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: Delmar Nursing and Rehabilitation Center DATE SURVEY COMPLETED: December 5, 2025

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 Recertification with Complaint survey was conducted at this facility from December 1, 2025, through December 5, 2025. The deficiencies contained in this report are based on observations, interviews, and review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 84 (eighty-four). The investigative sample totaled 20 (twenty) residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed December 5, 2025: F602, F609, F610, F756.		

Provider's Signature _____ Title NHA Date 12/29/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085041	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR NURSING & REHABILITATION CENTER	101 DELAWARE AVE., DELMAR, DE. 19940-1110 , DELMAR, Delaware, 19940

(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 CertiSurv, LLC on behalf of the Division of Health Care Quality, Office of Long-Term Care Residents Protection at this facility from December 1, 2025 through December 5, 2025. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		12/22/2025
F0000	INITIAL COMMENTS An unannounced Recertification with Complaint survey was conducted at this facility from December 1, 2025 through December 5, 2025. The deficiencies contained in this report are based on observations, interviews, and review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 84. The investigative sample totaled 20 residents.	F0000		12/22/2025
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §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. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, document review, and facility policy review, the facility failed to protect a resident's right to be free from misappropriation of resident property for 1 (Resident #67) of 8 sampled residents reviewed for abuse. Beginning on 07/05/2025 until 08/14/2025, the facility failed to protect and prevent misappropriation of medication with past non-compliance. Findings include: An undated facility policy titled, "Abuse, Neglect,	F0602	"Past Noncompliance - no plan of correction required"	08/14/2025

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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F0602 SS = D	Continued from page 1 Mistreatment, and Misappropriation of Resident Property," revealed, "d. Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent." An "Admission Record" revealed the facility admitted Resident #67 on 05/23/2025. According to the Admission Record, the resident had a medical history that included a diagnosis of chronic pain syndrome. A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/29/2025, revealed Resident #67 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident received as-needed pain medication. Resident #67's "Order Summary Report" for active orders as of 07/05/2025, revealed an order dated 05/30/2025, for oxycodone hydrochloride oral tablet 5 milligram, give one tablet by mouth every four hours as needed for pain. Contained within the facility investigation was a handwritten statement from Licensed Practical Nurse (LPN) #17 dated 07/04/2025, which indicated "On July 4, 2025 resident [Resident #67] asked for the little white pill. I checked the narcotics lock box and there was no card. I worked the night before [07/03/2025] there was a card and the narcotic sheet. When I checked the computer I was the last person that gave [Resident #67] PRN [pro re nata, as needed] oxycodone at 8:31 pm Thursday night 7/3/25. I checked [his/her] chart and no narcotic sheet was in the chart. Supervisor notified I reordered the medication." The facility five-day report dated 07/09/2025, revealed "[LPN #17] noticed that the oxycodone was missing on 7/4 [2025] when she went to give it. She had given it on 7/3/25 and was the last person to give it. Unable to locate medication or narcotic sheet." Per the five-day report, an "undetermined amount of Oxycodone could not be found or accounted for at this time." During an interview on 12/04/2025 at 10:47 AM, LPN #17 stated she worked on 07/04/2025 from 7:00 AM to 11:00 PM. LPN #17 stated she could not find Resident #67's oxycodone medication or the narcotic medication sheet and reported it to Registered Nurse (RN) #25. LPN #17 stated the staff searched for the medication and the medication sheet, but the medication and the medication sheet could not be found.	F0602		

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F0602 SS = D	Continued from page 2 During an interview on 12/03/2025 at 8:32 AM, RN #25 stated she was on duty as the charge nurse when it was reported by LPN #17 that Resident #67's medication card of oxycodone could not be located. RN #25 stated she reported the incident to the Administrator and the Director of Nursing (DON). During an interview on 12/04/2025 at 10:10 AM, former DON #10 stated she was not involved in the investigation of Resident #67's oxycodone medication because the Administrator conducted the investigation. As a result of Resident #67's missing oxycodone medication, the facility immediately implemented the following corrective actions: -On 07/05/2025, an audit of all narcotic medication cards was conducted to ensure no other medications were unaccounted for. No concerns were identified. -On 07/08/2025, the facility conducted an ad hoc (for this situation) quality assessment performance improvement (QAPI) meeting. -From 07/08/2025 to 07/09/2025, all nurses completed controlled substances competencies. -From 07/09/2025 to 07/18/2025, narcotic sheets were monitored daily for accuracy until narcotic count books were implemented on 07/18/2025. -On 07/14/2025, narcotic books were ordered by way of the pharmacy. -On 07/17/2025, the facility replaced the control drug count verification and narcotic sheet count with controlled substance book on Unit 1. -On 07/18/2025, the facility replaced the control drug count verification and narcotic sheet count with controlled substance book on Units 2, 3, and 4. -On 07/18/2025, the controlled substance policy was changed to include the controlled substance book being utilized for the narcotic count. -On 08/14/2025, the facility conducted an QAPI meeting. After review and verification of the facility's corrective actions, to include staff interviews, resident interviews, and observation of medication administration, the survey team determined the facility	F0602		

