DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Westminster Village Ctr Nursing Home **DATE SURVEY COMPLETED:** September 28, 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 September 21, 2026, through September 28, 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 sixty-three (63). The survey sample totaled thirty-two residents (32).		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS-2567-L survey completed September 28, 2026: F641, F679, F689, F812, F842, F908 and F921.	Cross refer to the CMS-2567-L survey completed September 28, 2026: F641, F679, F689, F812, F842, F908 and F921.	11/11/2026

Provider's Signature _____ Title LNHA Date 10/20/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085032	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE HEALTH	**1175 MCKEE ROAD , DOVER, Delaware, 19904**

(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 September 21, 2026 through September 28, 2026. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		11/11/2026
F0000	INITIAL COMMENTS An unannounced Annual and Complaint survey was conducted at this facility from September 21, 2026, through September 28, 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 sixty-three (63). The survey sample totaled thirty-two 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		11/11/2026

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

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

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F0000	Continued from page 1 UM - Unit Manager; Acetaminophen - a pain reliever used to treat mild pain and fever; Activities of daily living (ADLs) – tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; Anti-depressant – drug to counter depression; Anxiety- general term for several disorders that cause nervousness, fear, apprehension and worrying; BIMS – (Brief Interview for Mental Status) – assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); Bisacodyl - a medicine used to treat constipation; Care Plan- outlines the plan of action that will be implemented during a patient's medical care; Cognitively Impaired – abnormal mental processes; thinking or mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently; EMR - (Electronic Medical Record) - a systematized collection of patient and population electronically stored health information in a digital format; Gram (gm) - a unit of weight/mass; Interdisciplinary Team (IDT)- a coordinated group of staff from several different fields who work together towards a common goal or project; Lactulose - a medicine used to soften stools in the event of constipation; Minimum Data Set (MDS) – standardized assessment forms used in nursing homes; Milligram (mg) - a unit of weight/mass;	F0000		11/11/2026

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F0000	Continued from page 2 Milliliter (mL) - a unit of volume; Minimum Data Set (MDS) – standardized assessment forms used in nursing homes; PASARR - Preadmission Screening and Resident Review - screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; Psychosis – loss of contact/touch with reality; Remeron (Mirtazapine) – a medication used to treat depression.	F0000		11/11/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents, and to	F0812	On 9/21/26 the ice machine in the kitchen in the main kitchen in healthcare was immediately cleaned to remove all black spots. Also, on 9/22/26 Hobart inspected the dishwasher to ensure that required temperature is reached for the washing and rise cycle. Temperature was 175 for the wash and 185 rinse. Current residents have the potential to be affected by this practice. An audit of all ice machines and the dishwashing machine was conducted by the Director of Dining Services (Certified Dietary Manager). Audits confirmed that no black spots or areas of mildew were observed on the ice machines and that the dishwasher wash and rinse cycle were at required temperature. A root-cause analysis revealed the facility policies for required dishwasher temperatures and routine cleaning of the ice machine were not followed. The Director of Dining Services (Certified Dietary Manager) will provide re-education to the Health Care Dining Staff on the procedures regarding dishwasher temperatures and maintaining cleanliness of the ice machine. The Director of Dining Services (Certified Dietary Manager) will re-educate the Health Care Dining Staff on the "Shift Supervisor Checklist" which was updated to include the dishwasher to run on consecutive cycles to confirm required temperature is met before any items are added to the dishwasher and also includes the cleaning of the ice machines daily to prevent black spots or mildew. The "Shift Supervisor Checklist" is completed twice daily by the morning	11/11/2026

