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: Wilmington Nursing & Rehabilitation **DATE SURVEY COMPLETED:** December 4, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201	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 18, 2025, through September 29, 2025, however the revised exit date was December 4, 2025, due to the government shut down. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 129 (one hundred twenty-nine). The investigative sample totaled 27 (twenty-seven) residents.		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**	3201.1.0 - Regulations for Skilled and Intermediate Care Facilities	
3201.1.2	**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 was not met as evidenced by:	3201.1.2 - Scope Cross reference Ftags – F550, F557, F574, F635 , F641, F644, F677, F679, F686, F691, F692, F698, F756, F770, F791 and F880	1/9/2026

Provider's Signature Renee Boyer Title LNHA Date 1/22/2026 Rev.1/28/2026

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	Cross refer to the CMS-2567-L survey completed November 25, 2025: F550, F557, F574, F635, F641, F644, F677, F679, F686, F691, F692, F698, F756, F770, F791 and F880.		
3201.5.0	**Personnel/Administrative**	3201.5.0 – Personnel/Administrative	
3201.5.5	**The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following:**	3201.5.5 - The facility shall have written personnel policies and procedures. Personnel records shall be kept current and available for each employee, and include the following	
3201.5.5.1	**Results of tuberculosis screening**	3201.5.5.1 – Results of Tuberculosis Screening 1. No residents were identified. E13 is no longer employed at the facility. 2. All residents have the potential to be affected. 3. The root cause was noted to be the facility changed to a contracted dietary department, and the process was not followed to ensure all documentation/screening was in each contracted employee file. The process of utilizing a contracting pre-hire check list for Livewell Healthcare Solutions is now in place and being followed. The Check list includes results of TB screening, Completion of Criminal background check, results of the mandatory drug testing and certification that the employee is on the BBC website. The Human Resources Director was educated to ensure that the pre-hire checklist is being utilized, and all on-boarding documents are completed and maintained in any contracted employee personnel file per the facility process.	1/9/2026

NAME OF FACILITY: Wilmington Nursing & Rehabilitation **DATE SURVEY COMPLETED:** December 4, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.5.5.3	**Results of criminal background check**	4. The HR Director will audit all contracted employees to ensure each employee personnel file has the appropriate documentation of Tuberculosis Screening. These audits will be completed weekly x4 until 100% compliance is met. Monthly x2 until 100% compliance is met. The results of these audits will be brought to the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meetings monthly x3 months. 5. Date of Compliance 1/9/2026 1. No residents were identified. E13 is no longer employed at the facility. 2. All residents have the potential to be affected. Facility failed to obtain the necessary criminal background check for onboarding for E13 through Livewell Healthcare Solutions. 3. The root cause was noted to be the facility changed to a contracted dietary department, and the process was not followed to ensure all documentation/screening was in each contracted employee file. The process of utilizing a pre-hire check list is now in place and being followed. The Human	1/9/2026

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3201.5.5.4	**Results of mandatory drug testing**	Resources Director was educated to ensure that the pre-hire checklist is being utilized, and all on-boarding documents are completed and maintained in any contracted employee personnel file per the facility process. 4. HR and/or designee will audit the personal files of all contracted staff to ensure that the necessary criminal background checks are in place prior to taking their assignment. These audits will be completed weekly x4 until 100% compliance is met. Monthly x2 until 100% compliance is met. The results of these audits will be brought to the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meetings monthly x3 months. 5. Date of Compliance 1/9/2026 1. No residents were identified. E13 is no longer employed at the facility. 2. All residents have the potential to be affected. Facility failed to obtain the necessary mandatory drug testing for E13.	1/9/2026

