ELAWARE HEALTH
ND SOCIAL SERVICES
vision of Health Care Quality
ffice 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: Seaford Center Nursing Home

DATE SURVEY COMPLETED: September 3, 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 and Complaint Survey was conducted at this facility from August 24, 2026, through September 3, 2026. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was one hundred and four (104) residents. The survey sample totaled fifty-two (52) residents. Abbreviations/definition used in this report are as follows:		10/12/2026
3201 **3201.1.0** **3201.1.2**	**Regulations for Skilled and Intermediate Care Nursing Facilities** **Scope** **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:**		

Provider's Signature [signature] LNHA Title Administrator Date 10/2/26

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3201.5.0	Cross refer to the CMS-2567-L survey completed September 3, 2026: F552, F561, F580, F584, F605, F609, F677, F684, F689, F756, F760, F842, and F943.	Corrective Action of Areas Affected: A copy of E36 (Housekeeper) adult abuse registry was obtained for the personnel file. Other areas affected: The Housekeeping Supervisor will conduct an initial audit on all Housekeeping personnel files to ensure the Adult Abuse Registry was present for all current employees. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education on Personnel records is needed for the Housekeeping Manager.This was directly related to contract staff with Healthcare Services Group. Education given by the Nursing Home Administrator and/or designee will be completed by 10/12/26. Monitoring of Corrective Action: The Environmental Service District Manager and/or designee will conduct audits (attachment L) to ensure that all new Housekeeping employee files have a copy of the Adult Abuse Registry. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations	
3201.5.5	**Personnel/Administrative**		
3201.5.5.5	**The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following:** **Result of Adult Abuse Registry check.** **This requirement was not met as evidenced by:** Based on interview and review of facility records, it was determined that, for one (E36) out of fourteen staff sampled for adult abuse registry checks, the facility failed to ensure that the required adult abuse registry check was completed. Findings include: 8/28/26 - The facility was provided with a list of fourteen randomly selected names and instructed to provide documentation for results of adult abuse registry check results. 9/3/26 - A review of facility records lacked evidence of results of an adult abuse registry check for E36 (Housekeeper). 9/3/26 1:45 PM - During an interview, E2 (DON) confirmed that an adult abuse registry had not been completed for E36.		
3201.6.0 3201.6.9	9/3/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.		
3201.6.9.2	**Services to Residents**		

Provider's Signature ____________________ Title ____________________ Date ______________

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3201.6.9.2.4	**Communicable Diseases** **Specific Requirements for Tuberculosis** **Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a base line two step tuberculin skin test (TST) or single Interferon Gamma Release Assay (IGRA or TB blood test) such as QuantiFERON. Any required subsequent testing according to risk category shall be in accordance with the recommendations of the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services. Should the category of risk change, which is determined by the Division of Public Health, the facility shall comply with the recommendations of the Center for Disease Control for the appropriate risk category. While the requirement for a two-step is waived, facilities must complete a one-step TB test upon employment.** **This requirement was not met as evidenced by:** Based on interview and review of facility records it was determined that the facility failed to ensure that two (E36 and E37) out of fourteen sampled employees reviewed had completed pre-employment TB screening completed. Findings include: 8/28/26 - The facility was provided a list of fourteen names selected randomly and instructed to provide documentation of pre-employment tuberculosis testing. 9/3/26 - A review of facility records lacked evidence of pre-employment tuberculosis	Corrective Action of Areas Affected: E36 and E37's Quantiferon-TB Gold test results were placed in their personnel file. Other areas affected: The Housekeeping Supervisor and Infection Preventionist will conduct an audit on all Seaford Center personnel files and Housekeeping personnel files to ensure that a TB test or equivalent is present for all current employees. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education on required Personnel records is needed for the scheduler. Education given by the Nursing Home Administrator and/or designee will be completed by 10/12/26. Monitoring of Corrective Action: The Nursing Home Administrator and/or designee will conduct audits (attachment M) to ensure that all new employee files have a copy of a current TB test. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations	

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3225.9.0 3225.9.8 3225.9.8.4 3225.9.8.4.2	testing for E36 (Housekeeper) and E37 (LPN). 9/3/26 1:45 PM - During an interview, E2 (DON) confirmed that E36 and E37 had not received the required tuberculosis testing. 9/3/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference. **Records and Reports** **Reportable incidents are as follows:** **Significant injuries.** **Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.** **This requirement was not met as evidenced by:** Based on an interview, record review and review of other facility documentation for one (R85) out of six residents reviewed for falls, the facility failed to report to the state agency within eight hours. Findings include: 1. Review of R85's clinical record revealed: 10/28/21 - R85 was admitted to the facility. 1/7/26 - A quarterly MDS documented BIMS 0 indicating R85 is severely cognitively impaired. 6/1/26 - A care plan documented that R85 is dependent on staff for ADL care.		

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
Subchapter IV Criminal Background Checks; Mandatory Drug Screening; Long-Term Care Facilities; Nursing Home Compliance with Title XIX of the Social	2/23/26 4:50 PM - A facility's incident report documented R85 fell out of the bed. 2/27/26 4:14 PM - The facility failed to report R85's fall to the division within the eight-hour required time frame. 9/1/26 10:11 AM - During an interview with E8 (Unit Manager), it was reported that R85) was discovered on her room floor on 2/23/26 at 4:50 pm with a contusion to her left forehead. The healthcare provider was notified, resulting in orders for a skull X-ray and ongoing neurological checks. Later that evening, R85 experienced a shaking episode, prompting staff to contact the physician again, who then ordered the resident to be transferred to the hospital due to her earlier fall. 9/1/26 11:23 AM - During an interview, E1 (ADM) confirmed the report was not submitted to the State agency within 8 hours. Based on interviews and review of facility documentation, including the facility's corrective actions, fall audits, staff education, and ongoing monitoring plan, it was determined that the facility achieved compliance as of June 30, 2026. Therefore, the deficiency was cited as past noncompliance. **(a) Purpose. —** **The purpose of the criminal background check and drug screening requirements of this section and § 1142 of this title is the protection of the safety and well-being of residents of long-term care facilities licensed pursuant to this chapter. These sections shall be construed broadly to accomplish this purpose.**		

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Security Act. (81 Del. Laws, c. 206, § 40.) Delaware Code § 1141. Criminal background checks.	(b) Definitions. — As used in this subchapter: (1) "Applicant" means any of the following: a. A person seeking employment in a facility. (2) "Background Check Center (BCC)" means the electronic system which combines the data streams from various sources within and outside the State in order to assist an employer in determining the suitability of a person for employment in a long-term care facility. (3) "Criminal history" means a report from the Department regarding its review of the applicant's entire federal criminal history from the Federal Bureau of Investigation, under Public Law 92-544 as amended (28 U.S.C. § 534), and the applicant's Delaware record from the State Bureau of Identification. (5) "Facility" means any facility licensed under subchapter I of this chapter. (7) "SBI" means the State Bureau of Identification. (c) An employer may not employ an applicant for work in a facility before obtaining criminal history. The criminal history of any person not employed directly by the facility must be provided to the facility upon the person's commencement of work. An applicant's criminal history report obtained through the BCC's criminal history screening process is valid for any prospective	Corrective Action of Areas Affected: A copy of E36 (Housekeeper) Eligibility Letter was obtained for the personnel file. Other areas affected: The Housekeeping Supervisor will conduct an initial audit on all Housekeeping personnel files to ensure that an Eligibility Letter was present for all current employees. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education on Personnel records is needed for the Housekeeping Manager. This was directly related to contract staff with Healthcare Services Group. Education given by the Nursing Home Administrator and/or designee will be completed by 10/12/26. Monitoring of Corrective Action: The Environmental Service District Manager and/or designee will conduct audits (attachment N) to ensure that all new Housekeeping employee files have a copy of the Criminal Background Check. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations	

