ELAWARE HEALTH
ND SOCIAL SERVICES
vision of Health Care Quality
'fice 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: Lofland Park Center

DATE SURVEY COMPLETED: June 30, 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, Complaint and Emergency Preparedness Survey was conducted at this facility from June 23, 2026, through June 30, 2026. The deficiencies contained in this report were based on observation, interview, review of clients' records and a review of other facility documentation as indicated. The facility census on the first day of the survey was ninety-seven (97). The survey sample totaled forty-two (42) residents. Abbreviations/definitions used in this report are as follows: ADON – Assistant Director of Nursing; CNA – Certified Nurse's Aide; DON – Director of Nursing; LPN – Licensed Practical Nurse; NHA – Nursing Home Administrator; SA – State Agency.		
3201 **3201.1.0** **3201.1.1**	**Regulations for Skilled and Intermediate Care Facilities** **Scope** **A Nursing facility (NF) is a residential institution, as defined in 16 Delaware Code, §1102(4), which provides services to residents which include resident beds, continuous nursing services, and health and treatment services for individuals who do**		

Provider's Signature [signature], CEO, CNHA Title Administrator Date 7/24/2026

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	not currently require continuous hospital care. Care is given in accordance with a physician's orders and requires the competence of a registered nurse (RN).		
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 June 30, 2026: F605, F580, F689, F695, F756, and F812.	Cross refer to CMS 2567-L for F605, F580, F689, F695, F756, and F812.	8/6/2026
3201.9.8 **3201.9.8.4** **3201.9.8.4.2** **S/S – D**	**Reportable incidents are as follows:** **Significant injuries.** **Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.** This requirement was not met as evidenced by: Based on interview, record review and review of other facility documentation, it was	**Past Non-Compliance**	**4/30/2026**

Provider's Signature Tammy Lemmo, LNHA Title Administrator Date 7/24/2026

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	determined for two (R115 and R124) out of twenty-four (24) residents sampled for reportable incidents, the facility failed to report to the State Agency (SA) within the required 8 hours. Based on a review of the facility's evidence to correct the non-compliance and the facility's substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 4/30/26. Findings include: 1. Review of R115's clinical record revealed: 11/12/24 – R115 was admitted to the facility. 8/18/25 8:06 AM – A nursing progress note documented that R115 had an unwitnessed fall in his room and has a laceration to the ear and head. 8/18/25 11:28 AM – A nursing progress note documented that R115 was sent to the hospital for treatment of a laceration on the left side of the head. 8/18/25 – A physician's order was made to send R115 to the hospital. 6/26/26 2:00 PM – During an interview, E1 (NHA) confirmed that the incident was not reported to the State Agency and was unsure about why it was missed. E1 stated that the facility had begun audits of late-reportable incidents in January 2026. The facility completed re-education in March 2026 and then started system changes in April 2026. 2. Review of R124's clinical record revealed: 4/19/26 7:45 PM – A facility reported incident documented that R124 was found on the floor, lying face down with a laceration to		

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	the left eyebrow, right wrist and right knee. The report documented provider was notified and neurological assessment initiated. 4/20/26 10:39 AM – A reported incident was submitted to the State Agency. 6/25/26 12:44 PM – During an interview, E3 (ADON) confirmed that the report was submitted late to the State Agency and that facility wide education was initiated after the incident. 6/26/26 1:20 PM – During an interview, E1 (NHA) stated that from 1/30/26 to 4/30/26, the facility noted late incident reports and delayed 5-day follow-ups during interdisciplinary team meetings, prompting audits. These audits lacked 100% accuracy, leading to further adjustments. A new tracking system, administrative staff training, and audits were completed. When audits again fell short in late April, a root cause analysis and additional education for all facility staff on reportable incidents were completed. Based on the review of the facility's investigation, documented response, system changes, completion of training via electronic and in-person communication, and audits, it was determined that the facility met the requirements for past non-compliance as of 4/30/26. 6/30/25 12:00 PM - Findings were reviewed with E1, E2 (DON), and E3 during the exit conference.		