NAME OF FACILITY: Wilmington Nursing & Rehabilitation **DATE SURVEY COMPLETED:** December 4, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
3201.5.5.5 S/S – D	**Result of Adult Abuse Registry check.** **This requirement was not met as evidenced by:** Based on interview and review of facility documentation, it was determined that for one (E13) out of seven employees reviewed for	3. The root cause was noted to be the facility changed to a contracted dietary department, and the process was not followed to ensure all documentation/screening was in each contracted employee file. Agency has started application process in Delaware. The Human Resources director will collaborate with the contracted agency to certify that contracted employees are on the appropriate website. The Human Resources director will collaborate with Livewell Healthcare Solutions to certify that contracted employees are on the drug website. The Human Resources Director will utilize the pre-hire checklist to certify that the employee is on the drug testing website, and results are to be maintained in the contracted employee personnel file. 4. HR and/or designee will audit the personal files of all contracted staff to ensure that the proper employee drug testing was completed and are in their employee personnel file prior to taking their assignment. These audits will be completed weekly x4 until 100% compliance is met. Monthly x2 until 100% compliance is met. The results of these audits will be brought to the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meetings monthly x3 months.	1/9/2026

NAME OF FACILITY: Wilmington Nursing & Rehabilitation **DATE SURVEY COMPLETED:** December 4, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	staffing, the facility's personnel records lacked evidence of tuberculosis screening results, criminal background checks, mandatory drug testing and adult abuse registry checks. Findings include: 3/15/25 - E13's first day in the facility assigned as agency dietary staff. Review of E13's personnel record revealed missing evidence of the 2-step tuberculosis screening, recent criminal background check, mandatory drug testing and recent adult abuse registry check from E13's new and current agency employer when she was hired on 3/15/25. 9/25/25 11:30 AM – During an interview, E6 (HR) confirmed and stated "We don't have a file of E13's pre-employment background check paperwork from the [staffing agency] when they hired her on 3/15/25." 9/29/25 1:25 PM - Findings were reviewed with E1, E2 and E3 during the exit conference.	5. Date of Compliance 1/9/2026 1. No residents were identified. E13 is no longer employed at the facility. 2. All residents have the potential to be affected. Facility failed to obtain the necessary Adult Abuse Registry checks. 3. The root cause was noted to be that the contracted staffing agency failed to check the Adult Abuse prior to E13 employment. Employee was still listed under the facility name. The Nursing Home Administrator educated Livewell Healthcare Solutions and the Human Resources Director regarding their need to collaborate to certify that dietary staff employees are on the BCC website under agency name and not the facility. Livewell Healthcare Solutions has started an application process in Delaware so that the criminal background checks can be completed under agency name and not the facility. The Human Resources director will collaborate with Livewell Healthcare Solutions to certify that their contracted employees are on the BBC website. The Human Resources Director will utilize the pre-hire checklist to certify that the em-	

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SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
		ployee is on the BCC website, and results are to be maintained in the contracted employee personnel file. 4. HR and/or designee will audit the personal files of all agency staff to ensure that the proper Adult Abuse Registry check was completed and are in their employee personnel file prior to taking their assignment. These audits will be completed weekly x4 until 100% compliance is met. Monthly x2 until 100% compliance is met. The results of these audits will be brought to the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meetings monthly x3 months. 5. Date of compliance: 1/9/26	
3201.6.0	**Services to Residents**		
3201.6.9.2	**Specific Requirements for Tuberculosis**		
3201.6.9.2.4	**Minimum requirements for pre-employment tuberculosis (TB) testing require all employees to have a baseline 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**		

