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: Regency Healthcare and Rehab Center **DATE SURVEY COMPLETED: June 26, 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 26, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was eighty-five (85). The investigative sample totaled twenty (20) residents.		7/31/26
3201	**Regulations for Skilled and Intermediate Care Facilities**	Please refer to the CMS 2567-L survey completed June 26, 2026: F600, F656, F657, F684, F686, F880, F881 and F919.	
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 June 26, 2026: cross refer: F600, F656, F657, F684, F686, F880, F881 and F919.		

Provider's Signature _____ Title Nursing Home Administrator Date 7/14/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085012	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	**801 N. BROOM STREET , WILMINGTON, Delaware, 19806**

(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 26, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		07/13/2026
F0000	INITIAL COMMENTS An unannounced annual, complaint and emergency preparedness survey was conducted at this facility from June 23, 2026, through June 26, 2026. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was eighty-five (85). The investigative sample totaled twenty (20) residents.Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; BIMS (Brief Interview for Mental Status) - a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0 is reflective of severe cognition deficit, 8-12 reflects moderate cognition deficit and 13-15 is reflective of normal cognition; Cerebral Infarction - stroke in the brain; CNA - Certified Nursing Assistant; DON - Director of Nursing; Epilepsy - a chronic brain disorder characterized by recurrent, unprovoked seizures caused by abnormal electrical activity in the brain; Hemiparesis - unilateral weakness of the entire left or right side of the body; Hemiplegia - half of the body paralyzed;	F0000		07/13/2026

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

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

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

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	085012	A. BUILDING B. WING	06/26/2026

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F0000	Continued from page 1 LPN - Licensed Practical Nurse; MAR - Medication Administration Record; McGreer Criteria - standardized guidelines used to identify and monitor infections in long term care facilities; MDRO - bacteria that required Enhanced Barrier precautions; MDRO - multi - drug resistant organisms; MDS assessment - federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; NHA - Nursing Home Administrator; Neuropathy - disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness; Nurse Practitioner - N/P; PEG - percutaneous gastrostomy tube, an indwelling medical device that allows direct feeding of the stomach via a tube; PRN - as needed; RN - Registered Nurse; Urinalysis (UA) - diagnostic test used to determine presence of infection; Urinary Tract Infection (UTI) - bacteria in urine;	F0000		07/13/2026
F0881 SS = E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is NOT MET as evidenced by:	F0881	A. R11 continues to reside at the facility. The medical record for R11 was immediately reviewed by the Director of Nursing and Infection Preventionist. The antibiotic stewardship documentation was completed, including review of clinical indication, culture results, antibiotic appropriateness, duration of therapy, and physician documentation. The attending practitioner was notified and documentation completed. B. Residents with antibiotics initiated have the potential to be affected by this deficient practice. IP or designee will audit all residents receiving antibiotic therapy within the previous 30 days to verify: McGeer Criteria documentation, Initial antibiotic review, Ongoing antibiotic stewardship	07/31/2026

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F0881 SS = E	Continued from page 2 Based on interview and record review, it was determined that for one (R11) out of five residents reviewed for unnecessary medications, the facility failed to have evidence of ongoing antibiotic stewardship implementation when R11's antibiotic usage was not reviewed after not meeting facility antibiotic prescribing criteria. Findings include: CDC (Center for Disease Control and Prevention) guidance dated 2015, entitled, "The Core Elements of Antibiotic Stewardship for Nursing Homes" states, "...Standardize the practices which should be applied during the care of any resident suspected of infection or started on an antibiotic. These practices include...implementing an antibiotic review process, also known as an "antibiotic time-out," for all antibiotics prescribed in your facility. Antibiotic reviews provide clinicians with an opportunity to reassess the ongoing need for an antibiotic…". A facility policy entitled, "Antibiotic Stewardship-Staff and Clinician Training and Roles" included, "…2. The DON will monitor individual resident antibiotic regimens…3. The IP will audit and the DON will provide feedback to providers on antibiotic prescribing practices…". Review of R11's clinical record revealed: 12/27/24 – R11 was admitted to the facility. 4/15/26 8:25 AM – An Encounter Note entered in R11's clinical record documented, "…UA [urine analysis] was positive for UTI [urinary tract infection] and [R11] was ordered Sulfamethoxazole-Trimethoprim Oral tablet [antibiotic] 800-160 MG [milligrams] twice a day for 7 days…". 4/17/26 1:00 AM – An Encounter Note entered in R1's clinical record documented, "…[R11] is seen for follow up UTI…was started on [antibiotic]…however now susceptibility is back and shows organism is Klebsiella pneumoniae [bacteria]…change antibiotic to Amoxicillin-Pot Clavulanate 500-125 mg twice daily for seven days…". 6/25/26 1:45 PM – During an interview, the surveyor asked E6 (IP, LPN) what antibiotic surveillance criteria does the facility use. E6 stated, "We use McGreer criteria." 6/26/26 9:00 AM – Review of the facility's resident antibiotic surveillance tracking form for 4/2026 revealed it was documented that R11 did not meet	F0881	Continued from page 2 review at either Weekly High Risk or Monthly QAPI meetings with any deficiencies identified being corrected immediately. C. Root cause analysis indicates facility's antibiotic stewardship process was being discussed clinically but ongoing review was not consistently documented. IP and/or designee will in-service Infection Preventionist, DON, Nurse Managers and Providers regarding the importance of Antibiotic Stewardship policy reviewed, Antibiotic Time-Out form implemented for every resident receiving antibiotics, Weekly High Risk or monthly QAPI Meeting agenda explicitly include antibiotic review. D. The Infection Preventionist/designee will audit 100% of residents receiving antibiotics for: McGeer Criteria documentation, Initial antibiotic review, Ongoing review, Weekly High Risk and Monthly QAPI documentation. Monitoring will occur:1) daily until 100% success is achieved over 5 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	07/31/2026