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NAME OF FACILITY: Seaford Center Nursing Home

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
Delaware Code § 1142. Mandatory drug screening.	**employer for a period of 1 year from the date of the applicant's last fingerprinting.** **This requirement has not been met as evidenced by:** Based on interview and review of facility records it was determined for one (E36) out of fourteen staff sampled for pre-employment background checks the facility failed to perform the required criminal background check. Findings include: 8/28/26 - The facility was provided a list of fourteen randomly selected names and instructed to provide documentation of criminal background checks. 9/3/26 - A review of facility records lacked evidence of a criminal background check for E36 (Housekeeper). 9/3/26 1:45 PM - During an interview, E2 (DON) confirmed that a criminal background check was not completed for E36. 9/3/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference. **(a) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screening.** **(b) All applicants must submit to mandatory drug screening, as specified by regulations promulgated by the Department.** **(c) The Department shall promulgate regulations regarding the pre-employment testing of all applicants, for use of all of the following** **illegal drugs:**		

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	(1) Marijuana/cannabis. **(2) Cocaine.** **(3) Opiates.** **(4) Phencyclidine ("PCP").** **(5) Amphetamines.** **(6) Any other illegal drug specified by the Department under regulations promulgated under this section.** **(d) An agency, including temporary agencies, must provide the drug screening results it receives regarding an applicant referred to work in a facility to that particular facility so that the facility is better able to make an informed decision whether to accept the referral.** **(e) The employer must provide confirmation of the drug screen in the manner prescribed by the Department's regulations.** **(f) Any employer who fails to comply with the requirements of this section is subject to a civil penalty of not less than $1,000 nor more than $5,000 for each violation.** **(71 Del. Laws, c. 466, § 2; 72 Del. Laws, c. 2, § 1; 72 Del. Laws, c. 366, § 1; 78 Del. Laws, c. 303, § 2; 81 Del. Laws, c. 206, §42.)** **This requirement has not been met as evidenced by:** Based on interview and review of facility records it was determined for one (E36) out of fourteen sampled employees the facility failed to ensure that mandatory drug screening was completed prior to date of hire. Findings include: 8/28/26 - The facility was provided a list of fourteen randomly selected names and	Corrective Action of Areas Affected: A copy of E36 (Housekeeper) Drug Screen was obtained for the personnel file. Other areas affected: The Housekeeping Supervisor will conduct an initial audit on all Housekeeping personnel files to ensure that a Drug Screen was present for all current employees. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education on Personnel records is needed for the Housekeeping Manager. This was directly related to contract staff with Healthcare Services Group. Education given by the Nursing Home Administrator and/or designee will be completed by 10/12/26. Monitoring of Corrective Action: The Environmental Service District Manager and/or designee will conduct audits (attachment O) to ensure that all new Housekeeping employee files have a copy of the employees Drug Screen. The audit will occur daily until 100% compliance is achieved on 3 consecutive	

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	instructed to provide documentation of mandatory drug screening results. 9/3/26 - A review of facility records lacked evidence of drug screening results for R36 (Housekeeper). 9/3/26 1:45 PM - During an interview, E2 (DON) confirmed that a drug screen had not been completed for E36 prior to the date of hire. 9/3/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference. **§ 1162. Nursing staffing.** **Minimum Staffing Levels for Residential Health Facilities** **(c) By January 1, 2002, the minimum staffing level for nursing services direct caregivers shall not be less than the staffing level required to provide 3.28 hours of direct care per resident per day, subject to Commission recommendation and provided that funds have been appropriated for 3.28 hours of direct care per resident for Medicaid eligible reimbursement.** **Nursing staff must be distributed in order to meet the following minimum weekly shift ratios:** **RN/LPN CNA*** **Day - 1 nurse per 15 res. 1 aide per 8 res.** **Evening 1:23 1:10** **Night 1:40 1:20** *** Or RN, LPN, or NAIT serving as a CNA.**	reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations	

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	Nursing Facilities must be in compliance with 16 Del. code, Chapter 11, Subchapter VII 1162 Nursing Staffing at all times. **This requirement is not met as evidenced by:** A staffing audit was conducted by the State of Delaware, Division of Health Care Quality, Office of Long-Term Care Residents Protection. The facility was found to be noncompliant with 16 Delaware Code Chapter 11 Nursing Facilities and Similar Facilities. Based on review of facility documentation submitted for the staffing review, it was determined that five days out of forty-two days reviewed, the facility failed to provide a staffing level of at least 3.28 hours of direct care per resident per day (PPD). Findings include: Review of the Facility Staffing Worksheets, completed by E1 (Nursing Home Administrator) revealed the following: 07-19-2026 – PPD = 2.98 08-08-2026 -- PPD = 3.24 08-09-2026 -- PPD = 2.94 08-17-2026 – PPD = 3.15 08-22-2026 – PPD = 2.80 The facility failed to maintain the minimum PPD staffing requirement of 3.28.	Corrective Action of Areas Affected: The facility is unable to correct this deficient practice. Other areas affected: All residents are at risk when the facility falls below Eagle's Law HPPD. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education on Eagles Law staffing requirements is needed for the facility scheduler. Education given by the Nursing Home Administrator and/or designee will be completed by 10/12/26. Monitoring of Corrective Action: The Nursing Home Administrator and/or designee will conduct audits (attachment P) to ensure that Staffing ratios and HPPD are met daily. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD POST ACUTE	**1100 NORMAN ESKRIDGE HIGHWAY , SEAFORD, Delaware, 19973**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from August 24, 2026 through September 3, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		
F0000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility from August 24, 2026, through September 3, 2026. The deficiencies contained in this report are based on observations, interviews, a review of clinical records and a review of other facility documentation, as indicated. The facility census on the first day of the survey was one hundred and four (104). The survey sample totaled fifty-two (52) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; COTA - Certified Occupational Therapy Assistant CNA - Certified Nurse's Aide; DON - Director of Nursing; EMR - Electronic Medical Record; FMD - Facility Maintenance Director; LPN - Licensed Practical Nurse; NHA – Nursing Home Administrator; PPE - Personal Protective Equipment; RMD - Regional Maintenance Director RN - Registered Nurse;	F0000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2026