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3201.6.9.2.4.2 S/S – D	**the U.S. Department of Health and Human Services....** **Any person having a positive skin test, but a negative X-ray shall receive an annual evaluation for signs and symptoms of active TB if they cannot provide documentation of completion of treatment for LTBI (latent TB infection).** **This requirement was not met as evidenced by:** Based on interview and review of the facility documentation, it was determined that for one (E13) out of seven employees reviewed, the facility failed to ensure E13 met the minimum pre-employment requirements for tuberculosis screening. Findings include: 3/15/25 - E13's first day in the facility as agency dietary staff. E13 was missing evidence of the 2-step tuberculosis screening from E13's new and current agency employer when she was hired on 3/15/25. 9/25/25 11:30 AM – During an interview, E6 (HR) confirmed and stated, "We don't have a file of E13's tuberculosis screening from the [staffing agency] when they hired her on 3/15/25." 9/29/25 1:25 PM - Findings were reviewed with E1, E2 and E3 during the exit conference.	1. No residents were identified. Tuberculosis Screening was completed for E13. 2. All residents have the potential to be affected. 3. The root cause was noted to be the facility changed to a contracted dietary department, and the contracted agency did not have baseline pre-employment tuberculosis test completed as they were not aware of the need to complete the TB testing since the employee was a previous facility employee. The Nursing Home Administrator educated the contracted agency and the facility Human Resources Director regarding their need to collaborate to ensure a 2-step Tuberculosis Screening is completed for newly hired employees. The facility Human Resources director will collaborate with the contracted agency to ensure newly hired contracted employees have a 2 step Tuberculosis test completed and documented on the contracted agency's form, utilizing the pre-hire checklist, and results are be maintained in any contracted employee personnel file. 4. The HR Director will audit all contracted employees to ensure each employee personnel file has the appropriate documentation of Tuberculosis Screening on the contracted agency's form. These audits will be completed weekly x4 until 100% compliance is met. Monthly x2 until 100% compliance is met. The results of these audits will be brought to the Quality Assurance and Assessment Committee (QAA). The committee will	1/9/2026

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		determine the need for additional audits. The results will be reviewed at the QAA meetings monthly x3 months. 5. Date of Compliance 1/9/2026	
3105 **3105.4.0** **3105.4.1** **S/S – D**	**Title 16 Health and Safety Delaware Administrative Code** **Criminal History and Drug Testing for Nursing and Similar Facilities** **Persons Subject to the Law** **All persons working in facilities are required to be on the Master List of the BCC (Background Check Center). New applicants must be processed through the BCC and will automatically be placed on the Master List if hired. Current employees, whether grandfathered or note, must be added to the Master List through the process directed by DLTCRP.** **This requirement was not met as evidenced by:**	3105.4.0 Criminal History and Drug Testing for Nursing and Similar Facilities 3105.4.1 Persons Subject to the Law 1. No residents were identified. 2. All residents have the potential to be affected. Facility failed to certify that E13 was on the master list of the BCC (Background check center) through Livewell Healthcare Solution.	

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	Based on interview, review of facility documentation and the BCC website, it was determined that one (E13) out of seven facility and agency staff reviewed was not on the Master List of the BCC. Findings include: 6/21/23 – E13's first day in the facility as a regular dietary staff. E13's employment with the facility was terminated (date unknown) and E13 became an employee to the agency company as an agency dietary staff. 3/15/25 - E13's first day in the facility assigned as agency dietary staff. E13 was missing evidence of the mandatory drug screen from E13's new and current agency employer when she was hired on 3/15/25. According to the facility documentation provided, E13's mandatory drug screen was done on 6/19/23 when she was hired by the facility as a regular dietary staff on 6/21/23. 9/25/25 11:37 AM – During an interview, E6 (HR) stated that she is not certain if E13's agency employer entered her information into the BCC website when E13 became an employee of the staffing agency on 3/15/25. E6 added, "No. I don't have that information with me." Review of the BCC website revealed that E13 was not on the Master List of the BCC under the new agency employer name. 9/29/25 1:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse).	3. The root cause was noted to be that the facility failed to certify that E13 was on the BCC website under Livewell Healthcare Solutions. E13 was still listed under the Wilmington Nursing and Rehabilitation Center. The nursing home administrator educated Livewell Healthcare Solutions and the facility Human Resources Director regarding their need of collaboration to certify that dietary staff employees are on the BCC website under Livewell Healthcare Solutions. 4. HR and/or designee will audit the BCC website to certify that contracted employees are listed under Livewell Healthcare Solutions and not under Wilmington Nursing and Rehabilitation Center. These audits will be completed weekly x4 until 100% compliance is met. Monthly x2 until 100% compliance is met. The results of these audits will be brought to the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meetings monthly x3 months. 5. Date of compliance: 1/9/26	