Provider's Signature Tamara Dennis, GDD Title Administrator Date 7/24/2026

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Provider's Signature _____ Title _____ Date _____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085040	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOFLAND PARK CENTER	**715 E. KING STREET , SEAFORD, Delaware, 19973**

(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 June 23, 2026 through June 30, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		
F0000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from June 23, 2026, through June 30, 2026. The deficiencies contained in this report were based on observation, interview, review of clients' records and a review of other facility documentation as indicated. The facility census on the first day of the survey was ninety-seven (97). The survey sample totaled forty-two (42) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA – Nursing Home Administrator; COPD - lung condition that damages the lungs; H20 - water; RN - Registered Nurse; Sleep Apnea - sleep disorder characterized by abnormal pauses in breathing or instances of abnormally low breathing during sleep BiPAP – machine that helps the patient breathe; Bipolar Disorder – mood disorder;	F0000		

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 Gradual Dose Reduction (GDR) - tapering of a dose to determine if symptoms, conditions or risks can be managed by a lower dose or if the medications can be discontinued altogether; Medication Regimen Review (MRR) - monthly review by pharmacist of resident's medications, laboratory tests and any records necessary to determine whether or not irregularities exist; Psychotropic (medication) - any medication capable of affecting the mind, emotions and behavior; TAR - A list of daily/weekly/monthly treatments to be performed;	F0000		
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for four (R5, R26, R38, and R86) out of four residents reviewed for respiratory care the facility failed to ensure respiratory equipment for R5, and R86 were stored in plastic bagging when not in use, in addition, the facility failed to clean R26 and R38's oxygen concentrator filters weekly as ordered. Findings include: 1. R26's clinical record revealed: 9/22/22 – R26 was admitted to the facility. 4/14/26 1:11 PM - A physician's order for R26 documented "Clean external filter on oxygen concentrator as needed. 4/15/26 11:00 PM - A physician's order for R26 documented "Clean external concentrator filter every night shift on Wednesday." 6/23/26 9:47 AM - An observation of R26's oxygen	F0695	A. R28 & R38 oxygen concentrators were cleaned by the DON on 6/23/2026. R5 tubing was discarded and new tubing was obtained and labelled on 6/23/2026. Bags were obtained for R86 and R5 and mask & tubing were placed in the bags for proper storage on 6/23/2026. B. All residents with oxygen concentrators were checked and cleaned by the DON on 6/23/2026. Bags were placed in rooms for all residents with respiratory equipment requiring storage. An initial Regroup messaging education sent out to all staff by the DON regarding the cleaning process for oxygen concentrator filters, and storage of nebulizer, CPAP and BiPAP masks and tubing. C. A root cause analysis was completed on 7/20/2026 to determine the need to change the process for checking respiratory equipment for proper cleaning and storage. The new process includes an oxygen tubing change order for all residents with oxygen orders, changing the time for changing the tubing & cleaning concentrator filters from every Wednesday 11p-7a to 7a-3p shift, and initiating the responsible person to the respiratory therapist for the weekly tubing & concentrator filter tasks. In addition, a new process for storing tubing & masks will be as follows: 2nd floor - bags for tubing and nebulizer equipment will be hung on wall flow meter for storage when not in use; 1st floor & Memory Care units - oxygen tubing will be hung on the side of the concentrator and nebulizer equipment will be hung on command hooks located on the stand that the machine is placed on. Residents with additional tubing set up on the wheelchair for portable oxygen will have a set up bag hanging on the back of the wheelchair for tubing when not in	08/06/2026