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F0000	Continued from page 1 UM - Unit Manager; Abuse – to hurt, injure or damage or mental, physical, sexual, involuntary seclusion or misappropriation of resident property; Activity of daily living (ADLs) - tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Ammonia Level - is a measure of how much ammonia is currently in your blood; Antianxiety Medication – medication used to treat any of several disorders that cause nervousness, fear, apprehension and worrying; Antipsychotic- class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and other mental and emotional conditions; Brief Interview for Mental Status (BIMS) – assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Care Plan- outlines the plan of action that will be implemented during a patient's medical care; Cirrhosis - advanced from of liver disease that causes chronic inflammation and stiffness of the liver; eMAR - Electronic medical record; Gradual dose reduction (GDR) - tapering of a dose to determine if symptoms, conditions or risks can be managed by a lower dose or if the medications can be discontinued altogether; Gram (gm) - a unit of weight for measuring medication; Hepatic Encephalopathy - loss of brain function when a damaged liver doesn't remove toxins from the blood;	F0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2026

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F0000	Continued from page 2 Lactulose - an osmotic laxative used to treat chronic constipation and reduce ammonia levels in liver disease; MAR - Medication administration record; Milliliters (ml) - a unit of liquid volume or capacity in the metric system for measuring medication; Minimum Data Set (MDS) – standardized assessment forms used in nursing homes; Not Applicable - a particular piece of information, a question, or a rule does not relate to a specific situation; Pyxis - computer controlled automated medication dispensing cabinet used in healthcare settings.	F0000		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that, for one (R26) out of seven residents sampled for medication review, the facility failed to discuss the risks and benefits of proposed care. Findings include: Review of R26's clinical record revealed:	F0552	Corrective Action of Areas Affected: The facility was unable to correct this prior to discharge of R26. R26 was discharged from the facility on 09/03/26. Other areas affected: The DON/Designee will complete an initial audit to identify residents who are on psychotropic medications to ensure a consent was obtained by the resident or a progress note discussing the risk and benefits with the responsible party. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education for current staff is needed on Informed Consent,Supplemental Information for Psychotropic Medications. Education to licensed nurses will be given by the Director of Nursing and/or designee and be completed by 10/12/26.. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment A) to ensure accuracy and completion of psychotropic consents for 10% of the resident population. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	10/12/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085015	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEAFORD POST ACUTE	**1100 NORMAN ESKRIDGE HIGHWAY , SEAFORD, Delaware, 19973**

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F0552 SS = D	Continued from page 3 6/15/26 - R26 was admitted to the facility. 6/22/26 - An admission MDS documented that R26 was a BIMs of 6 indicating severe cognitive impairment. 6/15/26 3:37 PM - A physician's order documented lorazepam (anti-anxiety) 0.5 mg give one tablet every 12 hours as needed for anxiety, maximum of 1mg per day. 6/15/26 3:37 PM - A physician's order documented quetiapine fumerate (anti-psychotic) 25 mg give one tablet at bedtime for mood. 9/1/26 1:49 PM - During an interview, E12 (LPN) stated when a resident is admitted the resident or family member will complete a Psychotropic Medication Consent form and discuss the risk versus benefit at that time. E12 stated if the form was not completed a progress note should be completed to document that conversation occurred. 9/1/26 3:08 PM - During an interview, E13 (RN) stated the expectation was to complete the Psychotropic Medication Consent form with the resident or family during the admission process. During the completion of the form, the risks and benefits are discussed with resident and/or responsible party at that time. 9/2/26 10:15 AM - During an interview, E14 (Unit Clerk) confirmed that a Psychotropic Medication Consent form was not completed due to R26 was not prescribed any psychotropic medications. The EMR lacked evidence of the aforementioned consent form being completed or a progress note discussing the risk and benefits with the responsible party for R26. 9/3/26 2:45 PM - Findings were review with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.	F0552		10/12/2026
F0561 SS = D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.	F0561	Corrective Action of Areas Affected: The facility was unable to correct this prior to discharge of R18 and R92. R18 and R92 both discharged on 08/26/26. Other areas affected: The DON/Designee will complete an initial audit which will be completed to identify resident bathing preferences are care planned.	10/12/2026

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F0561 SS = D	Continued from page 4 §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review it was determined that for two (R18 and R92) out of two residents reviewed for choices, the facility failed to ensure care preferences were being honored. Findings include: 1. Review of R18's clinical record revealed: 8/15/26 - R18 was admitted to the facility. 8/16/26 - A care plan documented that R18 was at risk for decreased ability to perform ADL's related to limited mobility with the following interventions: monitor conditions that may contribute to ADL decline, monitor for decline in ADL function, monitor for complications of immobility and provide cueing for safety and sequencing to maximize current level of functioning. 8/20/26 - A Recreational Comprehensive Assessment documented it was very important for R18 to choose between a tub bath, bed bath or shower bath. 8/22/26 - An admission MDS documented that R18 was a BIMs of 15 indicating cognitively intact and was dependent for showering/bathing.	F0561	Continued from page 4 Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education for current licensed nurses and certified nursing assistants is needed on Resident Rights including resident preferences. Education given by the Director of Nursing and/or designee will be completed by 10/12/26. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment B) to ensure accuracy and completion of resident preferences on bathing for 10% of the resident population. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	10/12/2026

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F0561 SS = D	Continued from page 5 8/24/26 10:48 AM - During an interview, R18 stated that she prefers showers and had not received a shower since admission. R18 stated that staff had not offered a shower as a choice and did not state a shower stretcher was available for use. R18 stated she does not feel clean only receiving a bed bath. 8/28/26 10:01 AM - During an interview, E17 (CNA) stated the resident shower schedule is determined by the room number. 8/28/26 10:15 AM - During an interview, E18 (CNA) stated the resident shower schedule is determined by the room number and stated A bed is done on day shift and B bed is done on evening shift. E18 stated the residents will tell staff if they want a shower or a bed bath but staff does not ask the preference but will offer an alternative option if they refuse. 8/28/26 10:30 AM - During an interview, E8 (RN) confirmed that residents are assigned shower day and shift based on room number when admitted and confirmed residents are not given a choice of preferred day or time. 2. Review of R92's clinical record revealed: 8/12/26 - R92 was admitted to the facility. 8/13/26 - A care plan documented that R92 was at risk for decreased ability to perform ADL's related to limited mobility with the following interventions: monitor conditions that may contribute to ADL decline, monitor for decline in ADL function, monitor for complications of immobility and provide cueing for safety and sequencing to maximize current level of functioning. 8/19/26 - An admission MDS documented R92 was a BIMs of 15 indicating cognitively intact and requires a substantial/maximum assist of one for bathing/showering. 8/24/26 12:24 PM - During an interview, R92 stated her assigned shower time was in the evening and when she asked to get her shower was told staff did not have enough time or enough help. R92 stated she was not given a choice of the date/time of her shower and does not feel clean without showering. 8/28/26 10:01 AM - During an interview, E17 (CNA) stated the resident shower schedule is determined by the room number. 8/28/26 10:15 AM - During an interview, E18 (CNA)	F0561		10/12/2026