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F0812 SS = F	Continued from page 3 ensure that dishes and utensils were cleaned under sanitary conditions. Findings include: 9/21/26 10:18 AM - Observations of the ice machine in the kitchen and the ice machine in the main dining room revealed both of the ice machines had several areas of black spots, which appeared to be mold or mildew on some of the interior surfaces. 9/21/26 10:20 AM - Observation of the warewashing machine and interview with E22 (Dietary Director) revealed that the warewashing machine failed to reach the wash temperature required to provide sanitary washing of dishes and utensils on three (3) out of three (3) attempts, and the ware washing machine failed to reach the twmerature required for sanitization during the rinse cycle for two (2) out of three (3) attempts. 9/21//26 10:42 AM - Findings were reviewed with E22 (Dietary Director).	F0812	Continued from page 3 cook and the evening cook. Any variances will be reported to the Director of Dining Services (Certified Dietary Manager) or Cook Supervisor on duty, this includes weekends and holidays. The "Shift Supervisor Checklist" will be reviewed upon new hire as an addendum to the Skills Checklist. It is validated daily by the Director of Dining Services (Certified Dietary Manager) and/or the Cook Supervisor; this includes weekends and holidays. The Director of Dining Services (Certified Dietary Manager) will conduct an audit of the dishwasher in the main kitchen in healthcare to ensure required temperature is reached during the wash and rinse cycle. The Director of Dining Services (Certified Dietary Manager) will conduct an audit of the cleanliness of ice machine in the main kitchen in healthcare to ensure there are no black spots or areas of mildew present. Audits will be conducted daily x5 days until 100% compliance is verified that the required temperature is reached for the dishwasher and the cleaning of the ice machine is maintained; then weekly x4 weeks until 100% compliance is verified that the required temperature is reached for the dishwasher and the cleaning of the ice machine is maintained, then monthly x2 months until 100% compliance is verified that the required temperature is reached for the dishwasher and the cleaning of the ice machine is maintained. Results will be presented to the Quality Assurance Performance Improvement team for review and recommendation.	11/11/2026
F0908 SS = F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that essential kitchen equipment is maintained in safe operating condition. Findings include: 9/21/26 10:11 AM – An observation of the walk-in freezer revealed ice build-up on the floor under the fans, frozen ice droplets on the ceiling in front of the fans, and several smaller chunks of ice on various other areas of the floor. 9/28/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit	F0908	On 10/6/26 all foods were removed from the walk-in freezer, defrosting began to eliminate the ice build-up on the floor, droplets on the ceiling, and several smaller chunks on various other areas. On 10/8/26 the defrosted freezer lines to the fan were wrapped with insulation by our maintenance department. Freezer was brought back on-line and has maintained the proper temperature with no visible ice buildup. Current residents have the potential to be affected by this practice. An audit of freezer in the main kitchen of healthcare was conducted by the Director of Dining Services (Certified Dietary Manager), and no ice was seen on the floor, ceiling, or by the fans. The "Shift Supervisor Checklist" will be reviewed upon new hire as an addendum to the Skills Checklist. A root-cause analysis revealed the facility procedure	11/11/2026

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F0908 SS = F	Continued from page 4 conference.	F0908	Continued from page 4 for required inspection of the freezer was not followed. The Director of Dining Services (Certified Dietary Manger) will provide re-education to the Health Care Dining Staff on the "Shift Supervisor Checklist" which was updated to include the procedure for inspecting the freezer daily for ice buildup. The "Shift Supervisor Checklist" is completed twice daily by the morning cook and the evening cook. Any variances will be reported to the Director of Dining Services or Cook Supervisor on duty, this will include weekends and holidays. The Director of Dining Services (Certified Dietary Manager) will conduct an audit of the freezer in the main kitchen of healthcare to ensure no ice buildup is visible. Audits will be conducted daily x5 days until 100% compliance is verified that the freezer does not have any ice buildup; then weekly x4 weeks until 100% compliance is verified that the freezer does not have any ice buildup, then monthly x2 months until 100% compliance is verified that the freezer does not have any ice buildup. Results will be presented to the Quality Assurance Performance Improvement team for review and recommendation.	11/11/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F0641	Resident R64 still resides in the facility. On 9/24/26 a modification was completed and the significant weight loss question was updated to "yes" and resubmitted to CMS for R64. Current residents residing in the facility that have had a weight loss of 5% or more in the last month or loss of 10% in the last 6 months have the potential to be affected by this practice. MDS records for current residents with weight loss of 5% or more in the last month or loss of 10% in the last 6 months were audited by the Registered Dietitian Nutritionist to ensure if there was a significant weight loss it was documented correctly in the MDS. No other inaccuracies were found. A root-cause analysis revealed that the MDS Section K was not followed accurately by the dietitian. Regional Dietitian (MS, RDN, CSG, LDN, CDP) re-educated the Registered Dietitian on the MDS Section K – "Weight Change Coding Education." Prior to submissions of the residents MDS the RNAC will verify that the MDS is accurate for Section K. Any variances will be adjusted by the RNAC to accurately reflect the residents clinical record prior to submission.	11/11/2026