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F0695 SS = E	Continued from page 2 concentrator revealed layers of dust attached to the external filter. A review of review of R26's TAR documented the filter was last cleaned on 6/17/26. 06/23/26 1:30 PM - During an interview E2 (DON) reported filters should be cleaned weekly and as needed. E2 confirmed that R26's filter is dirty and removed the filter to clean it. 2. R38's clinical record revealed: 1/27/26 R38 was admitted to the facility. 4/8/26 11:00 PM - A physician's order for R38 documented clean external concentrator filter every night shift Wednesday. 6/23/26 10:15 AM - An observation of R38's oxygen concentrator revealed layers of dust attached to the external filter. A review of R38's TAR documented the filter was last cleaned on 6/17/26. 6/23/26 1:30 PM - During an interview E2 (DON) reported filters should be cleaned weekly and as needed. E2 confirmed that R26's filter is dirty and removed the filter to clean it. 3. R86's clinical record revealed: 10/1/25 - R86 was admitted to the facility. 10/2/25 11:38 AM - A physician's order documented Albuterol Sulfate nebulization solution 2.5mg/3ml) 0.083% 3 ml inhale orally via nebulizer every four hours as needed for shortness of breath. 6/23/26 1:09 PM - An observation revealed R86's nebulizer equipment was sitting on a black stand in the room; the T-adapter and tubing was dated but was not enclosed in a plastic bag. During an interview E2 (DON) confirmed the nebulizer equipment had not been placed in a bag. R86 stated, "They don't come back and put it in a bag, the only way they could put in a bag is if they came back to do it." E2 then stated, "I will take care of this." 4. R5's clinical record revealed: 5/26/26 - R5 was admitted to the facility. 5/30/26 – A physician's order for R5 documented nightly application of BiPAP therapy with pressure settings of 4–20 cmH_2O and supplemental oxygen delivered at 2 L/min.	F0695	Continued from page 2 use. BiPAP & CPAP masks will be placed in a bag labeled with the resident's name and placed with the machine. The Nurse Practice Educator will complete education on Nursing 230: Respiratory Equipment/Supply Cleaning/Disinfecting Policy and Procedure. Education on the policy, procedure and new processes (attachment A) will be completed with all licensed nurses and Respiratory Therapists by 8/6/2026. Any new Respiratory Therapists or Licensed Nurses will receive education on the new process through the orientation process. D. The DON/designee will complete audits (attachment B) to ensure oxygen concentrators filters are cleaned weekly and prn, and policy for proper storage of nebulizer, CPAP & BiPAP equipment is stored appropriately. 50% of the resident population with ordered oxygen, concentrators, CPAP or BiPAP will be audited daily until 100% compliance is achieved on 3 consecutive reviews, then biweekly until 100% is achieved on 3 consecutive reviews, then weekly until 100% is achieved on 3 consecutive reviews, then monthly until 100% is achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Improvement Committee monthly for review and recommendations.	08/06/2026

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F0695 SS = E	Continued from page 3 6/23/26 9:45 AM - An observation revealed R5's BIPAP mask lying on the bedside table, with the tubing on the floor. 6/23/26 10:00 AM - Confirmed with E4 (RN) that the CPAP tubing lying on the bedside table was not stored properly and was not placed in the designated storage bag. 6/30/25 12:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F0695		08/06/2026
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 6/23/26 9:08 AM - During the initial kitchen tour, an observation of an open bag of cheese cubes with no open date or discard date. Additionally, an observation of a container of thickened juice with no open date or discard date noted.	F0812	A. The cook discarded the bag of cubed cheese and container of thickened liquid on 6/23/2026. B. All other food was labeled and in compliance with proper storage requirements. C. A root cause analysis was completed on 7/20/2026 to determine the need for a revised dietary process to include a 7 day ahead preprinted labels for dating opened food which will be printed by the Food Service Manager or NHA. The Food Service Manager and NHA will place an organizer with 7 slots for each day of the week in the kitchen for employees to have easy access to the preprinted labels. The Food Service Manager also posted the Food Storage and Retention Guide in the main kitchen area for ease of understanding appropriate dates per food items. In addition, revised workflows for each dietary position were completed to include label/dating responsibilities (attachment C), which is highlighted at the bottom of each dietary position with "All food in coolers and freezers must be labeled and dated per posted department policy." The NHA and Food Service Manager provided all dietary staff education to include Food Storage Retention Guide, Job Flows, and Dating/Labeling (attachment D) at a mandatory staff meeting on 7/20/2026. D. The NHA/designee will complete audits (attachment E) to ensure proper labeling of opened food items. At least 10 items will be audited daily until 100% compliance is achieved on 3 consecutive reviews, then biweekly until 100% is achieved on 3 consecutive reviews, then weekly until 100% is achieved on 3 consecutive reviews, then monthly until 100% is achieved on 3 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Improvement Committee monthly for review and recommendations.	08/06/2026