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F0561 SS = D	Continued from page 6 stated the resident shower schedule is determined by the room number and stated A bed is done on day shift and B bed is done on evening shift. E18 stated the residents will tell staff if they want a shower or a bed bath but staff does not ask the preference but will offer an alternative option if they refuse. 8/28/26 10:30 AM - During an interview, E8 (RN) confirmed that residents are assigned shower day and shift based on room number when admitted and confirmed residents are not given a choice of preferred day or time. 9/3/26 2:45 PM - Findings were review with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.	F0561		10/12/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F0580	Corrective Action of Areas Affected: R44's EMR was reviewed for evidence that the provider was notified of the positive fracture. Other areas affected: The DON/Designee will conduct an initial audit to identify provider notification of positive xray results for the last 30 days. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education for current licensed nurses is needed on NSG115 Physician/Advanced Practice Provider Notification. Education given by the Director of Nursing and/or designee will be completed by 10/12/26. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment C) to ensure accuracy and completion of physician notification for positive xray results for 10% of the resident population. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	10/12/2026

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F0580 SS = D	Continued from page 7 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R44) out of three residents reviewed for change in condition, the facility failed to consult the Physician when R44 had a confirmed positive x-ray result. Findings include: Review of R44's clinical record revealed: 7/14/22 - R44 was admitted to the facility. 11/19/25 8:02 AM - A nursing progress note documented R44 was complaining of right rib pain and requested to get an x-ray. 11/19/25 8:09 AM - A physician's order documented x-ray to right rib cage related to previous fall for pain. 11/19/25 5:53 PM - A Radiology Results Report for R44 documented right lateral 8-9 rib fractures with displacement and mild soft tissue swelling. The report documented conclusion acute appearing right rib fractures. 11/20/25 11:00 AM - An SBAR physician communication form documented that R44 had a positive right rib fracture and a pain level 8 out of 10 noted.	F0580		10/12/2026

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F0580 SS = D	Continued from page 8 The EMR (electronic medical record) lacked evidence that a provider was notified of the positive fracture results for approximately 15 hours. 9/3/26 12:55 PM - During an interview, E19 (RN) stated the expectation when positive lab or x-ray results come in would be to notify the provider in person or via telephone if off hours. E19 stated the lab or x-ray results get faxed to the facility and the nurse was expected to check the fax machine after being obtained. 9/3/26 1:04 PM - During an interview, E8 (RN) stated the expectation for positive lab or x-ray results was to notify the provider and document in a progress note notification was completed. E8 also stated if positive results came in after hours the nurse would complete a telecommunication visit with an on-call provider which would be documented under a provider visit in the EMR. 9/3/26 1:15 PM - During an interview, E20 (NP) confirmed a positive x-ray would be an expected provider notification so the provider could determine if further intervention would be necessary at the time. 9/3/26 2:45 PM - Findings were review with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.	F0580		10/12/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the	F0584	Corrective Action of Areas Affected: Room 200 and 209 floors were cleaned on 9/3/26. Maintenance went into the bathroom and repaired the floor trim, replaced a ceiling tile and stripped and repainted the bathroom on 09/03/26. Other areas affected: The Housekeeping supervisor conducted an initial audit on all resident rooms to identify the floor care needs by the housekeeping team. Floor care has been provided to areas identified. Maintenance conducted an initial audit of resident bathrooms to identify walls, ceiling tiles or floor trim in need of repair. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education for housekeeping staff and maintenance is needed on OPS200 Safe and Homelike Environment. Education given by the Nursing Home Administrator and/or designee will be completed by 10/12/26.	10/12/2026

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F0584 SS = D	Continued from page 9 protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews it was determined for two rooms (200 and 209) out of fifty-two residents rooms reviewed for a homelike environment the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interiors in resident rooms. Findings include: 1. 8/24/26 9:27 AM – The surveyor entered room 200 and observed the floor to be sticky and dirty with fuzzy patches of dirt on the floor and what appeared to be old, dried food at the foot of the bed on the floors and on the right side of the bed next to the window. The bathroom was malodorous and the floor was dirty and sticky. There was a thick black ring around the base of the toilet, and the floor trim was dirty with a black substance adhered to the molding. There was a non-skid strip/mat in front of the shower that was dirty and had a sticky residue across the surface. 8/24/26 9:45 AM – The housekeeper was observed entering room 200 with a black broom that was visibly frayed, old and heavily used. The housekeeper exited the room, sprayed the bottom of	F0584	Continued from page 9 Monitoring of Corrective Action: The Environmental Service District Manager and/or designee will conduct audits (attachment D) to ensure resident rooms are cleaned to ensure a homelike environment. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	10/12/2026

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F0584 SS = D	Continued from page 10 the broom with a blue colored liquid from a spray bottle then placed the broom back on to the cleaning cart. The housekeeper left room 200 at this time. 8/26/26 9:45 AM - A second observation revealed that the floor in room 200 was dirty and sticky and had fuzzy patches of dirt on the floor. The bathroom floor was dirty and sticky there was a black thick ring around the base of the toilet and dark black stains on the shower trim on the outside of the shower. There was a non-skid strip/mat in front of the shower that was dirty and had a sticky residue across the surface. 8/26/25 11:00 AM – During an interview and observation, E27 (Housekeeper) confirmed that room 200 was not a homelike environment. E27 stated, "the floor is sticky, yes, and the room needs to have everything pulled out to get to the floors done. The dirt around the floor needs a different kind of cleaner to get this blackness off, and the bathroom needs a thorough cleaning, this is disgusting." 8/26/26 11:20 AM – During an interview and observation of room 200, E28 (FMD) and E29 (RMD) confirmed the findings in room 200. E28 then reported "Not being aware of the conditions in this room and it was not homelike." 2. 8/24/26 11:00 AM – The surveyor entered room 209 and observed that the floor was dirty with scuff marks in the room and bathroom. The floor trim around the bottom walls in the room had a black substance on it. The bathroom had an empty wash basin sitting on the floor on a plastic bag. The walls in the bathroom had raised bubbles with the appearance off the paint separating from the wall. The trim near the floors in the bathroom was not flush against the wall and black in color. The trim behind the toilet was pulled away from the wall and had exposed material behind the wall that was black in color. Further observation revealed a large brown stained ceiling tile over the bed in the room. 8/26/26 11:30 AM – During an interview and observation of room 209, E28 reported, "Not being aware of all the exiting concerns that are in this room. E28 then stated, "The wall in the bathroom was painted recently, and the damage is probably related to humidity. E28 and E29 confirmed, "No this is not a homelike environment." 9/3/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.	F0584		10/12/2026

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F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- . . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and	F0605	Corrective Action of Areas Affected: R67 medication was discontinued on 04/16/26. Other areas affected: The DON/Designee will conduct an initial audit for current residents to identify if a physician response to GDR recommendations or a rationale for continuing a psychotropic medication is documented for the last 30 days. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education on Pharmacy Recommended GDR is needed for the Nurse Practitioner and Director of Nursing. Education given by the Clinical Lead (RN) and/or designee will be completed by 10/12/26. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment E) to ensure a physician response to GDR recommendation or a rationale for continuing a psychotropic medication is documented. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations	10/12/2026

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F0605 SS = D	Continued from page 12 (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or	F0605		10/12/2026