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	9/29/25 1:25 PM - Findings were reviewed with E1, E2 and E3 during the exit conference.		
3105.9.0 3105.9.1	**Drug Tests** **The BCC provides an electronic conduit through the Delaware Health Information Network (DHIN) to transmit the results of a drug test from a DHIN participating laboratory to the employer. An employer that chooses not to engage a DHIN-participating laboratory will certify that a drug test has been secured by checking a box in the BCC. If the box is checked, it constitutes a representation that a drug test which complies with statutory requirements, 11 Del.C. 1142, has been secured prior to hiring.** **This requirement was not met as evidenced by:** Based on interview, review of facility documentation provided to the surveyor and review of the BCC website, it was determined that the facility's contracted staffing agency failed to certify on the BCC website that a drug test was performed prior to hiring one (E13) out of seven facility and agency staff reviewed. Findings include: Review of facility documentation provided revealed that E13 (agency dietary staff) was assigned to work at the facility prior to a mandatory drug test screening. E13 lacked evidence of a drug test performed when hired on 3/15/25 by the contracted staffing agency and was assigned to work in the facility.	1a. No residents were identified. E13 is no longer employed at the facility. 1b. No residents were identified. E13 is no longer employed at the facility. 2a. Facility failed to certify that E13's mandatory drug testing was on the BCC website through the agency. All	1/9/2026

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	9/25/25 at 11:39 AM – During an interview, E6 (HR) stated that E13's drug screen information on file was completed on 6/19/23 when E13 was hired by the facility. E6 further stated, "That's also the one on file with the BCC". 9/29/25 1:25 PM - Findings were reviewed with E1 E2 and E3 during the exit conference.	residents have the potential to be affected. 2b. Facility failed to ensure obtaining the necessary mandatory drug testing for E13 through a contracted agency. 3a. The root cause was noted to be that the contracted staffing agency failed to certify on the BCC website that a drug test was performed prior to hiring E13. Employee was still listed under the facility name. The Nursing Home Administrator contracted agency and the facility Human Resources Director regarding their need to collaborate to certify that dietary staff employees are on the BCC website under agency name and not the facility. Agency has started application process in Delaware so that the criminal background checks can be completed under agency name and not the facility. The Human Resources director will collaborate with the contracted agency to certify that contracted employees are on the BBC website. The Human Resources Director will utilize the pre-hire checklist to certify that the employee is on the BCC website, and results are to be maintained in the contracted employee personnel file. 3b. The root cause was noted that the facility contracted staffing agency failed to complete the necessary drug testing for a contracted employee under the agency name and not the facilities. Nursing Home Administrator and the Human Resources Director will work with the contracted staffing	

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		agency for the need to complete mandatory drug testing on contracted employees. Agency has started application process in Delaware so that these drug screenings can be completed. The Human Resources Director will utilize the pre-hire checklist to certify that the employee is on the Concentra website, and results are to be maintained in the contracted employee personnel file. 4a. HR and/or designee will review the BCC website to certify that contracted dietary employees for drug testing is on the BCC website. These audits will be completed weekly x4 until 100% compliance is met. Monthly x2 until 100% compliance is met. The results of these audits will be brought to the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meetings monthly x3 months. 5. Date of Compliance 1/9/2026	
3105.10.0 **3105.10.4** **S/S – D**	**Further Facility/Employer Responsibilities** **The employer must ensure that no Applicant is employed without first receiving the results of the Applicant's mandatory drug test.** **This requirement was not met as evidenced by:** Based on review of facility documentation provided to the surveyor and review of the BCC website, it was determined that the facility contracted to work one (E13) out of one agency staff reviewed without first receiving mandatory drug test results. Findings include: 6/21/23 – E13's first day in the facility as a regular dietary staff. E13's employment with the facility was terminated (date unknown) and E13 became an employee to the agency company as an agency dietary staff.	1. No residents were identified. E13 is no longer employed at the facility.	1/9/2026