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F0602 SS = D	Continued from page 3 implemented the above corrective actions beginning on 07/05/2025 until 08/14/2025, the facility implemented corrective actions to correct the identified deficient practice and prevent recurrence; thus, past noncompliance was cited.	F0602		
F0609 SS = E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Surveyor: Latoya Gordon Based on interview, record review, document review, and facility policy review, the facility failed to ensure staff reported allegations of abuse immediately to the Administrator/designee and the administrative staff timely reported allegations of abuse to the state survey agency for 4 (Residents #19, #42, #88, and #93) of 8 sampled residents reviewed for abuse. Findings include:	F0609	Corrective Action: All allegations involving residents 19, 42, 88, and 93 were reviewed with administrative oversight. Staff will be re-educated on abuse reporting requirements as per facility policy. Identification of other residents potentially affected: A retrospective review of all incidents and allegations for the past 90 days was conducted to ensure timely reporting. Systematic changes: Root cause analysis revealed lack of awareness of the urgency and importance to report allegations of abuse immediately. Both a nurse and Director of nursing failed to report allegations of abuse within the two-hour time frame requirement. Registered Nurse Staff Educator re-educated all staff (licensed and non-licensed) on abuse, neglect, and misappropriation reporting timelines. Reviewed and dated the Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy. Implemented an abuse reporting quick-reference tool posted on all units. (Active/Action Call Notification) Revised onboarding orientation to include mandatory abuse reporting competency validation. Monitoring: Administrator/designee will review all incident reports daily to confirm timely reporting. Incident reports will be reviewed weekly for 4 weeks,	01/13/2026

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F0609 SS = E	Continued from page 4 An undated facility policy titled, "Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property," revealed, "It is the policy of [facility name] that "abuse" allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property) are reported per Federal and State Law. The facility will ensure that all alleged abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, or not later than 24 hours if the events that caused the allegations do not involve abuse and do not result in seriously bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long term care facilities) in accordance with State law through established procedures." 1. An "Admission Record" indicated the facility admitted Resident #42 on 03/28/2025. According to the Admission Record, the resident had a medical history that included a diagnosis of major depressive disorder and anxiety disorder. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/04/2025, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident did not have any behaviors. Contained within the facility investigation file was a handwritten statement from Occupational Therapist (OT) #31 dated 06/12/2025, which indicated "On Wednesday, 6/11 [2025] prior to [Resident #52] doctor appointment, the nsg [nursing] aides were attempting to place L [left] shoulder brace. Pt [Patient (Resident #42)] accused the aide of "trying to break my arm," I was in a room close by & assisted with placing brace. The brace was already halfway secured & I finished & tightened the straps." The "Incident Tracking" indicated on 06/11/2025 at 9:00 AM, Resident #42 reported that a certified nurse aide (CNA) intentionally pulled their arm. Per the Incident Tracking, the facility notified the state survey agency of the resident's allegation of physical abuse on 06/12/2025 at 4:14 PM.	F0609	Continued from page 4 then monthly for 2 months until 100% compliance is obtained. Compliance trends will be reviewed monthly at Quality Assurance Performance Improvement (QAPI).	