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F0812 SS = E	Continued from page 4 6/23/26 9:20 AM - During an interview, E7 (Cook) confirmed the aforementioned items were not dated or labeled. E7 discarded those items in the trash during the interview. 6/30/25 12:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0812		08/06/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F0580	"Past Noncompliance - no plan of correction required"	04/20/2026

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F0580 SS = D	Continued from page 5 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R122) out of eleven residents reviewed for accidents, the facility failed to consult the physician when R122 experienced a change in condition. Based on review of the facility's evidence of correction, the deficient practice was determined to be Past Noncompliance, with substantial compliance achieved effective April 20, 2026. Findings include: Review of R122's clinical record revealed: 3/10/26 - R122 was admitted to the facility. 3/21/26 7:20 PM - A facility reported incident documented that R122 was found on the floor in his room after an unwitnessed fall and reported to staff that he hit his head during the fall. Staff (RN) completed an assessment and initiated neurological assessments at this time. 3/21/26 9:25 PM - An SBAR communication form documented that R122 had an unwitnessed fall and was reported to the provider. The SBAR documented that R122 denied pain, no injury noted, and provider advised continuing neurological assessments. 3/22/26 9:00 AM - A nursing progress note documented that "PT stated he seems off and had a physical decline during PT, not able to walk and less steady on his feet." 3/22/26 11:59 AM - A physical therapy (PT) progress note documented that R122 was having difficulty standing and was tolerating standing for 30 seconds before requesting to sit. The note	F0580		04/20/2026

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F0580 SS = D	Continued from page 6 documented that nursing was notified of R122's change in functional status. 3/22/26 6:40 PM - An SBAR communication form documented that R122 had a fall with complaint of knee pain of 10/10. On call provider was notified at approximately 7:00 PM with the following orders: x-ray of left knee, Tramadol 50 mg for pain and lidocaine patch to knee. 6/29/26 2:19 PM - During an interview, E4 (RN) stated the expectation would be to consult the provider of a change in condition and on the weekend to call the on-call provider. E4 stated that if the provider was notified a progress note or SBAR would have been completed. 6/30/26 9:15 AM - During an interview, E9 (PA) stated the expectation for a change in condition would be to notify the provider and continue to monitor resident. E9 stated that a resident post fall with a change in mentation would require a call to the provider for possible further evaluation. 6/30/26 11:55 AM – During an interview, E1 (NHA) stated that the facility recognized post fall change in condition were a focus of the IDT team and the facility had implemented the following: facility provided education on recognizing a change in condition, education on notifying the provider specifically on off hours and weekends, and also initiated ongoing audits for any residents who experienced a change in condition and outcome. Based on the facility's investigation, review of the event, implementation of corrective actions, staff education regarding recognition of changes in condition and timely physician notification (including after-hours and weekend notification procedures), and implementation of ongoing audits to monitor compliance, it was determined the facility returned to substantial compliance effective April 20, 2026. 6/30/25 12:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0580		04/20/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including:	F0605	A. The medical provider documented the rationale for contraindication for GDR for R28 in the clinical record on 7/8/2026. B. All current residents with psychotropic medication reviews were evaluated by the DON by 7/23/2026 and follow up with the medical provider for GDR rationale will be completed by 7/31/2026.	08/06/2026