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	Review of facility documentation provided revealed that E13 was an agency employee assigned to work as staff dietary aid effective 3/15/25 with no drug test results. 9/25/25 at 11:39 AM – During an interview, E6 (HR) stated that E13's drug screen information on file was completed on 6/19/23 when E13 was previously hired by the facility. E6 further stated, "I thought it's alright to use the same information since [E13] did not change assignments. She only changed employers effective 3/15/25 but she is still working in this facility, in the same department". 9/29/25 1:25 PM - Findings were reviewed with E1, E2 and E3 during the exit conference.	2. All residents have the potential to be affected. Facility failed to obtain the necessary mandatory employee for drug testing from the agency. 3. The root cause was noted to be the facility changed to a contracted dietary department, and the Human Resources Director's lack of knowledge that due to the employee changing to a contracted position in the facility the employee required that a new mandatory drug screen be completed under the agency name. The Human Resources Director was educated to ensure that any employee that changes to a contracted position needs to have a new mandatory drug testing completed. Agency has started application process in Delaware so that these drug screenings can be completed. The Human Resources Director will utilize the pre-hire checklist to certify that the employee is on the Concentra drug screen website, and results are to be maintained in the contracted employee personnel file. 4. HR and/or designee will audit the personal files of all facility staff that changed to contracted staff to ensure that the proper employee drug testing was completed and are in their employee personnel file prior to taking their assignment. These audits will be completed weekly x4 until 100% compliance is met. Monthly x2 until 100% compliance is met. The results	
3105.10.5 **S/S – D**	**The employer must maintain an accurate BCC Master List by promptly reflecting the termination of any person no longer working in the facility.**		1/9/2026

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	This requirement was not met as evidenced by: Based on interview, review of facility documentation provided and review of the BCC website, it was determined that the facility failed to update the BCC Master List when any person was no longer working in the facility. Findings include: Review of the Roster Sheet provided to the surveyor and the BCC website revealed that E13's (Dietary Staff) first day in the facility was 6/21/23. Review of the list of [agency] dietary staff revealed that E13 was an agency employee effective 3/15/25. 9/25/25 11:39 AM – During an interview, E6 (HR) stated that E13's information was still found in the BCC registry under the facility's name. Review of the BCC revealed that E13's name was still included in the facility's active employee list. 9/29/25 1:25 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	of these audits will be brought to the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meetings monthly x3 months. 5. Date of Compliance 1/9/2026 3105.10.5 – The Employer must ensure that no Applicant is employed without first receiving the results of the applicant's mandatory drug test. 1. No residents were affected by this deficient practice. 2. All residents have the potential to be affected. Facility failed to inform the proper agency related to the removal of E13 from the BCC Master List for the facility. 3. The root cause was noted to be the facility changed to a contracted dietary department. Facility failed to ensure that E13 was now listed under LiveWell Healthcare Solutions and not under Wilmington Nursing and Rehabilitation Center. This is related to the need for removal of E13 from the BCC Master List. Livewell Healthcare Solutions failed to make the transition from a facility employee to an agency. Nursing Home Administrator re-educated Livewell Healthcare Solutions	

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		and facilities Human Resources Director to ensure that all transitioned employees are listed on the master BCC website under Livewell Healthcare Solutions and not Wilmington Nursing and Rehabilitation Center. 4. HR and/or designee will audit the BCC Master List to ensure all agency staff (Livewell Healthcare Solutions) that are no longer employed by the facility are not listed on the BCC Master list. These audits will be completed weekly x4 until 100% compliance is met. Monthly x2 until 100% compliance is met. The results of these audits will be brought to the Quality Assurance and Assessment Committee (QAA). The committee will determine the need for additional audits. The results will be reviewed at the QAA meetings monthly x3 months. 5. Date of compliance: 1/9/26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD , WILMINGTON, Delaware, 19803