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F0609 SS = E	Continued from page 5 During an interview on 12/04/2025 at 1:30 PM, OT #31 stated she did not report the allegation because the aides and the nurse were in the resident's room. OT #31 stated she would consider what the resident alleged as an allegation of abuse because the resident stated staff hurt their arm. During an interview on 12/04/2025 at 12:55 PM, the Director of Nursing (DON) confirmed the incident reported by Resident #42 occurred on 06/11/2025.The DON stated staff were supposed to report allegations of abuse immediately. The DON stated the allegation should have been reported on 06/11/2025. During an interview on 12/04/2025 at 2:00 PM, the Administrator stated Resident #42 reported CNA #1 accidently hurt their arm, but it "pissed" them off. The Administrator stated she expected the incident to be reported as an allegation of abuse on the day that the incident happened. 2. An "Admission Record" revealed the facility admitted Resident #93 on 02/21/2025. According to the Admission Record, the resident had a medical history that included a diagnosis of metabolic encephalopathy. Contained within the facility investigation file was a document titled "Staff Coaching Form" for Licensed Practical Nurse (LPN) #7 dated 03/21/2025, which indicated "Description of Incident: On 3/21/25 Resident [Resident #93] made statement that CNA [certified nurse aide] had smacked hand while providing care. Residents [spouse] denied that the incident happened. Nurse did not report potential allegation of abuse. Action Steps: Nurse to report any allegation of Abuse or potential allegation of abuse to Nursing Supervisor, DON/ADON [Director of Nursing/Assistant Director of Nursing." During an interview on 12/02/2025 at 6:46 PM, LPN #7 stated she would have notified the DON of the allegation, but the DON was handling another incident at the time and was on the phone with another staff member. LPN #7 stated she was not sure if the resident's allegation was abuse; therefore, she did not report what the resident reported to her immediately. According to LPN #7, the former DON informed her that the incident should have been reported immediately.	F0609		

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F0609 SS = E	Continued from page 6 During an interview on 12/03/2025 at 2:52 PM, the DON stated if there was an allegation of abuse reported to staff, the staff should report the allegation immediately to the manager on duty. The DON stated the allegation involving Resident #93 was not reported to the manager on duty immediately and the staff was educated related to the reporting requirements. During an interview on 12/04/2025 at 10:50 AM, the Administrator stated that as soon as an allegation of abuse was made or occurred, it should be reported. The Administrator stated LPN #7 should have reported the resident's allegation of abuse immediately. 3. An "Admission Record" indicated the facility admitted Resident #63 on 05/24/2024. According to the Admission Record, the resident had a medical history to include a diagnosis of hypertensive heart disease. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/30/2024, revealed Resident #63 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. An "Admission Record" indicated the facility admitted Resident #77 on 09/30/2023. According to the Admission Record, the resident had a medical history to include a diagnosis of senile degeneration of the brain. A quarterly MDS, with an ARD of 11/23/2024, revealed Resident #77 had a BIMS score of 4, which indicated the resident had severe cognitive impairment. An "Admission Record" indicated the facility admitted Resident #88 on 03/03/2021. According to the Admission Record, the resident had a medical history to include a diagnosis of schizophrenia. A quarterly MDS, with an ARD of 12/11/2024, revealed Resident #88 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired in cognitive skills for daily decision making.	F0609		

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F0609 SS = E	Continued from page 7 Contained within the facility investigation file was a handwritten statement from the Activities Director (AD) dated 12/12/2024, which indicated "I was in my office getting ready to leave and I heard residents screaming. As I walk out [Resident #77] was on the left of [Resident #88]. [Resident #63] was yelling saying [Resident #77] had hit [Resident #88] in the face. [Resident #88's] lip was busted and bleeding." Contained within the facility investigation file was email correspondence from Licensed Practical Nurse (LPN) #17 to former Director of Nursing (DON) #8 dated 12/12/2024, that indicated "On December 11, 2024 I went to the kitchen to get ice cream and pudding for the nurse coming in at 7 pm. As I was coming back from the kitchen on station 2 I heard [the AD] hollering for me. When I got there [the AD] was standing beside [Resident #88]. [The AD] stated she was in her office and heard [Resident #88] and [Resident #63] yelling. [The AD] said that [Resident #63] told her that [Resident #77] had punched [Resident #88] in the face." The facility "Investigation Summary" indicated on 12/11/2024, Resident #63 reported that Resident #77 hit Resident #88. Per the Investigation Summary, the Administrator was notified of the incident on 12/13/2024. During an interview on 12/05/2025 at 11:32 AM, the Director of Nursing stated she did not know why the allegation was not reported in a timely manner. During an interview on 12/05/2025 at 12:39 PM the Administrator stated staff were expected to report any and all allegations of abuse and neglect to their direct supervisor immediately. The Administrator stated the allegation should have been reported immediately. 4. An "Admission Record" revealed the facility admitted Resident #19 on 08/10/2029. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and senile degeneration of the brain. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/22/2025, revealed Resident #19 had a Staff Assessment for Mental Status (SAMS), that indicated the resident was severely	F0609		