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F0881 SS = E	Continued from page 3 McGreer criteria for the Sulfamethoxazole-Trimethoprim Oral Tablet or Amoxicillin-Pot Clavulanate Oral Tablet antibiotic medications prescribed. 6/26/26 10:30 AM – During an interview, the surveyor asked E2 (DON) how the facility reviews residents prescribed antibiotics that do not meet McGreer criteria. E2 stated, "I am not involved with antibiotic stewardship, E4 handles that. Nursing does meet with the providers and we discuss the residents at morning meeting." 6/26/26 10:45 AM – During an interview, the surveyor asked E1 (NHA) how residents are reviewed when prescribed an antibiotic that does not meet McGreer criteria. E1 stated, "Residents who do not meet the criteria are reviewed during our weekly high-risk meeting and again at monthly QAPI [quality assurance] meeting." The surveyor requested documentation of R11's antibiotics review. E1 stated, "I will look for the documentation." 6/26/26 11:15 AM – E1 gave the surveyor a facility document entitled, "Progress Note", that documented, "…Resident: [R11] Date: 4/15/2026…UM reviewed UA [urinalysis] with provider. UA was positive for UTI and resident was ordered Sulfamethoxazole-Trimethoprim Oral Tablet…". No documentation was provided for the ongoing review of R11's antibiotic prescriptions after 4/15/26. 6/26/26 12:15 PM – Findings were reviewed with E1 and E2. 6/26/26 1:45 PM – Findings were reviewed with E1, E2 and E4 (DCS) during the exit conference.	F0881		07/31/2026
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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-	F0600	"Past Noncompliance - no plan of correction required"	06/26/2026

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F0600 SS = D	Continued from page 4 §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of other facility documents, it was determined that for one (R32) out of three residents reviewed for abuse, the facility failed to ensure that R32 was free from verbal abuse from a staff member on 1/9/26. Based on review of the facility's evidence to correct the deficient practice and substantial compliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 1/11/26. Findings include: A facility document entitled "Abuse Prevention Policy", dated 2001 and revised 4/21, included, "Mental abuse is the type of verbal or non-verbal abuse conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation or degradation. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written or gestured communication, or sounds to residents within hearing distance, regardless of age, ability to comprehend or disability." R32's clinical record revealed: 12/27/24 – R32 was admitted to the facility with diagnoses including, but not limited to, heart disease, right above the knee amputation, muscle weakness and food insecurity. 12/31/25 – R32's annual MDS documented a BIMS score of 15, indicating a fully intact cognitive status. The MDS also documented that R32 was independent with eating and wheelchair mobility. 1/10/26 5:01 PM – A facility incident report submitted to the Division included, "Resident reported today, 1/10/26, that he asked a CNA for an extra sandwich to have after dinner while in the dining room eating on 1/9/26. He [R32] said that she [CNA] told him to get it himself and that if she did get him the sandwich that she would spit on it…" 6/25/26 1:00 PM – During an interview, the Surveyor asked R32 about the incident. R32 stated, "I am okay. I get plenty of food to eat here. I just wanted to have a sandwich to eat later in case I got hungry later. That girl was rude, but the rest of the staff are	F0600		06/26/2026

