen by RN and lead Respiratory Therapist. D. Audits of tracheostomy care by observation of actual care will be conducted with a random rotating sample of 20% of tracheostomies weekly for 4 weeks until 100% compliance is achieved, then monthly for 2 months until 100% compliance is maintained.	03/17/2026

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F0695 SS = D	Continued from page 20 she removed the old inner cannula and placed the new inner cannula. LPN1 replaced the trach ties with new ties and a foam collar. LPN1 performed the trach care alone and without securing the trach site to prevent dislodgment. LPN1 said that "trach care" meant "to suction if needed, replace the gauze and change ties . . . only clean around the trach site with saline if drainage was noted." During an interview on 02/11/26 at 5:28 PM, the Director of Nursing (DON) said that the nurses were checked off on skills during on-the-job training (OJT). The DON went on to say that the nurses were responsible for performing the care correctly and it was not her responsibility to oversee the nurses' practice, that she delegated the responsibility to the Staff Development Coordinator (SDC), the Infection Preventionist, and the unit managers to monitor that the nurses performed tasks accurately. The DON said that the nurse could perform trach care without a second person if the nurse performing the task was competent. Review of LPN1's personnel file provided by the Administrator revealed a "Classroom Orientation Checklist, Day 3," dated 04/22/25, covered the topic of "Trach Care and Emergency Dislodgement" during orientation. A "Competency Assessment Tracheostomy Care," dated 12/09/25, signed by LPN1 and the SDC, that reflected LPN1 demonstrated competency. Procedure guidelines outlined "Assess resident for respiratory distress . . . Set up supplies on sterile field . . . Site and Stoma Care: Clean the stoma with two peroxide-soaked gauze pads [using a single sweep for each side] . . . Rinse the stoma with saline-soaked gauze pads [using a single sweep for each side] . . . Wipe with dry gauze [using a single sweep for each side]." Review of the facility policy titled, "Tracheostomy Care," revised November 2023, revealed " Site and Stoma Care: 1. Apply clean gloves. 2. Clean the stoma with two peroxide-soaked gauze pads [using a single sweep for each side] 3. Rinse the stoma with saline-soaked gauze pads [using a single sweep for each side] 4. Wipe with dry gauze [using a single sweep for each side] 5. Disinfect the stoma with the antiseptic-soaked gauze pads [using a single sweep for each side]. Allow to air dry or wipe with clean, dry gauze. 6. With two staff members present, remove neck ties and replace with clean ones 7. Apply a fenestrated [split] gauze pad around the insertion site . . . "	F0695		03/17/2026

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F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (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	F0880	A. Contact Isolation precautions for Resident R52 were initiated on 2/4/26 and completed on 2/16/26 per physician order. Attending physician determined that respiratory isolation was not necessary. B. 3 residents were identified with isolation precautions, and were reviewed by DON and Provider and no changes were required. Order, care plan, task and signage were verified to be correct. C. Root cause: Dermatologist stated that recommendation for respiratory precautions was made in error because nares were not cultured. IP failed to document the clarification discussion with Medical Director on 2/4/26. IP was re-educated on 3/5/26 by Corporate Clinical Nurse regarding Infection Preventionist Long Term Care Isolation Verification, Signage and Documentation Reference. Direct care staff received education regarding Infection Prevention and Control specific to the use of PPE in the implementation of isolation and the categories of transmission-based precautions. RN completing assessment and verifying physician orders for admissions, re-admissions and hospital returns is responsible for verifying the need and type of isolation precautions with physician and is responsible for verifying that signage is in place and PPE is available. The IP RN oversees this process. D. All residents with current orders for isolation will be audited weekly for 4 weeks by DON or designee until 100% compliance is achieved and then monthly for 2 months until 100% compliance is maintained. Results will be reviewed by QAPI.	03/17/2026