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F0609 SS = E	Continued from page 8 impaired in cognitive skills for daily decision making. The MDS indicated the resident was dependent on staff for activities of daily living. The "Incident Reporting System" indicated on 03/30/2025 at 10:45 AM, Resident #19 was found to have a yellow fading bruise on their right upper arm and left thigh. Per the Incident Report System, the resident was not able to vocalize how the bruising occurred. The Incident Report System indicated the facility notified the state survey agency of the injury of unknown origin on 04/02/2025 at 11:02 AM. During an interview on 12/05/2025 at 3:15 PM, the Administrator stated she expected an injury of unknown origin to be reported to the state survey agency within two hours, and the incident with Resident #19 was not timely reported.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, document review, and facility policy review, the facility failed to implement their abuse policy when they failed to obtain witness statements from involved staff for 3 (Residents #19, #77, and #80) of 8 sampled residents reviewed for	F0610	Corrective action: Investigations for residents 19, 77, and 80, were reviewed and supplemented where possible. Staff training and education provided regarding mandatory witness statement timely collection per facility policy Identification of other residents potentially affected: Facility conducted a review of all abuse allegations over the past 6 months for completeness. Systematic changes: Root cause analysis revealed failure to thoroughly investigate allegations of abuse by gathering witness statements and interviewing all residents that could have been affected by the allegation of abuse. The Director of nursing failed to obtain statements from all staff that witnessed the incident. The Social Worker failed to do interviews with all residents who could have been potentially affected. Registered Nurse Staff Educator provided education to staff on obtaining witness statements timely and Social Worker educated on interviewing all residents that	01/13/2026

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F0610 SS = D	Continued from page 9 abuse. Findings include: An undated facility policy titled, "Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property," revealed "E. Investigation "Abuse" Policy Requirements: It is the policy of [facility name] that reports of 'abuse' are promptly and thoroughly investigated. Procedure: The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. a. Investigation of "abuse": When an incident or suspected incident of "abuse" is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: * Who was involved * Residents' statements – For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction and document findings. * Resident's roommate statements (if applicable) * Involved staff and witness statements of events." 1. An "Admission Record" revealed the facility admitted Resident #19 on 08/10/2029. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and senile degeneration of the brain. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/22/2025, revealed Resident #19 had a Staff Assessment for Mental Status (SAMS), that indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated the resident was dependent on staff for activities of daily living. The facility five-day report dated 04/07/2025 indicated on 03/30/2025, Resident #19 was found to have a bruise on their right upper arm and left thigh. Per the five-day report, the resident was unable to state how the bruise occurred. The five-day report indicated the skin assessment completed revealed the resident had a purple/yellow fading bruise on the right upper bicep and skin discoloration on the left thigh. Contained within the facility investigation file was a	F0610	Continued from page 9 could have been affected by the allegation. Standardized investigation checklist implemented, requiring: Witness statements from all staff involved in a timely manner. Documentation of immediate protective interventions and educate staff, as need. Administrator/Director of Nursing oversight required before investigation closure. Monitoring: Director of Nursing/designee will audit all investigations weekly for 4 weeks, then monthly for 2 months to ensure all statements obtained timely and investigation is complete until 100% compliance is obtained. Findings reviewed at Quality Assurance Performance Improvement Committee (QAPI	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELMAR NURSING & REHABILITATION CENTER	**101 DELAWARE AVE., DELMAR, DE. 19940-1110 , DELMAR, Delaware, 19940**

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F0610 SS = D	Continued from page 10 document titled "Accident/Incident Statement Form RN [registered nurse] Supervisor" completed by RN #15 and dated 03/30/2025, which indicated "3. List all nursing staff caring for the resident during the time of incident and one shift prior: [Licensed Practical Nurse [LPN) #12 [Certified Nurse Aide (CNA) #11] [CNA #29] [CNA #28]." However, the facility investigation file did not contain evidence of statement from CNA #28 or CNA #29. During an interview on 12/05/2025 at 3:15 PM, the Administrator stated staff from the previous shifts since the last resident's skin check should have been interviewed. 2. An "Admission Record" revealed the facility admitted Resident #77 on 09/30/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of senile degeneration of the brain. A quarterly Minimum Data Set (MDS), with an Assessment Reference Data (ARD) of 05/24/2025, revealed Resident #77 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. An "Admission Record" revealed the facility admitted Resident #80 on 11/14/2024. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and vascular dementia. A quarterly MDS, with an ARD of 05/20/2025, revealed Resident #80 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. The facility five-day report dated 08/19/2025 indicated on 08/14/2025, Resident #77 wheeled over to Resident #80 and started to pull Resident #80's hair. Per the five-day report, Resident #80 yelled and staff separated the residents immediately. The five-day report indicated Resident #80's scalp was red but there were no break in the skin noted. During an interview on 12/05/2025 at 11:01 AM, Licensed Practical Nurse (LPN) #17 stated she witnessed the	F0610		