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F0600 SS = D	Continued from page 5 nice." The Surveyor asked R32 whether there were any previous instances where a staff member had been rude to him about food or anything else. R32 stated, "No, that was the only time." 6/25/26 1:30 PM - During a combined interview, E1(NHA) and E2 (DON) stated, "Abuse of any kind is not tolerated. We provided support to the resident, checked whether any other residents received similar treatment and educated the staff on abuse prevention immediately." The facility failed to ensure that R32 was free from abuse by the staff member. The facility's action plan included: Upon learning of the incident, the staff member was immediately removed from the schedule. DON completed a random audit of residents on 1/10/26 with no further deficient practice identified. The facility immediately initiated reeducation for all staff members on abuse prevention on 1/10/26. A review of risk management for 90 days was completed to assess that no additional incidents of abuse occurred, with no additional incidents identified. The facility conducted ongoing audits to monitor compliance. The facility conducted interviews for 3 residents for 5 days, then 3 residents per week for 3 weeks, and then monthly for at least 3 months until substantial compliance is achieved. The facility QAPI committee reviewed the results of the observations made by the DON/designee to identify any trends/conduct root cause analysis and develop a plan of action for follow-up and resolution if necessary. 6/26/26 1:00 PM – Based on the Surveyor's review of the facility's investigation, documented response, completion of staff education from 1/10/26 to 1/11/26, staff interviews, and no further incidents of abuse, this deficient practice was considered past non-compliance with a compliance date of 1/11/26. 6/24/26 11:00 AM – Findings were confirmed with E1 (NHA), and E2 (DON). 6/26/26 1:45 PM - Findings were reviewed with E1, E2 and E4 (DCS) during the exit conference.	F0600		06/26/2026

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F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by:	F0656	A. R26 continues to reside at the facility. Comprehensive care plan was immediately updated during survey to reflect anticoagulation therapy, bleeding risks, monitoring, and interventions for R26. The ADON or designee will be responsible for corrective action. B. Residents with orders for anticoagulant medications have the potential to be affected by this deficient practice. The ADON or designee will audit current residents with orders for anticoagulant medications to ensure their respective care plan are updated. C. The root cause analysis determined physician orders for anticoagulant medications were not consistently incorporated into care plans. The Facility Educator will educate licensed nurses. New anticoagulant orders will be reviewed during the daily morning interdisciplinary clinical meeting (Monday–Friday). The Assistant Director of Nursing (RN) or designee will ensure care plans are updated to reflect new anticoagulant medications, their risks, monitoring needs, and interventions within 24 hours of initiation or medication changes. D. The ADON or designee will audit resident orders for anticoagulant medications: 1) daily until 100% success is achieved over 5 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	07/31/2026

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F0656 SS = D	Continued from page 7 Based on record review and interview, it was determined that for one (R26) out of 20 residents reviewed for care plans, the facility failed to develop a person-centered care plan for an identified need. Findings include: Review of R26's record revealed:7/30/25 – R26 was admitted to the facility with diagnoses including atrial fibrillation, VTE (Venous Thrombosis and Embolism) and dementia. 7/30/25 – An order for Eliquis (an anticoagulant/blood thinner) 5 mg twice a day was entered into R26's medication profile. 8/5/25 – R26's admission MDS (Minimum Data Set Screening Tool) documented under the High-Risk Drug Class section that R26 was receiving anticoagulation therapy. 11/4/25 – R26's quarterly MDS documented under the High-Risk Drug Class section that R26 was receiving anticoagulation therapy. 12/8/26 – An order to change the dose of Eliquis to 2.5 mg twice a day was entered into R26's medication profile. 2/4/26 – R26's quarterly MDS documented under the High-Risk Drug Class section that R26 was receiving anticoagulation therapy. 5/6/26 - R26's quarterly MDS documented under the High-Risk Drug Class section that R26 was receiving anticoagulation therapy. 6/24/26 2:45 PM – Review of R26's EHR (Electronic Health Record) lacked evidence that R26's comprehensive care plan addressed anticoagulation therapy, including associated bleeding risks, monitoring needs, and interventions to reduce the risk of bleeding complications. 6/24/26 3:49 PM – During an interview, E14 (RN, MDS Coordinator) reviewed R26's EHR and confirmed that R26 was receiving anticoagulation therapy which was not addressed in R26's comprehensive care plan. 6/24/26 3:55pm – Findings reviewed and confirmed during an interview with E1 (NHA). 6/24/26 1:45 PM - Findings were reviewed with E1, E2 (DON) and E4 (DCS) during the Exit Conference.	F0656		07/31/2026

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F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R67) out of 20 residents reviewed for care plans, the facility failed to review and revise a person-centered care plan for an identified need. Findings include: Review of R67's clinical record revealed: 3/15/22 - R67 was admitted to the facility with diagnoses including dementia and major depression disorder. 2/24/26 - R67's annual MDS assessment documented that R67's cognition was moderately impaired. R67 had no mood and behavior issues during the review period and was not receiving antipsychotic medication.	F0657	A. R67 continues to reside at the facility. ADON has updated the Care Plan to reflect antipsychotic medication, monitoring requirements, and/or potential side effects. B. Residents with orders for antipsychotic medications have the potential to be affected by this deficient practice. The UM or designee will audit current residents with orders for antipsychotic medications to ensure their respective care plan are updated to reflect the antipsychotic medication, monitoring requirements, and/or potential side effects. C. The root cause analysis determined physician orders were not consistently incorporated into care plans. Licensed nurses will be educated. New antipsychotic orders will be reviewed during the daily morning interdisciplinary clinical meeting (Monday–Friday). The RN Unit Manager or designee will ensure care plans are updated within 24 hours of initiation or medication changes. Facility educator or designee will in-service licensed nursing staff on developing and updating a comprehensive care plan to account for orders of antipsychotic medications. Care plans will be updated and new orders will be reviewed in clinical meeting to reflect new antipsychotic medications, their risks, monitoring needs, and interventions. D. The UM or designee will audit resident orders for antipsychotic medications: 1) daily until 100% success is achieved over 5 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	07/31/2026