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F0605 SS = D	Continued from page 13 she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review and review of other facility records it was determined for one (R67) out of seven residents reviewed for unnecessary medications the facility failed to ensure the physician reviewed recommendations for R67 for a dose reduction for a psychotropic medication. Findings include: R67's clinical record revealed: 11/15/23 – R67 was admitted to the facility. 7/8/24 9:00 PM – A physician's order for R67 documented, "Doxepin 100 mg, give one capsule by mouth one time a day for generalized anxiety disorder." 10/17/25 – A review of a pharmacist recommendation for R67 titled "Note to the Physician" documented, "This resident has been taking the following psychotropic medication: Doxepin 100 mg since 7/8/24. Please evaluate the current dose and consider a dose reduction. Condition stable: Attempt dose reduction for Doxepin 50 mg every day." The review lacked evidence of a physician response, an attempt at a gradual dose reduction, and/or a documented rationale for continuing Doxepin 100 mg daily. 9/3/26 9:24 AM – During an interview, the surveyor asked E2 (DON), "What is the timeframe within which the physician should have responded to the recommendation for R67's gradual dose reduction?" E2 reported, "Monthly." The surveyor reviewed with E2 the pharmacist's recommendation dated 10/17/25 for a gradual dose reduction of Doxepin 100 mg. E2 confirmed and stated, "No, the physician did not review or respond to the recommendation." Further review of R67's clinical record revealed that Doxepin 100 mg was discontinued on 4/14/26. 9/3/26 2:45 PM – Findings were reviewed with E1 (NHA), E2 (DON), and E7 (Clinical Lead) during the	F0605		10/12/2026

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	085015	A. BUILDING B. WING	09/03/2026

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F0605 SS = D	Continued from page 14 exit conference.	F0605		10/12/2026
F0609 SS = D	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: Based on interview and record review, it was determined that two (R61 and R112) out of three residents reviewed for abuse and neglect the facility failed to report an allegation of abuse and neglect within the appropriate time frame. Based on the facility's evidence to correct the noncompliance at the time of the current survey, the deficiency was determined to be past non-compliance as of 8/23/26. Findings include: 1. Review of R61'S clinical record revealed: 6/27/23 - R61 was admitted to the facility with diagnoses including, but not limited to chronic respiratory failure, diabetic retinopathy, hypertension, and epilepsy.	F0609	"Past Noncompliance - no plan of correction required"	10/12/2026

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F0609 SS = D	Continued from page 15 8/9/26 2:54PM – A facility reported incident was submitted to the State Agency documented that E3 (CNA) was providing peri care to R61 on 8/3/26 with complaints of being rough. 8/26/26 at 10:39 AM – During an interview, E4 (RN) stated that E5 informed her that R61 did not want E3 assigned to provide her care on 8/9/26. E4 reported that she removed E3 from R61's assignment. E4 acknowledged that she did not enter R61's room or speak with R61 to determine why R61did not want E3 assigned to her care. 8/26/26 at 11:00 AM – During an interview, E6 (RT) stated that on 8/9/26, she was at the nursing station when FM1 exited R61's room. FM1 stated that she needed to report an incident that occurred on 8/3/26. FM1 reported that her sister had received peri care from a male CNA who was rough. E6 stated that she immediately reported the allegation to E2 (DON). 8/26/26 at 11:55 AM – During an interview, E2 (DON) stated that he was contacted by E6 on 8/9/26 regarding an allegation of abuse. E2 stated that he immediately contacted E8 (UM) and instructed her to report the allegation to the State Agency. E2 confirmed that the allegation of abuse was not reported to the State Agency within the required two-hour timeframe. E2 stated that five staff members were suspended for failing to report the allegation. 8/31/26 9:40 AM During the interview, E3 stated that R61 activated her call bell at approximately 8:00 PM. E3 reported that he entered R61's room and assisted her to the bathroom because she was having a bowel movement. E3 stated that he used a washcloth to provide perineal care and reported that R61 told him to wipe her thoroughly. E3 stated that he told R61 to stop, but R61 did not explain why she wanted him to stop. E3 reported that he continued to observe fecal matter on R61's buttocks and explained to her that she needed to be cleaned thoroughly to prevent infection. The facility failed to report an allegation of abuse within the two-hour time frame. 2. Review of R112's clinical record revealed: 4/8/26 - R112 was admitted to the facility. 5/19/26 4:23 PM - A facility reported incident was submitted to the State Agency regarding R112 not receiving care on 4/27/26.	F0609		10/12/2026

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F0609 SS = D	Continued from page 16 9/1/26 11:23 AM - During an interview, FM3 stated on 4/27/26 when visiting R112 it was noted that he was visibly soaked. FM3 stated that R112's clothes were soaked in urine, and a puddle was noted underneath his wheelchair. FM3 stated it was reported to E23 that R112 needed to be changed, that E23 stated that they would be there after their dinner break. FM3 stated R112 waited over an hour and E23 had not come to complete care. FM3 stated they went to the nurse's station to request assistance for R112 after waiting. 9/1/26 11:44 AM - During an interview, E5 (CNA) stated she was present when FM3 reported that R112 needed ADL care on 4/27/26. E5 stated that FM3 reported that R112 needed care and that E23 went to dinner, over an hour. E5 stated that she and another staff member took R112 to his room to complete care. 9/1/26 11:48 AM - During an interview, E1 (NHA) and E7 (Clinical Lead) confirmed that three staff members were aware of the allegation of neglect for R112 on 4/27/26 and did not report to management. E7 stated that all three staff members were suspended for failing to report the allegation. The facility failed to report an allegation of neglect within the eight-hour time frame. Based on the facility's investigation, review of the event, implementation of corrective actions, staff education regarding recognition of allegations of neglect, staff education regarding ADL care, and implementation of ongoing audits to monitor compliance, it was determined the facility returned to substantial compliance effective August 23, 2026. 9/3/26 2:45 PM - Findings were review with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.	F0609		10/12/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review it was determined that for three (R4, R111 and R112)	F0677	"Past Noncompliance - no plan of correction required"	10/12/2026

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F0677 SS = D	Continued from page 17 out of three residents reviewed for ADL (Activities of Daily Living) the facility failed to provide ADL care for dependent residents. Based on review of the facility's evidence of correction, the deficient practice was determined to be Past Noncompliance, with substantial compliance achieved effective August 23, 2026. Findings include: 1. Review of R4's clinical record revealed: 9/10/25 – R4 was admitted to the facility with diagnoses including but not limited to right leg below-knee amputation, cystitis, diabetes, difficulty walking, and spinal stenosis. 3/31/26 6:22 PM - A facility reported incident documented that a family member reported R4's call bell was on and staff did not provide ADL care. 3/31/26 - A review of CNA task list documented R4 received care 3/31/26 at 2:46 PM. 6/10/26 – R4's care plan documented that R4 was at risk for decreased ability to perform ADL's related to limited mobility, with the following interventions: included that she has decreased ability to perform ADL's, monitor for decline in ADL's and monitor for complications 6/20/26 - A quarterly MDS documented that R4 was a BIMS 15, indicating cognitively intact and was dependent for toilet hygiene. 9/1/26 12:48 PM - During an interview, E5 (CNA) stated on 3/31/26 that the call bell for room XXX had been active for approximately 45 minutes. E5 then walked down the hallway to locate staff member E11 to respond to the request. When asked why she did not answer the call bell, E5 confirmed that she did not answer the bell because she was actively at the nurses' station working on staffing duties at the time. 9/2/26 10:00 AM - During interview with FM2, she stated on 3/31/26 that R4's call bell remained activated for an extended period during the evening shift. FM2 could not recall the exact time. FM2 reported that she went to the nurses' station and spoke with E5 (CNA), informing E5 that R4's call bell had been activated for an extended period and that her mother was wet. E5 stated that she would get someone to assist R4. FM2 stated that her mother was subsequently changed; however, she was unable to recall the name of the CNA who provided the care.	F0677		10/12/2026