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F0605 SS = D	Continued from page 7 §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F0605	Continued from page 7 C. A root cause analysis was completed on 7/20/2026 to determine a new process was needed to review Medication Review Regimens (MRRs) for GDRs. When the consultant pharmacist completes the MRR for a resident, she ensures the document is uploaded into PharMerica electronic platform ViewMasterRx under consulting reports. The DON/designee will utilize the ViewMasterRx consulting reports by clicking on the view reports link to review the uploaded pdf report from the previous day. This report will be reviewed daily in the Morning Clinical meeting for any MRR that has been completed by the pharmacy. The DON/designee will document any reports containing pharmacy recommendations that need to be addressed by provider and/or nursing in the center's Clarity application for provider/nursing follow up. Follow up needed will be documented in the pre-work using the Other tab of the Clarity application indicating follow-up is needed. The DON/designee will update the Clarity application documentation after the follow-up documentation has been completed at which time the MRR will be resolved on the Clarity application. Once the provider has completed/signed the MRR request with the appropriate documentation, the document will be given to medical records to upload in the residents' medical record under the documents tab. The Nurse Practice Educator will compete education on Medication Monitoring for Medication Management section 8.4 for Gradual Dose Reduction for Psychotropic Medications with emphasis on the physician documenting the clinical rationale for why any additional attempted dose reductions at that time would be likely to impair the resident's function or increase distressed behavior (attachment A). Education will be completed with all nursing leadership to include the DON, Assistant Director of Nursing, Infection Preventionist, and Unit Managers, and current medical providers to include the Medical Director and nurse practitioner on staff. Education on the new process will occur by 7/28/2026. A separate virtual education was provided to the current psychiatric providers by TeamHealth leadership on 7/20/2026 on the importance of thorough GDR documentation which must include why a GDR is clinically appropriate and attempted or why a GDR is not clinically appropriate or contraindicated. D. The DON/designee will complete audits (attachment F) to ensure GDR documentation by the provider is completed to include rationale for any	08/06/2026

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F0605 SS = D	Continued from page 8 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner	F0605	Continued from page 8 contraindication for GDR. All MRRs will be audited monthly until 100% is achieved on 5 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Improvement Committee monthly for review and recommendations.	08/06/2026

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F0605 SS = D	Continued from page 9 evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R28) out of five residents sampled for medication review, the facility failed to document the rationale for a contraindicated GDR (gradual dose reduction) of a psychotropic medication. Findings include: Review of R28's clinical record revealed: 9/26/18 - R28 was admitted to the facility. 7/10/24 - A physician's order documented divalproex sodium (anticonvulsant) 500 mg give one tablet daily at bed time for bipolar mood stabilization. 10/2/24 - A physician's order documented buspirone 15 mg (anti-anxiety) twice a day for anxiety. 10/7/25 - A monthly medication regimen review (MRR) documented a recommendation to attempt dose reduction on divalproex to 250 mg. 10/2025 - A review of provider progress notes for the month of October lacked evidence of a rationale or contraindication for a GDR of the aforementioned medication. 1/8/26 - A MRR documented a recommendation to attempt dose reduction of buspirone to 10 mg. 1/2026 - A review of provider progress notes for the month of October lacked evidence of a rationale or contraindication for a GDR of the aforementioned medication. 6/26/26 11:41 AM - During an interview, E2 (DON) reviewed providers progress notes and confirmed that the progress note lacked evidence of a rationale or contraindication for GDR's. 6/30/25 12:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0605		08/06/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out	F0677	"Past Noncompliance - no plan of correction required"	09/05/2025