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REGENCY HEALTHCARE & REHAB CENTER	**801 N. BROOM STREET , WILMINGTON, Delaware, 19806**

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F0657 SS = D	Continued from page 9 2/24/26 - R67 was care planned for the use of antidepressant medication related to depression with interventions including administering medications per order and monitoring R67 for any changes in behavior or mood. 3/9/26 - R67 had a physician's order for aripiprazole 5 mg tablet by mouth once a day, an antipsychotic medication, for major depressive disorder. 4/23/26 - A psychiatric encounter note documented that a gradual dose reduction of the R67's antipsychotic medication was evaluated during this visit and was not recommended at this time. 5/27/26 - R67's quarterly MDS assessment documented that R67's cognition was moderately impaired. R11 had no mood and behavior issues during the review period and was receiving antipsychotic medication. 6/24/26 - Further review of R4's care plan for major depressive disorder lacked evidence that it was reviewed and revised to address R67 receiving an antipsychotic medication and for its side effects to be monitored including involuntary movements, tremors, dry mouth, urinary retention, seizures, blurred vision, rashes, sedation, dystonia or rigidity. 6/24/26 - A review of R67's Medication Administration Reports from April 2026 through June 23, 2026, revealed that R26 was monitored for side effects for taking antipsychotic medications including involuntary movements, tremors, dry mouth, urinary retention, seizures, blurred vision, rashes, sedation, dystonia or rigidity. 6/24/26 11:00 AM - During an interview, E11 (LPN) confirmed that R67's care plan interventions did not include the use of antipsychotic medication and its side effects for monitoring. 6/25/26 1:30 PM - Findings were discussed with E1 (NHA) and E2 (DON).	F0657		07/31/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment	F0684	A. R56 continues to reside at the facility. His Pain patch order was reviewed and resident assessed. R71 continues to reside at the facility. Resident receiving bowel protocol reviewed and treatment initiated. Physicians notified as appropriate. B. Resident requiring pain patches have the	07/31/2026

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F0684 SS = D	Continued from page 10 of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of other facility documents, it was determined that for two (R56, and R71) out of three residents reviewed for care and services in accordance with professional standards, it was determined that the facility failed to ensure that R56's medication pain patch was removed on the evening shift according to the physician's order. For R71, the facility failed to ensure that the bowel protocol was implemented when R71 did not have a bowel movement for 5 days. Findings include: 1. R56's clinical record revealed: 10/12/22 - R56 was admitted to the facility with diagnoses including, but not limited to, cardiovascular accident, and back pain. 10/6/25 – R56's pain care plan documented, "[R56] has a potential for alteration in comfort related to pain." The interventions included, "Assist with turning and repositioning as needed. Medication as ordered." 4/10/26 – R56's quarterly MDS assessment documented a BIMS score of 6, indicating a severe cognitive impairment. R56 required partial to moderate assistance from staff for repositioning in bed, and transfers between surfaces. 5/3/26 – R56's physician's orders included, "Icy Hot External Patch 5% (menthol topical analgesic.) Apply to lower back topically one time a day and remove per schedule. Apply at 0900 [9:00 AM] and remove at 2000 [8:00 PM]". 6/23/26 8:00 PM – R56's clinical record documented that the patch was removed. 6/24/26 9:30 AM – During the medication administration, E7 (LPN) was observed removing a patch from R56's back. The patch was dated 6/23/26 and the time was 9:00 AM. The Surveyor asked E7 whether the patch should still be on at the current time. E7 stated, "My computer screen only shows me what medications I should give on my shift." E7 checked the previous evening record, and stated, "The order was signed off, the patch should	F0684	Continued from page 10 potential to be affected by this deficient practice. DON or designee will audit residents with scheduled topical medications. Residents with prolonged absence of bowel movement have the potential to be affected by this deficient practice. The DON or designee will audit residents with prolonged absence of bowel movement to ensure initiation of bowel protocols is underway timely. Daily clinical meeting will ensure look back is performed to ensure that the proper process was followed. C. Root cause analysis indicated that licensed nursing staff did not consistently follow physician orders, electronic health record (EHR) bowel protocol alerts, and medication administration requirements related to scheduled pain patch removal and timely initiation of bowel protocol. The Staff Development Coordinator and/or designee will provide education to all licensed nurses regarding adherence to physician orders for pain patch application and removal, timely initiation of bowel protocol, and accurate documentation. Unit Managers and Nursing Supervisors will review PCC bowel protocol alerts at the beginning of each shift and communicate residents requiring intervention during shift report. Certified Nursing Assistants (CNAs) will continue to document bowel movements each shift and immediately notify the licensed nurse of residents meeting bowel protocol criteria. The daily morning interdisciplinary clinical meeting (Monday through Friday) will include review of residents receiving scheduled pain patches and residents meeting bowel protocol criteria to verify physician orders, EHR alerts, documentation, and timely implementation of required interventions. D. The Director of Nursing (DON) or designee will conduct direct observation and record review to verify compliance with scheduled pain patch administration and removal. Compliance will be verified by comparing physician orders, the Medication Administration Record (MAR), and direct visual observation of the resident to ensure pain patches are applied, dated, timed, and removed according to physician orders. For bowel protocol compliance, the DON or designee will audit 100% of residents meeting facility bowel protocol criteria to verify timely initiation of bowel protocol interventions. Compliance will be verified through review of PCC bowel movement documentation, bowel protocol alerts, physician	07/31/2026