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F0677 SS = D	Continued from page 18 2. Review of R111's clinical record revealed: 8/4/25 - R111 was admitted to the facility. 2/18/26 - An MDS documented that R111 was a BIMs of 14 indicating cognitively intact and dependent of one assist for toileting hygiene. 5/13/26 - A facility reported incident for an allegation of neglect by R111 was reported that staff member did not provide ADL care on the 3:00 PM to 11:00 PM shift. 5/13/26 untimed - A witness statement written by E21 (CNA) documented that at 11:15 PM went to provide ADL care and R111 stated that staff did not provide care on the previous shift. E21 also documented that R111's brief and sheets were wet with urine when ADL was provided. 5/13/26 untimed - A witness statement written by E22 (RN) documented that E21 reported that R111 was upset and bed sheets were soaked. E22 went to interview R111 and documented that R111 stated only one staff member came in to deliver her dinner tray. E22 documented that the on-call provider, leadership and R111's responsible party were notified of the incident. 5/20/26 - A care plan documented that R111 was at risk for decreased ability to perform ADL's related to limited mobility with the following interventions: monitor conditions that may contribute to ADL decline, monitor for decline in ADL function, monitor for complications of immobility and provide cueing for safety and sequencing to maximize current level of functioning. 9/2/26 9:23 AM - During an interview, E2 (DON) stated that staff reported R111's allegation of care not being completed on 5/13/26 and that E23 (CNA) was suspended immediately pending investigation. E2 stated that the expectation is for the CNAs to complete rounds every two hours and that E23 admitted she did not complete care on R111 on 5/13/26. 9/2/26 9:35 AM - During an interview, E7 (Clinical Lead) confirmed that the facility recognized deficient practice and implemented a plan of correction post incident. E7 confirmed that all staff education was completed, audits were implemented and process changes were implemented. 3. Review of R112's clinical record revealed:	F0677		10/12/2026

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F0677 SS = D	Continued from page 19 4/8/26 - R112 was admitted to the facility. 4/9/26 - A care plan documented that R112 was at risk for decreased ability to perform ADL's related to limited mobility with the following interventions: monitor conditions that may contribute to ADL decline, monitor for decline in ADL function, monitor for complications of immobility and provide cueing for safety and sequencing to maximize current level of functioning. 4/15/26 - An admission MDS documented that R112 had a BIMs score of 12 indicating moderate cognitive impairment and was dependent of one staff for toileting hygiene. 5/19/26 4:23 PM - An allegation of neglect for R112 was reported to the State Agency. 9/1/26 11:23 AM - During an interview, FM3 stated on 4/27/26 when visiting R112 it was noted that he was visibly soaked. FM3 stated that R112's clothes were soaked in urine, and a puddle was noted underneath his wheelchair. FM3 stated it was reported to E23 that R112 needed to be changed, that E23 stated that they would be there after their dinner break. FM3 stated R112 waited over an hour and E23 had not come to complete care. FM3 stated they went to the nurse's station to request assistance for R112 after waiting. 9/1/26 11:44 AM - During an interview, E5 (CNA) stated she was present when FM3 reported that R112 needed ADL care on 4/27/26. E5 stated that FM3 reported that R112 needed care and that E23 went to dinner, over an hour. E5 stated that she and another staff member took R112 to his room to complete care. E5 confirmed that R112 was saturated with urine, clothing was wet and that urine was leaking onto the floor under R112's chair. E5 stated the expectation was to complete rounds for ADLs every two hours during shift and that R112 was not provided care. 9/2/26 9:23 AM - During an interview, E2 stated that the expectation is for the CNAs to complete rounds every two hours and that E23 was under investigation for a prior incident during this time. E2 stated that E23 was terminated after this incident for not providing ADL care to multiple residents. 9/2/26 9:35 AM - During an interview, E7 (Clinical Lead) confirmed that the facility recognized deficient practice and implemented a plan of correction post incident. E7 confirmed that all staff education was	F0677		10/12/2026

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F0677 SS = D	Continued from page 20 completed, audits were implemented and process changes were implemented. Based on the facility's investigation, review of the event, implementation of corrective actions, staff education regarding recognition of allegations of neglect, staff education regarding ADL care, and implementation of ongoing audits to monitor compliance, it was determined the facility returned to substantial compliance effective August 23, 2026. 9/3/26 2:45 PM - Findings were review with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.	F0677		10/12/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that, for one (R18) of the fifty-two residents included in the investigative sample, the facility failed to provide appropriate services, resulting in R18 having to reschedule a necessary medical follow-up appointment. Findings include: Review of R18's clinical record revealed: 8/15/26 - R18 was admitted to the facility. 8/15/26 - A hospital discharge summary documented that R18 was scheduled for a general surgery follow up appointment on 8/17/26 at 8:30 AM. 8/19/26 1:38 PM - A physician's order documented R18 for a follow up appointment on 8/24/26 at 11:15 AM. 8/24/26 10:53 AM - During an interview, R18 stated she was scheduled for a follow visit today and was told the appointment had to be rescheduled due to issues with transportation. R18 stated she was	F0684	Corrective Action of Areas Affected: The facility was unable to correct this prior to discharge of R18. R18 discharged from the facility on 08/26/26. Other areas affected: The NHA/Designee will audit current residents to identify if appropriate transportation is scheduled for medical follow up appointments. Systemic Changes to Prevent Future Occurrences : A root cause analysis was completed to determine that education on OPS143 Transportation and Escort: Patient was needed for the appointment scheduler and nursing staff. Education given by the Nursing Home Administrator and/or designee will be completed by 10/12/26. Monitoring of Corrective Action: The Nursing Home Administrator and/or designee will conduct audits (attachment F) to ensure the correct transportation service is scheduled for new admissions. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	10/12/2026

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F0684 SS = D	Continued from page 21 concerned about missing the appointment and that staff did not ask what accommodations would be needed for transportation. R18 stated she needed transport via stretcher as she just had surgery and sitting in a wheelchair puts pressure on her abdominal wound. 8/24/26 12:03 PM - A physician's order documented R18 for a follow up appointment on 8/26/26 at 11:15 AM. 8/31/26 10:01 AM - During an interview, E25 (scheduler) stated the resident is responsible to notify staff of any outside appointments and will also review discharge summaries for upcoming appointments. E25 stated that R18 was scheduled for an appointment on 8/24/26 for a wheelchair transport and was not aware that R18 needed stretcher accommodations. E25 stated there was not a set process for scheduling appointments and E25 schedules them as she is aware of them. 8/31/26 10:20 AM - During an interview, E26 (RN) stated the expectation is for staff to review the discharge instructions or for the resident to notify staff of upcoming appointments. E26 stated then the staff member will notify E25 of the appointment verbally or place paperwork in the bin on the unit. E26 stated the nurse will place an order in the EMR during off orders if E25 was not on shift. The facility failed to provide appropriate services which results in R18 having to reschedule a medical necessary follow up appointment. 9/3/26 2:45 PM - Findings were review with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.	F0684		10/12/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by:	F0689	Corrective Action of Areas Affected: R12's smoking apron was placed on 08/26/26 during supervised smoking. Other areas affected: The NHA/Designee will conduct an initial audit for current residents who smoke to identify if a smoking apron is needed. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education on OPS137 Smoking/Smokeless Tobacco and Smoking Safety was needed for all staff. Education on Smoking Safety will be given by the Nursing Home Administrator and/or designee by 10/12/26. A binder was created for residents who	10/12/2026