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F0677 SS = D	Continued from page 10 activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, it was determined that for one (R16) out of 10 residents reviewed for Activities of Daily Living (ADL's). The facility failed to ensure that a resident who was dependent on staff for ADL's received the necessary assistance with personal care. Due to the facility's corrective measures following the incident this is being cited as past non-compliance with a correction date of 9/5/25, which was verified by interviews and review of facility records. Findings include: Record review for R16 revealed: 8/8/25 – R16 was admitted to the facility. 8/15/25- R16 's MDS admission assessment doc umented a BIMS score of 9, indicating cognitive impairment and was partial to moderate assistance for toileting. 8/29/25 - A review of the CNA task flow sheet documented bathing, toileting and hygiene lacked evidence of completion. 9/5/25 - A review of the facility's five-day follow-up investigation revealed the allegation of neglect was verified. The investigation documented that E13 (CNA) reported R16 was asleep in the morning. E13 acknowledged that R16 did not receive incontinent care, turning and repositioning, or hydration until approximately 1:30 PM, about seven hours into the scheduled shift. The investigation concluded that required resident care had not been provided. Additional interviews obtained after the exit: During an interview, E11 (RN) stated that if she is notified that a resident did not receive required ADL care, she would immediately direct the nursing assistant to provide the care and notify the unit manager of the concern. During an interview E12 CNA, stated that when we are unable to provide care to a resident, she notifies the charge nurse. During an interview, E10 (Unit Manager) confirmed that on 8/29/25, a telephone interview was	F0677		09/05/2025

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F0677 SS = D	Continued from page 11 conducted with E13 (CNA) as part of the facility's investigation. E10 stated that E13 reported arriving for her scheduled 6:00 AM to 2:00 PM shortly after 6:00 AM. E13 stated she entered R16's room around breakfast time and, with the assistance of another CNA, repositioned the resident while the resident was sleeping. E13 stated the next time she entered R16's room was approximately 1:00 p.m. to prepare the resident for discharge after the family had arrived. When asked whether she had provided incontinent care before that time, E13 stated, "I'm not going to lie, no I didn't." The facility's Plan of Correction documented that the resident had been transferred to the hospital prior to implementation of corrective actions. The facility placed the CNA on administrative leave pending the outcome of the investigation. Identification of other residents potentially affected, the facility completed head-to-toe skin assessments for residents requiring incontinent care and reported no additional skin concerns. Certified Nursing Assistants received re-education on the facility's Continence Management and Perineal Care policy. The facility implemented weekly skin audits of ten residents requiring incontinent care. The Nursing Home Administrator and Director of Nursing were designated responsible for oversight of the corrective actions. Interviews, documents and observations verified the facility had met the requirements for past noncompliance as of 9/5/26.	F0677		09/05/2025
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review and review of other facility records, it was determined that for one (R25) of eleven residents reviewed for accidents, the facility failed to provide an accident-free environment. R25 fell from a Hoyer lift onto the floor during a transfer due to improper use of the lift by	F0689	"Past Noncompliance - no plan of correction required"	01/09/2026