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F0641 SS = D	Continued from page 5 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and record review, it was determined for one (R64) out of thirty-two (32) sampled residents, the facility failed to ensure the MDS was accurate. Findings include: Cross refer F710 and F692. Review of R64's clinical record revealed: 7/1/25 - R64 was admitted to the facility. 12/3/25 - An MDS documented that R64 had a loss of 5% or more in the last month or loss of 10% in last 6 months. R64's documented weight was 180 pounds. 3/4/26 - A significant change MDS documented that R64 had a loss of 5% or more in the last month or loss of 10% in last 6 months. R64's documented weight was 170 pounds. 6/5/26 - A quarterly MDS documented that R64 had a loss of 5% or more in the last month or loss of 10% in last 6 months. R64's documented weight was 155 pounds. 9/9/25 - A quarterly MDS documented that R64 had no loss of 5% or more in the last month or loss of 10% in last 6 months. R64's documented weight is 150 pounds. 9/24/26 2:18 PM - During an interview, E8 (RNAC) and E9 (RNAC) stated that each department was responsible to complete certain sections of the MDS (Minimum Data Set) and the expectation was for the person responsible to ensure accuracy. E8 and E9 confirmed that if the resident had a weight loss of 5% in one month or 10% in 6 months, the question regarding significant weight loss would be marked "yes," and for R64 it was marked "no."	F0641	Continued from page 5 The RNAC (Registered Nurse) will conduct an audit of current residents' MDS who have had a weight loss of 5% or more in the last month or a weight loss of 10% in the last 6 months to ensure each assessment is accurately coded in the MDS. Audits will be conducted weekly x4 weeks until 100% compliance is verified, then monthly x2 months until 100% compliance is verified. Results will be presented to the Quality Assurance Performance Improvement team for review and recommendation.	11/11/2026

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F0641 SS = D	Continued from page 6 9/24/26 - A modification of MDS was completed and the significant weight loss question was updated to "yes" for R64. 9/28/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0641		11/11/2026
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R10) out of one resident reviewed for activities the facility failed to implement resident centered activities programs that incorporates the resident's interests and hobbies, including access to supplies for independent painting. Findings include: Review of R10's clinical record revealed: 6/30/25 - R10 was admitted to the facility. The facility lacked evidence of an admission activities assessment for R10. 1/3/26 - An Activities Annual Participation Review form documented that R10 prefers independent activities and had participated in artistic activities such as "Crafts with [Program Provider]" and independent in room art projects. 1/13/26 - A care plan documented that R10 was able to self-direct her day and communicate preferences with the following interventions: [R10] enjoys painting, watching TV, and using her smart phone; [R10] was an artist and a member of a local Art League; It is important that R10 takes care of personal belongings.	F0679	R10 still resides in this facility. On 9/22/26 Activities Director interviewed resident R10 and received a list of art supplies to purchase for the resident. Order was placed on 9/22/26. Supplies were received in the week of 9/28/26 and a dedicated art cart was created for resident R10. Resident R10 was pleased with the supplies. Current residents residing at this facility who have identified activity interests have the potential to be affected by this practice. An audit of current residents in the facility was conducted by the Director of Community Life (Activity Director Certified) to ensure their activity interests are met. No other residents were noted to be found. A root-cause analysis revealed the facility policy on "Resident Rights and Responsibilities" & "Recreational/Community Life Programming" was not followed. The Nursing Home Administrator (NHA) will re-educate the Activities Department regarding the policy of "Resident Rights and Responsibilities" & "Recreational/Community Life Programming" to ensure that residents activity interest is met. Director of Community Life will maintain a roster of residents who are independent recreators and meet with them monthly to ensure that they have the supplies, resources, and space to perform their preferred activity. The Director of Community Life (Activity Director Certified) will conduct an audit of 5 random residents to ensure their identified interests of choice are offered, daily x5 days until 100% compliance is verified; then weekly x4 weeks until 100% compliance is verified, then monthly x2 months until 100% compliance is verified to ensure all resident activity needs are being met. Results will be presented to the Quality Assurance Performance Improvement team for review and recommendation.	11/11/2026

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F0679 SS = D	Continued from page 7 7/10/26 - A quarterly MDS documented that R10 had a BIMS score of 13, indicating cognitively intact. 9/21/26 10:54 - During an interview, R10 stated that she loves to paint and expressed that she did not feel the facility offered enough activities to meet her needs. R10 stated she does not have the supplies she needs to paint when she wants to, and that the facility had not provided the supplies required to paint. R10 stated the facility offers other activities like bingo, and she was not interested in attending. R10 also stated she would like to paint every day if she could. 9/22/26 2:00 PM - During an interview, E13 (Activities Director) stated the facility was expected to complete an activities assessment after admission to determine what activities the resident prefers to participate in. E13 stated the facility has a member from the community who comes to the facility once a month and does crafts with the residents. E13 stated that this community member will bring R10 supplies when she visits the facility because they know each other from the art community prior to R10 being admitted to the facility. E13 confirmed that R10 expressed verbally that painting was not offered enough and that painting should be offered more to meet R10's preferences and needs. 9/22/26 2:20 PM - E13 provided a list of activities that R10 had attended over the last three months. The list included "Crafts with [Program Provider]" monthly. The list lacked evidence that R10 was painting independently or provided painting in a group setting. The facility lacked evidence that R10 was receiving activities that met her preferences and interest. 9/23/26 11:23 AM - During an interview, R10 stated that the facility has made accommodations to provide painting as an activity to her three times a week now instead of once a month with the community member. R10 stated she was most grateful and appreciated the facility making this change to meet her needs. 9/28/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0679		11/11/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F0689	"Past Noncompliance - no plan of correction required"	01/21/2026