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F0689 SS = D	Continued from page 22 Based on observation, interview, and record review, it was determined that for one (R12) out of six residents reviewed for accidents, the facility failed to provide assistive devices to prevent accident hazards. Findings include: R12's clinical record revealed: 4/30/26 – R12 was admitted to the facility. 8/7/26 – A quarterly MDS documented that R12 had severe cognitive impairment with a BIMS score of 4. The MDS also documented that R12 had no impairments to his upper or lower extremities and was independent in all self-care and mobility abilities. 8/22/26 – A care plan for R12 documented that he may smoke with supervision per the smoking evaluation, with an intervention to provide or assist with the smoking apron. 8/22/26 12:17 PM – A smoking safety evaluation documented that R12 needed supervision and a smoking apron due to a medical condition and shaking during smoking. 8/26/2026 9:10 AM – An observation of R12 seated outside in the designated smoking area with a lit cigarette in his right hand. R12 was observed not wearing the smoking apron. E15 (CNA) was observed monitoring the residents smoking with the lock box next to her. 8/26/2026 9:15 AM – During an interview, E15 stated that staff know which residents require a smoking apron through word of mouth and a list that is kept on the units. E15 stated that the smoking aprons are kept in the lock box that they bring out with them during the smoking times. 8/26/2026 10:22 AM – During an interview, E16 (RN UM) stated that a list of residents who require a smoking apron is kept in the lock box that is taken out with the staff and on the units. If the resident does not want to put the apron on, they cannot smoke. An observation revealed that R12 was documented on the list requiring a smoking apron. 9/3/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.	F0689	Continued from page 22 smoke to identify who needs a smoking apron. The staff member who supervises smoking takes the binder with them to ensure the smoking apron is in place. Monitoring of Corrective Action: The Nursing Home Administrator and/or designee will conduct audits (attachment G) to ensure identified residents who smoke and need an apron are compliant. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	10/12/2026

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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 drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for two (R5 and R44) out of seven residents reviewed for medication review, the facility failed to ensure the provider documented that irregularities were reviewed. Findings include:	F0756	Corrective Action of Areas Affected: A GDR of R5's medication was completed on 03/30/26. A GDR of R44's Sertraline was completed on 09/17/26 and Lorazepam was completed on 08/28/26. Other areas affected: The DON/Designee will conduct an audit for current residents to identify pharmacy recommendations for the last 30 days to ensure they have been acknowledged and signed by the provider. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education on Pharmacy Recommendations is needed for the Nursing leadership team. Education given by the Clinical Lead (RN) and/or designee will be completed by 10/12/26. The pharmacy recommendations will be reviewed in the clinical morning meeting with the provider to be addressed and signed at that time. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment H) to ensure a physician response to Pharmacy recommendation is documented. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations	10/12/2026

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F0756 SS = D	Continued from page 24 1. Review of R5's clinical record revealed: 1/8/23 - R5 was admitted to the facility. 10/30/24 - A physician's order for R5 documented trazodone HCl Oral 100 MG give one tablet by mouth at bedtime for Depression. 10/16/25 - A Monthly Medication Pharmacy review documented that R5 was prescribed trazodone 100 mg daily since 11/29/24 and evaluate the current dose and consider a dose reduction. The form lacked evidence of provider acknowledgement and signature. 11/11/25 - A Monthly Medication Pharmacy review documented that R5 was prescribed trazodone 100 mg daily since 11/29/24 and evaluate the current dose and consider a dose reduction. The form lacked evidence of provider acknowledgement and signature. 1/15/26 - A Monthly Medication Pharmacy review documented that R5 was prescribed trazodone 100 mg daily since 11/29/24 and evaluate the current dose and consider a dose reduction. The form lacked evidence of provider acknowledgement and signature. 3/30/26 - A physician's order for R5 documented trazodone HCl Oral 50 MG give one tablet by mouth at bedtime for depression GDR (gradual dose reduction). 9/3/26 9:24 AM - During an interview, E2 (DON) stated "The expectation was for the provider to sign the recommendation from pharmacy monthly, then the nurse would implement the changes in the EMR if needed." 9/3/26 10:42 AM - During an interview, E24 (NP) stated the expectation was for the provider to sign the recommendation from pharmacy and evaluate the resident for the recommendation. E24 stated that if the form was not signed then it had not been reviewed. E24 stated at the time of the recommendation R5 was not appropriate for a dose reduction and the medication was adjusted in March when behaviors were stable. The facility failed to ensure the provider reviewed and documented irregularities were reviewed. 2. Review of R44's clinical record revealed: 1/14/2 – R44 was admitted to the facility.	F0756		10/12/2026

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F0756 SS = D	Continued from page 25 8/11/25 - A physician's order for R44 documented lorazepam 0.5 mg, give one tablet by mouth at bedtime for generalized anxiety disorder. 9/22/25 - 1/16/26 – Monthly Medication Pharmacy reviews showed no recommendations for this resident. 10/2/25 - A physician's order for R44 documented sertraline 100 mg, give one and a half tablets, for a total dose of 150 mg, daily for depression. 2/12/26 - A Monthly Medication Pharmacy review documented that R44 was prescribed sertraline 150 mg daily since 10/2/25 and lorazepam 0.5 mg daily at bedtime since 8/11/25. The recommendation was to evaluate the current dose and consider a trial dose reduction for the lorazepam of 0.5 mg every other day. The form lacked evidence of provider's acknowledgement and signature. 4/2026 – The facility lacked evidence of a Monthly Medication Pharmacy review. 9/3/26 9:24 AM - During an interview with E2 (DON), the surveyor asked the DON "What is the Facility's process for the medication regimen review recommendations once received? The DON reported "I was printing them out myself and handling them myself, but that process has changed and now the unit managers will be doing this." The surveyor asked, "What is the time frame that the provider should respond to the recommendations?" The DON reported "Monthly. The expectation is for the provider to sign the recommendation from pharmacy, then the nurse would implement the changes in the EMR if needed." 9/3/26 2:45 PM - Findings were review with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.	F0756		10/12/2026
F0760 SS = D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and review of other facility records, it was determined that, for one	F0760	Corrective Action of Areas Affected: Facility unable to correct R67's medication omission for Lactulose. Other areas affected: The DON/Designee will conduct an initial audit on medication omissions for the last 7 days. Residents identified as missing a scheduled medication will be assessed by the MD/NP and if new orders are indicated they will be carried out. Systemic Changes to Prevent Future Occurrences :	10/12/2026