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F0689 SS = D	Continued from page 12 two staff members. The Hoyer lift fell on R25's right knee. R25 complained of pain and was sent to the hospital for further evaluation and treatment. Due to the facility's corrective measures following this incident, this deficiency is being cited as past non-compliance with a corrected date of 1/9/26, which was verified through interviews and review of facility records. Findings include: 10/22/25 – R25 was admitted to the facility. 1/8/26 6:30 PM - A review of a facility incident report submitted to the Division documented "R25 fell from the Hoyer lift at this time." 1/8/26 9:38 PM – A review of a facility incident report to the Division documented "CNA notified nursing that [R25] had fallen from the Hoyer." Further review of the report indicated R25 complained of feeling a snap in the back, and right knee pain due to the Hoyer lift falling on the R25's right side. 1/14/26 – A review of the facility's five day follow up submitted to the Division documented that E5 (CNA) reported assisting E6 (CNA) with transferring R25 from the chair to the bed. R25 was placed on the Hoyer pad and raised to waist level while E6 guided R25's legs. E5 further reported closing the base of the Hoyer lift slightly because the room was tight, causing Hoyer to tip over. E5 stated an attempt was made to reopen the Hoyer, but the attempt was unsuccessful. E5 further reported that R25 landed on the floor and the bars of the Hoyer lift struck R25's legs. 1/8/26 6:46 PM – A facility SBAR (Situation, Background, Assessment, and Recommendation) form documented recommendation to perform neurological checks and send R25 to the hospital. 1/8/26 11:30 PM – R25 returned to the facility. 1/9/26 3:17 AM – A facility progress not for R25 documented, "Pain, right lateral thigh; pain score 2; aching; non radiating R25 position was changed. Non medication interventions provided relief." 1/9/26 6:03 AM – A review of R25's hospital Xray results of the right knee documented "No acute fracture or dislocation. Degenerative changes primarily involving the medial compartment. 6/29/26 12:42 PM – During a telephone interview E5 (CNA) reported "[E6] (CNA) asked for assistance transferring [R25] to bed. I was operating the lift, and	F0689		01/09/2026

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F0689 SS = D	Continued from page 13 it was hard to move. The roommate's recliner chair was in the way, so I slightly opened the base of the Hoyer lift so [E6] could navigate the lift to the bed. [E6] was holding [R25's] legs while guiding the transfer. I noticed one wheel of the Hoyer lift lifted off the floor, and I tried to widen the base, but I couldn't. [R25] was waist high in the lift and I was turning it, the lift tipped over onto [R25]. I went down too while trying to prevent the fall. I was removed from the unit and received hands on training for the lift and safety." 6/29/26 1:55 PM – During an interview, E6 reported "I called [E5] to assist with putting [R25] back into the bed. [E5] was operating the Hoyer lift while I guided [R25's] legs. We didn't realize the other resident's recliner chair was in the way. The Hoyer started to tip over, and we both tried to stop it, but [E5] ended up going down on the floor too. The nurse was notified right away." E6 then stated, "I was not allowed to assist another resident until I completed Hoyer lift and safety training and demonstrated competency." 6/30/26 10:34 AM – During a telephone interview, E8 (RN) reported "That was a long time ago I don't remember all the details. What I do recall is that I was immediately notified by one of the CNAs. although I don't remember which one. I assessed [R25], provided education to [E5, E6] and other staff, and documented that education in my statement. I completed the SBAR form, and I know that [R25] was sent to the hospital. However, since this occurred in January, I don't recall all of the detail." 6/30/26 9:15 AM- During an interview, E2 (DON) reported "I was notified immediately. [E5 and E6] were removed from the unit. I wasn't sure whether the Hoyer lift malfunctioned, so the equipment was removed from the unit and tagged for inspection by maintenance. [E5 and E6] were not allowed to return to the floor until they completed and demonstrated competency in the use of the Hoyer lift." The facility's immediate action included: 1/8/26 6:30 PM – The attending on-call provider was notified. 1/8/26 6:37 PM - R25 was transferred to the hospital by 911. 1/8/26 6:45 PM – R25's family was notified. 1/8/26 - A facility form titled "Quality Assurance & Assessment" was completed by E5 and E6.	F0689		01/09/2026