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F0689 SS = D	Continued from page 8 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and review of facility documentation, the facility failed to implement safe repositioning practices during in-bed care for one resident (R64) out of two residents reviewed for accidents, resulting in the resident sliding from the bed and striking her head on a bedside chair. 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 1/21/26. Findings include: Review of R64's clinical record: 7/1/25 - R64 was admitted to the facility. 7/2/25 - A care plan documented that R64 was dependent for ADLs with an intervention documenting R64 requires one person assist by staff to turn and reposition in bed every two hours and as needed. 10/28/25 - An MDS documented that R64 was dependent for ADLs for turning and repositioning which is defined as "staff does all the work or the assistance of two or more staff is required for the resident to complete the activity." 1/13/26 11:37 AM - A facility reported incident documented that during AM care R64 rolled off the side of the bed. 1/13/26 untimed - A witness statement documented that E14 (CNA) was providing care to R64 and rolled R64 away from her. When R64 was rolled away, E14 went to grab a wipe from the bedside table and R64 started sliding from the bed. E14 was unable to prevent R64 from sliding off the bed and R64 hit her head on a chair sitting by the bed. The witness statement further documented that R64 was not turned properly and if turning a resident away from you a second staff person should be there for safety.	F0689		01/21/2026

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F0689 SS = D	Continued from page 9 1/13/26 - A progress note from outside provider documented that R64 had clinical testing completed and no acute injury or bleeding occurred post fall. R64 was discharged and returned to the facility. 9/28/26 1:20 PM - During an interview, E15 (CNA) stated that when providing care to a resident the expectation was to roll the resident towards you unless a second person was present during care. E15 confirmed that rolling a resident away was not proper body mechanics for bed mobility and was not safe resident handling for bed mobility. E15 confirmed that the facility did provide education after the 1/13/26 incident and updated the policy of a two-person assist for all residents using an air mattress. 9/28/26 1:30 PM - During an interview, E9 (RNAC) stated that a care plan is updated when a resident had a change with the plan of care. E9 stated therapy determines how many staff members are required with a dependent resident. E9 stated that R64 was dependent with care and required a one person assist prior to 1/13/26. E9 confirmed that the facility provided education post incident on 1/13/26 and updated facility process for all residents with air mattresses with two-person assist. 9/28/26 2:15 PM - Based on the facility's investigation, review of the event, implementation of corrective actions, staff education regarding ADL care and body mechanics with repositioning, and updated policy and process on providing ADL care requiring two person assist for all residents who use an air mattress, it was determined the facility returned to substantial compliance effective January 21, 2026. 9/28/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0689		01/21/2026
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.	F0842	R4 still resides in the facility. On 9/23/26 three orders – acetaminophen 325mg, bisacodyl 5mg, & lactulose 20gm/30ml were changed from via mouth to via peg-tube for resident R4. All other medications reflect via the peg-tube. Current residents residing in the facility that require tube feeding have the potential to be affected by this practice. An audit of current residents who are in the facility who require tube feeding was conducted by the RNAC (RN) to ensure that physician orders are followed as to route of administration of their current medications. Physician orders were followed for	11/11/2026

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F0842 SS = D	Continued from page 10 §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility 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	F0842	Continued from page 10 each identified resident. No variances were noted. A root-cause analysis revealed the facility policy on "24 Hour Chart Check" was not followed. A root-cause analysis revealed the need for re-education of licensed nurses by the Director of Nursing (RN) or designee (RN), on the 24-Hour Chart Check Policy which includes the process for ensuring that all residents' medications are reviewed and verified to have the correct instructions for administration, dosage, and route of administration. Any newly admitted or existing residents with a new order for tube feeding will be reviewed in morning clinical meeting to ensure route of medication administration is accurate and follows physician orders. The "24 Hour Chart Check" policy will be reviewed upon new hire as an addendum during nursing orientation. The Director of Nursing (RN)/designee (RN) will conduct an audit of all residents who receive tube feedings to ensure that all medications that are prescribed are being followed by physician's orders regarding route of administration. Audits will be conducted daily x5 days until 100% compliance is verified; then weekly x4 weeks until 100% compliance is verified, then monthly x2 months until 100% compliance is verified. Results will be presented to the Quality Assurance Performance Improvement team for review and recommendation.	11/11/2026