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F0684 SS = D	Continued from page 11 have been removed last evening." 6/24/26 9:45 AM – During an interview, E15 (N/P) stated, "The patch is mentholated and should not cause toxicity. But it might cause skin irritation. The manufacturer's instructions to apply in the morning and remove in the evening should have been followed." The facility failed to ensure that R56's medicated pain patch was removed per the physician's orders. 6/24/26 11:00 AM – Findings were confirmed with E1 (NHA), and E2 (DON). 2. The facility's undated bowel management policy entitled, "Bowel Protocol" included, "Physician ordered bowel protocol includes: Milk of Magnesia (laxative)…give if no bm (bowel movement) in 3 days…administer one suppository if no results from Milk of Magnesia within 24 hrs…Fleet Enema…give the following shift if no results from suppository. Call MD if no results from fleet enema by the end of the shift given." R74's clinical record revealed: 3/15/23 – R74 was admitted to the facility with diagnoses including neuropathy and cerebral infarction. 9/8/25 – An order was entered in R74's clinical record documented, "Lactulose (laxative) Solution…BM PROTOCOL if no BM for 3 days give 30 mL (milliliters)…". 9/8/25 – An order was entered in R74's clinical record documented, "…Bowel Protocol administer one suppository if no results from Milk of Magnesia or Lactulose within 8 hrs…". 3/5/26 – R74's quarterly MDS assessment documented a BIMS score of 14, indicating an intact cognition. 3/5/26 – R74's updated care plan documented, "…Potential for constipation…Resident will have a bowel movement every 3 days through next review…monitor consistency and frequency of bowel movements…". 5/28/26 1:00 AM – An Encounter Note entered in R74's clinical record documented, "…[R74] is seen today for complaints of constipation, no bowel movement x3 days. [R74] does have a long history	F0684	Continued from page 11 orders, MAR/TAR documentation, nursing progress notes, and confirmation that required interventions were initiated according to facility policy. Any identified noncompliance will be corrected immediately, additional staff education will be provided as indicated, and follow-up monitoring will be completed. The DON or designee will conduct review of pain patch administration and removal are done correctly as well as bowel protocol compliance at daily morning meeting and at end of day wrap-up to confirm all actions were verifiably completed: 1) daily until 100% success is achieved over 5 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	07/31/2026

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F0684 SS = D	Continued from page 12 of constipation…". 5/28/26 11:06 AM – An Administration Note entered by E8 (LPN) documented, "…Gave 30 mL of Lactulose during this shift, [R74] stated he did not have a BM in the last several days. BM protocol implemented…". 6/23/26 4:09 PM – During an interview, R74 stated, "I will not have a bowel movement for long periods of time." 6/24/26 9:00 AM – Review of R74's "Documentation Survey Report" for 5/2026 revealed that on 5/23/26, 5/24/26, 5/25/26, 5/26/26, 5/27/26 or 5/28/26, it was documented that R74 had no bowel movement. R74 did not have a bowel movement for over 5 days before the bowel management protocol was implemented. The bowel management protocol was implemented after R74 complained to staff of constipation. 6/26/26 8:16 AM – During an interview, E8 stated, "The CNAs document the residents' bowel movements. If a resident does not have a bowel movement in 3 days, an alert in [EHR (electronic health record)] will trigger." The surveyor asked E8 who initiates the bowel protocol if a resident does not have bowel movement in 3 days. E8 stated, "I would initiate the BM protocol." The surveyor asked E8 if R74 had complained of constipation or had any triggered alerts. E8 stated, "I'm sorry, I don't remember." 6/26/26 8:30 AM – During an interview E9 (CNA) stated, "I don't know the BM protocol but if a resident is not going, I would tell the nurse. We document the residents' bowel movements in [EHR]. I think the nurses get an alert if a resident has not had a BM." 6/26/26 12:15 PM – Findings were reviewed with E1 (NHA) and E2 (DON). 6/26/26 1:45 PM - Findings were reviewed with E1, E2 and E4 (DCS) during the exit conference.	F0684		07/31/2026
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a	F0686	A. R4 continues to reside at the facility. Resident assessed and wound treatment immediately completed following policy. No changes or decline in wound was assessed. Licensed nurse completing the treatment was immediately educated. Unit Manager or designee will be responsible for corrective action.	07/31/2026