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F0610 SS = D	Continued from page 11 incident between Resident #77 and Resident #80. LPN #17 stated the facility usually requested witness statements from the staff, but she was unaware if facility management asked for her statement, because the incident occurred at the end of her shift and she went home. The facility investigation file did not contain a witness statement from LPN #17. During an interview on 12/05/2025 at 11:23 AM, the Director of Nursing (DON) stated LPN #17 was the nurse on the unit at the time and witnessed the incident between Resident #77 and Resident #80. The DON stated she was unaware if LPN #17 was asked for a witness statement. During an interview on 12/05/2025 at 11:29 AM, the Administrator stated there should have been witness statements from any staff that was in the area at the time of the incident.	F0610		
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) 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	F0756	Corrective action: Resident #37's medication order was corrected to include drug strength. Physician review and signature obtained for pharmacist recommendation. Identification of other residents potentially affected: A facllity wide audit of all current MRR's was conducted to verify physician response and follow-up are timely and accurate. Systematic changes: Root cause analysis revealed that medication regimen reviews were not being completed within a timely manner. The unit manager failed to review a recommendation for a drug strength to be corrected. Registered Nurse Staff Educator provided education to Unit Managers on the importance of completing Medication Regimen Reviews within a timely manner.	01/13/2026

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F0756 SS = D	Continued from page 12 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: Surveyor: Rachele Kemp Based on interview, record review, and facility policy review, the facility failed to ensure a pharmacy recommendation was implemented for 1 (Resident #37) of 5 sampled residents reviewed for unnecessary medications. Findings include: An undated facility policy titled, "Medication Regimen Review and Reporting," indicated, "Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities." The policy specified, "2. The Consultant's Pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated." Per the policy, 8. The facility follows up on the recommendations to verify that appropriate action has been taken. Recommendations shall be acted upon in a timely manner. a. For those issues that require Physician intervention, the attending Physician either accepts and acts upon the report and recommends or rejects all or some of the report and should document his or her rationale of whey the recommendation is rejected in the resident's medical record."	F0756	Continued from page 12 Implemented a Medication Regimen Review tracking log with defined timelines for physician response. Consultant Pharmacist escalation process revised to minimize overdue recommendations. Reviewed and dated Medication Regimen Review and Reporting policy. Monitoring: Director of Nursing/designee will review Medication Regimen Review logs weekly for 4 weeks, then monthly for 2 months to ensure all Medication Regimen recommendations have been reviewed and signed by physician within a timely manner until 100% compliance is obtained. Results reported to Quality Assurance Performance Improvement meeting	

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F0756 SS = D	Continued from page 13 An "Admission Record" revealed the facility admitted Resident #37 on 08/29/2025. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and cerebral atherosclerosis. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/29/2025, revealed Resident #37 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Resident #37's "Order Summary Report" for active orders as of 12/05/2025, revealed an order dated 08/29/2025, for lactobacillus capsule, give two capsules by mouth one time a day related to cerebral atherosclerosis. Resident #37's pharmacy MRR for 09/02/2025, revealed a recommendation from the Consultant Pharmacist to "Add a strength" to the resident's order for lactobacillus capsule. Per the pharmacy MRR, the resident's order for lactobacillus only indicated to give two capsules by mouth one time a day. During an interview on 12/05/2025 at 8:10 PM, Licensed Practical Nurse Unit Manager #9 stated he was unable to locate Resident #37's MRR that contained the physician's signature to indicate the physician reviewed the Consultant Pharmacist's recommendation. During an interview on 12/05/2025 at 9:31 AM, the Consultant Pharmacist stated the recommendation for Resident #37's order for lactobacillus had not been corrected. The Consultant Pharmacist stated every medication needed to include a strength. During an interview on 12/05/2025 at 1:18 PM, Resident #37's primary physician stated if he would have seen the Consultant Pharmacist's recommendation for Resident #37's order for lactobacillus, he would have signed the recommendation to indicate agreement. Resident #37's primary physician stated lactobacillus was available in different strengths and he expected the order to include the dosage (strength).	F0756		

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F0756 SS = D	Continued from page 14 During an interview on 12/05/2025 at 1:45 PM, the Director of Nursing (DON) stated she expected staff to maintain a copy of the signed MRR for each resident. Per the DON, the physician should respond to the pharmacist's recommendations within a day or two. The DON stated the pharmacist's recommendation for Resident #37's lactobacillus should have been follow-up on. During an interview on 12/05/2025 at 2:16 PM, the Administrator stated MRRs should be completed in a timely fashion and followed up on by the physician.	F0756		