(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 An unannounced Emergency Preparedness survey was conducted at this facility from September 18, 2025 through September 29, 2025. The facility census was one hundred and twenty-nine (129) on the first day of the survey. In accordance with 42 CFR 483.73, an emergency preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		12/04/2025
F0000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from September 18, 2025 through September 29, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 129. The investigative sample totaled 27 residents. Abbreviations/definitions used in this report are as follows: AA - Activity Aide; AD - Activity Director; ADON - Assistant Director of Nursing; Bloodborne pathogen - bacteria or viruses carried in blood that can cause disease; CNA - Certified Nursing Assistant; Congestive heart failure - a long term condition where the heart is unable to pump enough blood to meet the body's needs; Diabetes mellitus - disease where sugar levels are too high;	F0000		12/04/2025

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD , WILMINGTON, Delaware, 19803

(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
F0000	Continued from page 1 Diabetic foot ulcer - an open sore or wound that forms on the bottom of the foot due to diabetes complications; DON - Director of Nursing; DOR - Director of Recreation; Epilepsy - a long-term chronic disease that causes repeated seizures; FSD - Food Service Director; Midline catheter - vascular access device inserted into peripheral veins for intravenous therapy; MDRO - multidrug resistant organism, an antibiotic-resistant germ that can cause infection; MTP - metatarsophalangeal joint, connects bones of the foot to bones of toes; Natal cleft - vertical groove that separates the buttocks; NHA - Nursing Home Administrator; NP - Nurse Practitioner; PASARR - Preadmission Screening and Resident Review, a multi-level screening test performed on residents to determine least restrictive setting their mental well being; Plantar - relating to sole of foot; Pelvic drain - a tube that inserted in to the pelvic area to collect and drain excess fluid; PPE - personal protective equipment, items designed to protect individuals from exposure to infectious agents; PRN - as needed; Q shift - every shift; Shin - front of leg below the knee; Sharps container - puncture-resistant container used for safe disposal of sharp medical instruments; SSD - Social Services Director;	F0000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	Continued from page 2 TAR - Treatment Administration Record, list of daily/weekly/monthly treatments to be performed; UA/C&D - Urinalysis Culture and Sensitivity, urine testing to determine presence of infection and best medication for treatment; Venous ulcer - leg sores caused by poor blood circulation in the veins; Urostomy tube - A tube that allows urine to exit the body though an alternate opening;	F0000		
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.	F0550	F550 Resident Rights A. R50 and R83 currently reside in the facility and menus are being distributed by the Activity Director/Activity Assistant weekly on Wednesdays. B. Residents that currently reside in the facility have the potential to be affected by this deficient practice. C. Root cause analysis identified that the facility's previous process had a dietary staff member distribute the menus. There was a change in the dietary staff and in the management of the dietary department, and the facility failed to ensure the process continued. A new process was developed and the Activities Department has been designated to distribute patient menus weekly on Wednesdays for the following week. The Staff Development Coordinator/designee educated the activities department staff on the process of distributing menus to residents. D. Activities Director/designee will randomly interview 10 residents to ensure they receive menus. These audits will be completed daily x5 days, weekly x3 weeks, monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance 1/9/2026	01/09/2026

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F0550 SS = E	Continued from page 3 §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure residents' rights to a dignified existence and self-determination when the facility failed to develop a system that notified residents of the daily menu. Findings include: 9/18/25 8:53 AM - During resident screening R50 stated, "They don't give us menus. We never know what we having until it gets here. Then, if you don't want it you have to wait cause you ordering something else. I said something to them, and they said they don't have to give us a menu". 9/18/25 9:46 AM - During resident screening, R83 stated, "It's great here, only complaint I have is there's no menu or calendar of what's being served, but if you get it and don't like it, they will bring something else." 9/18/25 11:40 AM - During a tour of the facility, the surveyor observed that the facility's common room for dining and activities displayed a posting of the daily menu at the entrance on both the first and second floors. 9/18/25 12:48 PM - During an interview, E36 (CNA) confirmed that residents were not provided a menu or made aware of the daily meals until they were served to the residents. 9/18/25 12:51 PM - During an interview, E37 (CNA) confirmed that residents were not provided a menu or other means of knowing the meals prior to being served. E37 stated, "I do try to go look at the posting so I can tell them if they ask." 9/22/25 10:13 AM During an interview, E35 (FSD) confirmed that residents are not distributed/made aware of the daily menu. E35 stated, "Activities is supposed to be implementing a new process to do that in the next few weeks. All residents do receive a copy of the always available options". 9/22/25 11:55 AM - During an interview, R108, the resident council president, confirmed that residents do	F0550		