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F0686 SS = D	Continued from page 13 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for one (R4) of two residents reviewed for pressure ulcers, the facility failed to ensure that R4, a resident with a Stage IV pressure injury, received treatment and services consistent with professional standards of practice to promote wound healing and prevent infection during a wound dressing change. Findings include: The facility's "Wound Care" policy (2001) indicated that staff were required to assemble all necessary supplies before beginning the procedure; maintain a clean field; perform hand hygiene before and after glove removal; use appropriate personal protective equipment (PPE), including gowns and gloves as indicated; utilize a no-touch technique when providing wound care; wear sterile gloves when directly contacting the wound; and bring only the disposable supplies needed for the treatment into the resident's room. The policy further specified that disposable supplies taken into the room were not to be returned to the treatment cart. Cross refer F880 A review of R4's clinical record revealed the following 1/25/25 - R4 was admitted to the facility with diagnoses including left-sided paralysis and a Stage IV pressure injury to the sacrum. 1/31/25 - The admission Minimum Data Set (MDS) assessment documented that R4 was severely cognitively impaired, required the assistance of two or more staff members for bed mobility and repositioning, was always incontinent of bowel and bladder, and had one unhealed Stage IV pressure injury present on admission.	F0686	Continued from page 13 B. Residents dependent on wound treatments have the potential to be affected by this deficient practice. UM or designee will audit current residents receiving wound care to verify adherence to wound treatment procedures. C. The root cause analysis determined that licensed nursing staff did not consistently follow the facility's Wound Care Policy related to hand hygiene, glove changes, and required personal protective equipment (PPE) during wound treatments. The Staff Development Coordinator and/or designee will provide education to all licensed nursing staff regarding proper wound care procedures, including hand hygiene before and after wound care, changing contaminated gloves as indicated, appropriate PPE utilization, and infection prevention practices. All licensed nurses will successfully complete return demonstration utilizing a wound care competency checklist prior to independently performing wound treatments. To ensure sustained compliance, the Wound Nurse and Unit Manager will review all new wound care orders during the daily morning interdisciplinary clinical meeting (Monday through Friday) to verify that treatments are completed according to physician orders and facility policy. Weekly wound rounds conducted by the wound care provider will include review of wound treatment technique, documentation, and opportunities for immediate coaching if deficiencies are identified. Unit Managers and Nursing Supervisors will verify that appropriate PPE supplies, hand hygiene products, and required signage are available on every shift. Infection prevention reminders will be reinforced during shift huddles, and any identified noncompliance will result in immediate corrective action, staff re-education, and repeat competency validation. D. UM or designee will audit current residents receiving wound care to verify adherence via observation to wound treatment procedures including proper hand hygiene, glove changes, PPE utilization: 1) daily until 100% success is achieved over 5 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved.	07/31/2026

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F0686 SS = D	Continued from page 14 4/30/25 - A skin integrity care plan documented R4's healed Stage IV sacral pressure injury. 1/3/26 - R4's annual MDS assessment documented no unhealed Stage IV pressure injury. 4/29/26 - A wound assessment documented that R4's Stage IV pressure injury to the sacrum had reopened. 5/1/26 - R4's significant change MDS assessment documented one unhealed Stage IV pressure injury. 5/1/26 - R4's care plan for impaired skin integrity and at risk for further breakdown related to incontinence and immobility was initiated with interventions to provide wound treatment to sacrum as ordered by the physician. 6/10/26 - R4's physician order directed staff to cleanse the sacral wound with normal saline solution (NSS) or wound cleanser, pat dry, apply medical-grade honey fiber, and cover with a bordered dressing daily during the evening shift and as needed for dressing displacement or soiling. 6/24/26 - A wound assessment documented that R4's Stage IV pressure injury to the sacrum was improving with delayed wound closure. 6/24/26 4:00 PM to 4:30 PM - During R4's incontinent care and a wound dressing change, the following infection control concerns were observed: After R4 had a bowel movement, E13 provided incontinent care. Following completion of incontinent care, E13 repositioned R4 using the same contaminated gloves without performing hand hygiene. E12 removed gauze from an opened multiuse package, saturated the gauze with wound cleanser, cleansed the wound, applied the prescribed treatment, and completed the dressing change. The facility failed to provide wound care consistent with professional standards of practice for R4's existing Stage IV pressure injury when E13 failed to perform hand hygiene and change gloves after providing incontinent care and before repositioning R4 during the wound dressing procedure. 6/24/26 4:33 PM - During an interview, E13 acknowledged, "I did not change my gloves after I	F0686	Continued from page 14 Results of audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	07/31/2026