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F0689 SS = D	Continued from page 14 1/8/26 – The mechanical Hoyer lift was removed from the unit, and a lockout/ tagout device was applied pending inspection by maintenance. on the lift for maintenance to inspect. 1/9/26 – E5 and E6 completed hands-on training, a skills check list, return demonstration, and re-education on the proper use of the Hoyer lift, gait belt, and safe resident handling using mechanical lifts. 1/9/26 1:19 PM – A maintenance work order documented, "Lift needs inspected for safety function." The lift was inspected, no defects were identified and the lift was returned to service. 6/30/26 – The facility's response to R25's fall, which resulted from the improper use of the Hoyer lift by staff, included removing the Hoyer lift from service for inspection. E8 documented education provided to E5, E6 and other staff assigned to the unit following the incident. E5 and E6 were removed from resident care duties, until they successfully completed hands-on competency training for Hoyer lift transfers and gait belt use. Interviews with E5 and E6, along with review of facility records, confirmed that the required education and competency validation had been completed. 6/30/25 12:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F0689		01/09/2026
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d)	F0756	A. MRRs for R28 for 10/7/2025 and 1/8/2026 were completed by the provider 7/21/2026. B. All current residents with MRRs for July were evaluated by the DON by 7/23/2026 and follow up with the medical provider will be completed by 7/31/2026. C. A root cause analysis was completed on 7/20/2026 to determine a new process was needed to review Medication Review Regimens (MRRs). When the consultant pharmacist completes the MRR for a resident, she ensures the document is uploaded into PharMerica electronic platform ViewMasterRx under consulting reports. The DON/designee will utilize the ViewMasterRx consulting reports by clicking on the view reports link to review the uploaded pdf report from the previous day. This report will be reviewed daily in the Morning Clinical meeting for any MRR that has	08/06/2026

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F0756 SS = D	Continued from page 15 of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R28) out of five residents reviewed for medication review, the facility failed to ensure the provider documented that irregularities were reviewed. Findings include: Review of R28's clinical record revealed: 9/26/18 - R28 was admitted to the facility. 7/10/24 - A physician's order documented divalproex sodium (anticonvulsant) 500 mg give one tablet daily at bed time for bipolar mood stabilization. 10/2/24 - A physician's order documented buspirone 15 mg (anti-anxiety) twice a day for anxiety. 10/7/25 - A monthly medication regimen review (MRR) documented a recommendation to attempt dose reduction on divalproex to 250 mg. The MRR lacked physician's signature and acknowledgement the recommendations were reviewed. 1/8/26 - A MRR documented a recommendation to attempt dose reduction of buspirone to 10 mg. The	F0756	Continued from page 15 been completed by the pharmacy. The DON/designee will document any reports containing pharmacy recommendations that need to be addressed by provider and/or nursing in the center's Clarity application for provider/nursing follow up. Follow up needed will be documented in the pre-work using the Other tab of the Clarity application indicating follow-up is needed. The DON/designee will update the Clarity application documentation after the follow-up documentation has been completed at which time the MRR will be resolved on the Clarity application. Once the provider has completed/signed the MRR request with the appropriate documentation, the document will be given to medical records to upload in the residents' medical record under the documents tab. The Nurse Practice Educator will compete education on Medication Monitoring for Medication Regimen Review and Reporting Section 8.1 Policy and Procedures with emphasis on for those issues requiring physician intervention, the attending physician either accepts and acts up on the report and recommendations or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the the resident's medical record. The Nurse Practice Educator will complete education (attachment A) with all nursing leadership to include the DON, Assistant Director of Nursing, Infection Preventionist, and Unit Managers, and current medical providers to include the Medical Director and nurse practitioner on staff by 8/6/2026. D. The DON/designee will complete audits (attachment G) to ensure MRR documentation by the provider is completed timely and in the electronic health record. All MRRs will be audited monthly until 100% is achieved on 5 consecutive reviews. Results of audits will be presented to the Quality Assurance Performance Improvement Committee monthly for review and recommendations.	08/06/2026

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F0756 SS = D	Continued from page 16 MRR lacked physician's signature and acknowledgement the recommendations were reviewed. 6/26/26 11:41 AM - During an interview, E2 (DON) stated the expectation is for the provider to complete and sign the MRR recommendation form and if changes need to be made the provider would document those changes in the EMR (electronic medical record). E2 confirmed the aforementioned MRR forms were not signed and the provider progress notes lacked evidence of acknowledgement of the recommendations. 6/30/26 12:00 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0756		08/06/2026