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F0760 SS = D	Continued from page 26 (R67) out of seven residents reviewed for pharmacy services, the facility failed to maintain an adequate supply of Lactulose for R67, resulting in four missed doses. Findings include: R67's clinical record revealed: 11/15/23 – R67 was admitted to the facility with diagnoses including, but not limited to, hepatic encephalopathy and cirrhosis of the liver. 4/14/26 8:00 PM – A review of a physician's order for R67 documented, "Lactulose oral solution 10 gm/mL, give 45 mL by mouth three times a day for encephalopathy." 6/1/26 8:00 AM – A review of R67's MAR (Medication Administration Record) revealed that R67 did not receive Lactulose 45 ml. 6/1/26 9:36 AM – An eMAR (Electronic Medication Administration Record) progress note documented, "Lactulose oral solution 10 gm/15 mL, give 45 mL by mouth three times a day for encephalopathy, awaiting pharmacy delivery." 6/1/26 1:23 PM – An eMAR progress note documented, "Lactulose oral solution 10 gm/15 mL, give 45 mL by mouth three times a day for encephalopathy, awaiting pharmacy delivery." 6/1/26 2:00 PM – A review of R67's MAR revealed that Lactulose was not administered. 6/1/26 3:22 PM - A review of a follow up progress note authored by E39 (NP) documented "Last administered dose of Lactulose 5/31/26 due to supply issue." 6/1/26 8:00 PM – A review of R67's MAR revealed that Lactulose was not administered. 6/1/26 9:30 PM – An eMAR progress note documented, "Lactulose oral solution 10 gm/15 mL, give 45 mL by mouth three times a day for encephalopathy, awaiting pharmacy delivery." 6/2/26 8:00 AM – A review of R67's MAR, documented by E30 (LPN), revealed that R67 was administered Lactulose 45 mls. 6/2/26 11:10 AM - A review of laboratory results for an ammonia level for R67 documented 102.0. The collecting laboratories normal reference range for the results was 9.0 - 30.0. The ammonia level was flagged as high.	F0760	Continued from page 26 A root cause analysis was completed to determine that education on medication omission is needed for licensed nursing staff. The Lactulose was on order from the pharmacy. The high dosage and what was approved by the insurance company did not align for an every 14 day supply. Pharmacy was contacted and the shipment and insurance approval was changed to every 7 days. Education given by the Director of Nursing and/or designee will be completed by 10/12/26 on ensuring medication supply is available. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment I) to ensure there are no medication omissions. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations	10/12/2026

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F0760 SS = D	Continued from page 27 6/2/26 2:00 PM – A review of R67's MAR revealed that Lactulose was not administered by E30. 6/2/26 2:21 PM – An eMAR progress note documented, "Lactulose oral solution 10 gm/15 mL, give 45 mL by mouth three times a day for encephalopathy, on order from pharmacy." 6/2/26 2:40 PM – A progress note documented that, per the pharmacy, Lactulose was being sent on a 14-day (q14) shipment schedule and should be changed to a 7-day shipment schedule. The pharmacy edited the supply request, and the medication was being sent that day. 6/2/26 3:35 PM – A review of a facility transaction report from the Pyxis machine documented that E30 retrieved two doses of Lactulose 10 gm/15 mL, 30 mL each. 9/3/26 10:11 AM – During a telephone interview, E30 reported, "Typically, we run out of [R67's] Lactulose prior to the refill because the dose was so high. [R67] was getting 45 mL three times a day. There would be times we would order, and it would be too soon, so we would pull it from the Pyxis. We had to take out two doses because [R67] required 45 mL, and there were only 30 mL doses." E30 further reported and confirmed that R67 missed multiple doses. 9/3/26 2:45 PM – Findings were reviewed with E1 (NHA), E2 (DON), and E7 (Clinical Lead) during the exit conference.	F0760		10/12/2026
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility	F0842	Corrective Action of Areas Affected: The facility failed to ensure the clinical record contained accurate documentation of R29's ADL task for bathing. The facility is unable to correct this prior documentation. Other areas affected: The DON/Designee will conduct an initial audit on all residents ADL bathing tasks for the last 7 days to ensure not applicable is not documented incorrectly. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that education on ADL documentation is needed for the certified nurse aides. Education on ADL documentation will be given by the Director of Nursing and/or designee and be completed by 10/12/26.	10/12/2026

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	085015	A. BUILDING B. WING	09/03/2026

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F0842 SS = D	Continued from page 28 must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident;	F0842	Continued from page 28 Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment J) to ensure there are no not applicable ADL bathing tasks documented . The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations	10/12/2026

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F0842 SS = D	Continued from page 29 (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R29) out of thirty-six sampled residents for identifiable information in the clinical record, the facility failed to ensure the clinical record contained accurate documentation. Findings include: R29's clinical record revealed: 10/12/19 – R29 was admitted to the facility. 6/30/26 – A review of a revised care plan for R29 documented resident is resistive to cares and has behaviors and is non- compliant with care interventions. 8/28/26 1:00 PM - A review of R29's ADL's for bathing (shower/bathe self) documented 'not applicable' for 65 out of 90 opportunities in June 2026, 66 out of 91 opportunities in July 2026, and 44 out of 85 opportunities in August 2026. 8/28/26 1:35 PM – During an interview, E17 (CNA) reported, "If [R29] refuses to be bathed then you would document resident refused in the CNA documentation for tasks. There is no reason to document 'not applicable' for a resident that refuses care." 8/28/26 1:45 PM – During an interview the surveyor asked E32 (RNAC), "What would be the reason the CNA would document 'not applicable' for bathing?" E32 reported, "You shouldn't see 'not applicable'	F0842		10/12/2026

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F0842 SS = D	Continued from page 30 for bathing unless that person was not in the facility. E32 then stated, "They should be documenting 'resident refused.' The documentation should be accurate and say the resident refused." 9/3/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.	F0842		10/12/2026
F0943 SS = D	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is NOT MET as evidenced by: Based on interview and facility documentation it was determined that for one out of fourteen employees sampled the facility failed to provide abuse, neglect, exploitation and dementia training for a new staff person. Findings include: 8/28/26 – The facility was provided a list of fourteen names selected randomly and instructed to provide documentation of in-service training for abuse, neglect, exploitation, and dementia training for new and existing staff. 7/15/26 – E36 was hired. E36's record review lacked evidence of abuse and dementia training. 9/3/26 1:45 PM – During an interview and record review E2 (DON) confirmed E36 did not have the	F0943	Corrective Action of Areas Affected: A copy of R36's abuse and dementia training was placed in her personnel file. Other areas affected: The Housekeeping Supervisor will conduct an initial audit on all Housekeeping personnel files to ensure abuse and dementia training was present for all current employees. Systemic Changes to Prevent Future Occurrences: A root cause analysis was completed to determine that this deficiency is directly related to contracted housekeeping staff with Healthcare Services Group. Education on Personnel records is needed for the Housekeeping Manager. Education given by the Nursing Home Administrator and/or designee will be completed by 10/12/26. Monitoring of Corrective Action: The Environmental Service District Manager and/or designee will conduct audits (attachment K) to ensure that all new Housekeeping employee files have a copy of abuse and dementia training. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations	10/12/2026

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F0943 SS = D	Continued from page 31 required in-service training. 9/3/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E7 (Clinical Lead) during the exit conference.	F0943		10/12/2026