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F0686 SS = D	Continued from page 15 cleaned [R4], and I did not wear my PPE gown when I started providing care." 6/24/26 4:38 PM - In an interview, E12 stated that she touched the privacy curtain with her gloved hand and that she did not wear the required gown for her PPE. E12 further stated and confirmed that E13 did not change her gloves after E13 completed R4's incontinent care. 6/25/26 1:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 6/26/26 1:45 PM - Findings were reviewed with E1, E2 and E4 (DCS) during the exit conference.	F0686		07/31/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F0880	A. R4 and R56 continue to reside at the facility. Resident assessed and PPE compliance corrected immediately. Staff reeducated before returning to resident care. B. Potentially all residents with Enhanced Barrier Precautions (EBP) have the potential to be affected by this deficient practice. Audit all residents requiring Enhanced Barrier Precautions to verify signage, physician orders, PPE availability and staff compliance C. The facility failed to consistently follow EBP requirements and identify PPE location before providing care. Facility IP and Staff Developer will review EBP policy, PPE carts standardization and staff competencies. Current and newly hired staff, including agency personnel, will receive education regarding Enhanced Barrier Precautions with return demonstration. Random observations will occur on all shifts. D. IP or designee will audit current residents with Audit Enhanced Barrier Precautions during resident care: 1) daily until 100% success is achieved over 5 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	07/31/2026

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F0880 SS = D	Continued from page 16 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews and record reviews, it was determined that for two (R4 and R56) of seven residents reviewed for infection control, the facility failed to implement an effective infection prevention and control program. Specifically, the facility failed to implement Enhanced Barrier Precautions (EBP) for R4 during incontinent care and a wound dressing change despite an active physician's order and posted EBP signage. For R56, a resident with a multidrug-resistant organism (MDRO), the facility also failed to implement Enhanced Barrier Precautions during medication	F0880		07/31/2026

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F0880 SS = D	Continued from page 17 patch administration. The facility's "Enhanced Barrier Precautions (EBP)" policy, revised February 2025, stated that Enhanced Barrier Precautions are an infection prevention measure intended to reduce the transmission of multidrug-resistant organisms (MDROs) in nursing homes. The policy required staff to don gowns and gloves before performing high-contact resident care activities for residents with known MDROs or those at increased risk for MDRO transmission. High-contact care activities requiring gowns and gloves included providing hygiene, changing briefs or assisting with toileting, and performing wound care involving any skin opening requiring a dressing. Cross Refer: F686 A review of R4's clinical record revealed the following: 6/10/26 - R4 had an active physician's order requiring Enhanced Barrier Precautions. 6/24/26 3:50 PM - An Enhanced Barrier Precautions sign was observed posted outside R4's room. 6/24/26 4:00 PM - E13 (CNA) entered the room wearing gloves but did not don the required gown before repositioning R4. 6/24/26 4:01 PM - E12 entered the room, placed the wound treatment supplies on an overbed table lined with paper towels. E12 then performed hand hygiene with sanitizer, donned gloves, but did not wear the required gown. 6/24/26 4:00 PM - 4:30 PM - An observation revealed that E12 (LPN) and E13 (CNA) provided incontinent care following R4's bowel movement and completed a wound dressing change to the sacral wound without wearing the required isolation gowns, despite the resident being on Enhanced Barrier Precautions. 6/24/26 4:33 PM - During an interview, E13 acknowledged that she did not wear the required gown when providing incontinent care and changing R4's dressing. When asked about the purpose of the Enhanced Barrier Precautions sign posted	F0880		07/31/2026