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F0842 SS = D	Continued from page 11 legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (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 (R4) out of thirty-two (32) sampled residents reviewed for identifiable information in the survey sample, the facility failed to ensure the clinical record contained accurate documentation. Findings include: R4's clinical record revealed: 4/14/26 - R4 was admitted to the facility with diagnoses including, but not limited to, stroke and difficulty swallowing food and liquid. 4/14/26 – A care plan documented that R4 required tube feeding due to his difficulty swallowing. 4/14/26 2:42 PM – An active order for R4 for acetaminophen 325 mg, to give two tablets by mouth every 4 hours as needed for mild pain was entered in the electronic chart. 4/14/26 2:43 PM – An active order for R4 for bisacodyl 5 mg, to give one tablet by mouth once daily as needed for constipation, was entered in the electronic chart. 4/14/26 2:45 PM – An active order for R4 for lactulose 20gm/30mL, to give 30 mL by mouth every 8 hours as needed for constipation, was entered in the electronic chart. 4/14/26 3:20 PM – An order for R4 documented that	F0842		11/11/2026

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F0842 SS = D	Continued from page 12 he has nothing by mouth for diet, texture, and consistency. 4/28/26 – An admission MDS documented that R4 had an impairment affecting one side of his upper extremities; his eating ability was not assessed due to his medical condition and safety concerns, and he used a feeding tube for swallowing and nutrition. 9/23/26 10:54 AM – During an interview, E11 (LPN) stated that a nurse supervisor enters orders from the provider into residents' charts. E11 also stated that R4 does not receive any food, liquids, or medications by mouth; everything goes into the feeding tube. 9/23/26 11:09 AM – During an interview, E12 (RN Supervisor) stated that supervisors primarily enter orders into the resident charts. E12 also stated that chart checks are completed at night. E12 confirmed that R4 does not take any medications by mouth and that the three medication orders were a batch selection and were not updated to be administered via R4's feeding tube. 9/28/26 2:45 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0842		11/11/2026
F0921 SS = D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that for one out of the two dining rooms, the facility failed to maintain a clean, safe, and sanitary environment by allowing dried food to accumulate on the wall surface. Findings include: 9/21/25 10:AM - During direct observation in the dining room on the long-term care unit, brownish-orange residue was observed in multiple areas on the dining room wall. 9/21/26 11:15 AM - During an interview, E5 (CNA), stated that dietary usually cleans the tables after meals, and housekeepers clean the walls and floors. E5 confirmed that the LTC dining room wall had	F0921	On 9/21/26 brownish-orange residue in multiple areas of the dining room wall on our Long-Term Care neighborhood were thoroughly cleaned. Current residents have the potential to be affected by this practice. An audit of current dining room walls was completed by the Environmental Services Support Manager to ensure that no brownish-orange residue or food stains were located. A root-cause analysis revealed the facility policies for "Housekeeping Department Operations" were not followed. Environmental Services Support Manager will re-educate the housekeeping department on the policy "Housekeeping Department Operations" and ensure walls and ceilings are maintained free from debris. The daily housekeeping checklist has been updated to include to ensure walls and ceilings are maintained free from debris in the dining rooms. The "Housekeeping Checklist" will be reviewed upon new hire as an addendum to the Skills Checklist. The Environmental Services Support Manager will conduct an audit of dining room walls to ensure	11/11/2026

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F0921 SS = D	Continued from page 13 brownish-orange residue in multiple areas for about a week; she said a resident usually throws his food. 9/21/26 11:25 AM – During an interview, E6 (LPN) stated that the dietary staff cleans the tables, and housekeeping will clean the floor and walls. She noticed brownish-orange residue in multiple areas on the dining room wall for a couple of days. 9/21/26 12:30 PM - During an interview, E4 (housekeeping) stated that he cleans walls only when specifically asked, but acknowledged that inspecting and wiping down wall surfaces is not part of his routine daily cleaning schedule. 9/21/26 1:07 PM – During an interview, E7 (housekeeping supervisor) confirmed a brownish-orange residue on multiple areas of the dining room wall and stated that she would clean the wall immediately. 9/28/26 2:45 PM - Findings were review with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	F0921	Continued from page 13 they are free from debris or food stains. Audits will be conducted daily x5 days until 100% compliance is verified; then weekly x4 weeks until 100% compliance is verified, then monthly x2 months until 100% compliance is verified. Results will be presented to the Quality Assurance Performance Improvement team for review and recommendation.	11/11/2026