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F0880 SS = D	Continued from page 22 prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure use of personal protective equipment (PPE) in the implementation of respiratory isolation for one of one resident (Resident (R) 52) reviewed for transmission-based precautions out of a total sample of 32 residents. This failure had the potential to lead to the transmission of droplet pathogens from resident to staff not wearing a mask or eye protection. Findings include: Review of R52's "Admission Record," located under the "Profile" tab of the EMR, revealed R52 was admitted to the facility on 04/04/25, with the most current re-entry on 01/27/26, with diagnoses that included cellulitis (a common infection of the skin and the soft tissues underneath), unspecified dementia, carcinoma in situ (cancer that remains in the original cells where it started, without spreading to nearby tissues) of skin of scalp and neck and actinic keratosis (precancerous skin lesions that form on sun-exposed areas of the body). Review of R52's "Order Summary Report," located under the "Order" tab of the EMR, reflected an order dated 02/04/26 for "Contact Isolation: MRSA ([Methicillin-resistant Staphylococcus aureus] type of	F0880		03/17/2026

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F0880 SS = D	Continued from page 23 bacteria that is resistant to several antibiotics) Skin, nares every shift for MRSA." Review of an order written by R52's dermatologist, dated 02/04/26, located under the "Misc" tab of the EMR revealed, "Patient is MRSA positive, needs respiratory and contact isolation." Review of R52's "Care Plan," located in the EMR under the "Care Plan" tab, initiated on 02/09/26, did not reflect interventions specific and relevant to respiratory isolation precautions to ensure appropriate personal protective equipment was worn to prevent airborne and droplet transmission of MRSA. During an observation on 02/08/26 at 10:52 AM, an isolation sign was not posted outside of R52's room to inform of transmission-based precautions or of what PPE should be worn. At 2:48 PM, a contact precautions sign was posted outside of R52's room listing the required PPE (gown and gloves) staff should be put on before entering the room. During an interview on 02/11/26 at 9:45 AM, Certified Nurse Aide (CNA) 15 said that she wore a gown and gloves before entering R52's room because there was a contact precautions sign posted outside his room. CNA14 said that she did not know that she should wear a mask or that R52 should be on respiratory isolation. During an interview on 02/11/26 at 10:38 AM, Licensed Practical Nurse (LPN) 2 said that she was an agency nurse and reviewed orders and care plans to orient herself to residents. LPN2 was unaware of respiratory precautions as written on 02/04/26. LPN2 said that she received shift change report from the off-going nurse that R52 was on contact precautions for MRSA related to wounds on his legs. LPN2 said that she verified that by reviewing the orders and care plan that indicated contact precautions. During an interview on 02/11/26 at 12:35 PM, the Infection Preventionist (IP) stated that she was responsible for overseeing the tasks performed by Registered Nurse (RN) 2, the IP in training. The IP said that she was aware that R52 was on contact precautions for MRSA but did not conduct record review as part of oversight of RN2. The IP said that signs for respiratory and contact isolation should be posted as ordered for MRSA. The IP said that it was the responsibility of the nurses to communicate in change of shift report that R52 was on respiratory and contact isolation for MRSA.	F0880		03/17/2026

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F0880 SS = D	Continued from page 24 During a phone interview on 02/11/26 at 1:36 PM, the Doctor of Osteopathic Medicine ([DO] dermatologist) stated that the wound culture she performed on R52 legs resulted with MRSA. The DO said that she wrote the order to place R52 on respiratory and contact isolation for MRSA. The DO said that it was her medical professional opinion that R52 be placed on respiratory isolation in addition to contact isolation because MRSA could be dormant in the nares and spread by respiratory droplets. Review of the facility's policy titled, "Isolation – Categories of Transmission-based Precautions," revised September 2022, indicated "Policy Statement Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; . . . or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents . . . 5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC [Centers for Disease Control and Prevention] precaution[s], instructions for use of PPE, and/or instructions to see a nurse before entering the room . . . 1. Droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets [large-particle droplets larger than 5 microns in size that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning] . . . 3. Masks are worn when entering the room. 4. Gloves, gown and goggles are worn if there is risk of spraying respiratory secretions."	F0880		03/17/2026