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F0880 SS = D	Continued from page 18 outside the room, E13 stated, "It is to protect myself." 6/24/26 4:38 PM - In an interview, E12 (LPN) acknowledged that she should have worn the required PPE gown while performing the wound dressing change. E12 stated, "I saw the sign, but I did not see the PPE cart by the door, and I did not know the resident's PPE supplies were hanging on the bathroom door. I only realized I had not worn the gown after I finished the treatment." The facility failed to wear the required isolation gowns while providing incontinent care and wound treatment under Enhanced Barrier Precautions. 6/25/26 1:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON). 2. R56 clinical records revealed: 10/12/22 - R56 was admitted to the facility with diagnoses including, but not limited to, cardiovascular accident and back pain. 4/10/26 – R56's quarterly MDS assessment documented a BIMS score of 6, indicating a severe cognitive impairment. R56 required partial to moderate assistance from staff for repositioning in bed, and transfers between surfaces. 10/6/25 – R56's care plan documented, "[R56] is on enhanced barrier precaution r/t [related to] MDRO." The interventions included, "Wear gowns and gloves during high contact activities. (E.g. bathing, turning)". 6/24/26 9:30 AM – During the medication administration, E7 (LPN) entered R56's room to administer a medicated patch to his back. E7 repositioned R56 in the bed and removed the current medicated patch from his back. E7 then applied a new patch to the area. E7's clothing came in contact with R56's bed linen both times during the repositioning and removal and administration of the patches. During an interview, E7 stated, "I thought he was not on barrier precautions anymore." E7 failed to observe enhanced barrier precautions during R56's medication administration despite the obvious sign on the door, and the care plan for MDRO.	F0880		07/31/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085012	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0880 SS = D	Continued from page 19 6/24/26 10:00 AM – Findings were confirmed with E1 (NHA), and E2 (DON). 6/26/26 1:45 PM - Findings were reviewed with E1, E2 and E4 (DCS) during the exit conference.	F0880		07/31/2026
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, for two (R50 and R51) out of three residents reviewed for environment, it was determined that the facility failed to ensure the call system was accessible when each residents' call bell was observed closed inside the residents' bedside table drawers. Findings include: 1. Review of R50's clinical record revealed: 6/13/19 - R50 was admitted to the facility with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting the right side. 6/1/26 – A quarterly MDS assessment documented that R50 had an upper extremity impairment on one side and a BIMS score of 8, indicating a moderately impaired cognition. 6/23/26 3:46 PM – R50 was observed laying in bed. R50's call bell was closed inside his bedside table drawer. 6/23/26 5:01 PM – R50 was observed laying in bed. R50's call bell was closed inside his bedside table drawer. During an interview, the surveyor asked E10 (LPN) why the call bell was closed inside the bedside table drawer. E10 stated, "I will take it out." 6/26/26 12:15 PM – Findings were reviewed with E1 (NHA) and E2 (DON).	F0919	A. R50 and R51 continue to reside at the facility. Upon identification of the deficient practice, the call bells for both residents were immediately removed from the bedside table drawers and placed within each resident's reach. The Director of Nursing/designee immediately notified the interdisciplinary team of the findings and reinforced the expectation that call bells must remain readily accessible to residents at all times unless clinically contraindicated or refused by the resident. Charge Nurses and assigned CNAs immediately verified that each resident's call bell was accessible during routine rounding. B. Residents have the potential to be affected by this deficient practice. To ensure resident safety, the Unit Manager/designee completed an audit of all resident rooms to verify that call bells were within reach. In addition, Charge Nurses and assigned CNAs will verify during routine rounds at the beginning of each shift and throughout the shift that each resident's call bell remains accessible and functioning. Any identified concerns will be corrected immediately. C. The facility's resident call bell expectations were reviewed and reinforced by the Director of Nursing (RN) and/or Unit Manager (RN/LPN) with all licensed nurses and Certified Nursing Assistants. Education included the following expectations: 1) Call bells must be placed within the resident's reach at all times unless otherwise clinically indicated; 2) Call bell accessibility will be verified during the beginning-of-shift safety check, during routine rounding throughout each shift, and after providing resident care; 3) If a call bell is found out of reach or not functioning, staff are required to immediately correct the issue and report any malfunction for repair; 4) Charge Nurses are responsible for supervising compliance with call bell accessibility during each shift and providing immediate corrective coaching when needed. As a system change, the facility revised its new employee orientation process to include education and competency validation regarding resident call bell accessibility, routine rounding expectations, and resident safety responsibilities before staff independently provide resident care. The Unit	07/31/2026

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	085012	A. BUILDING B. WING	06/26/2026

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F0919 SS = D	Continued from page 20 2. Review of R51's clinical record revealed: 7/20/23 – R51 was admitted to the facility with diagnoses including epilepsy and dementia. 3/26/26 – A quarterly MDS assessment documented R51 had no upper or lower extremity impairments and a BIMS score of 5, indicating a severely impaired cognition. 6/23/26 9:17 AM – R51 was observed laying in bed. R51's call bell was closed inside his bedside table drawer. 6/23/26 3:46 PM - R51 was observed laying in bed. R51's call bell was closed inside his bedside table drawer. 6/23/26 5:01 PM - R51 was observed laying in bed. R51's call bell was closed inside his bedside table drawer. During an interview, the surveyor asked E10 (LPN) why the call bell was closed inside the bedside table drawer. E10 stated, "I will take it out." 6/26/26 12:15 PM – Findings were reviewed with E1 (NHA) and E2 (DON). 6/26/26 1:45 PM - Findings were reviewed with E1, E2 and E4 (DCS) during the exit conference.	F0919	Continued from page 20 Manager/designee is responsible for implementation and ongoing compliance. D. The Unit Manager/designee will audit a sample of 5 randomly selected residents on their respective floors to ensure Charge Nurses and assigned aides are ensuring call bells are within reach of residents. Monitoring will occur as follows: 1) daily until 100% success is achieved over 5 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	07/31/2026