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F0550 SS = E	Continued from page 4 not receive a menu of the daily meals served. R108 stated, "We used to but now we don't." 9/22/25 11:58 AM - During an interview, E12 (DOR) reported that presently the activities department staff does not distribute menus to residents. 9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0550		
F0557 SS = D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that for two (R11 and R62) out of 38 sampled residents, the facility failed to provide dignity and respect when facility staff called R11 and R62 "feeders". Findings include: 9/26/25 1:00 PM – During a dining observation inside R11's room, E5 (LPN, UM) told the Surveyor that R11 and her roommate [R62] were both "feeders" and that a staff should be in the room to assist and feed them. 9/26/25 1:30 PM – Finding was discussed with E5. 9/29/25 1:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse). 9/29/25 1:25 PM - Finding was reviewed with E1 , E2 and E3 during the exit conference.	F0557	F557 Respect, Dignity/Right to Have Personal Property A. R11 and R62 no longer reside in the facility. E5 was educated to provide dignity and respect and to address residents needing assistance with feeding, not to refer to them as "feeders". B. Residents currently residing in the facility that require assistance with feeding have the potential to be affected by this deficient practice. An initial audit of residents that require assistance with feeding has been completed. C. Root cause analysis noted to be staff member failed to use proper verbiage regarding a resident that needed assistance with feeding. The Staff Development Coordinator/designee will educate facility staff to provide dignity and respect and to address residents as needing assistance with feeding, not to refer to them as "feeders". D. Unit Mangers/designee will randomly round unit during mealtimes to ensure residents are addressed with dignity and respect and are not referred to as "feeders". These observation audits will be completed daily x5 days, then weekly x3 weeks, then monthly x2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 12/23/2025	01/09/2026
F0574 SS = C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or	F0574	F574 SS=C A. No residents were identified by this practice. B. Residents currently residing in the facility have	01/09/2026

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F0574 SS = C	Continued from page 5 she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) (iii) Information regarding Medicare and Medicaid eligibility and coverage; (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; (v) Contact information for the Medicaid Fraud Control Unit; and	F0574	Continued from page 5 the potential to be affected by this practice. Nursing Home Administrator immediately placed a new poster on how to file a complaint with the State. C. The Regional Director of Clinical Services educated the Nursing Home Administrator related to the posting required in the facility related to reporting formal complaints to the state. The Activity Director will notify/educate residents currently residing in the facility on the process of making a formal complaint to the state. The posters explaining the process are displayed on both floors and easily seen. D. Nursing Home Administrator/designee will audit the bulletin boards to ensure that the updated posters for the grievance process are in place. These audits will be completed weekly x4 weeks, and then monthly x2 months to ensure substantial compliance. The results of the audits will be brought to the Quality Assurance and Preference Committee (QAPI). The committee will determine the need for additional audits. The results will be reviewed at the QAPI meetings monthly x3 months. E. Date of compliance: 12/23/2025	

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F0574 SS = C	Continued from page 6 (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that information informing residents of how to formally complain to the State Agency was displayed. Findings include: 9/24/25 1:45 PM - During a resident council meeting all residents in attendance denied knowledge of how to make a formal complaint to the state of Delaware. 9/24/25 2:08 PM - During a tour of the facility for compliance with required posting, the first-floor bulletin case that displayed information for residents/visitors lacked a display of information regarding how to make a complaint to the state agency. 9/24/25 2:27 PM - E1 (NHA) confirmed the finding. 9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0574		
F0635 SS = D	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for one (R150) out of one resident reviewed for admission orders, the facility failed to ensure wound treatment orders were entered. Findings include: Review of R150's clinical records revealed: 9/16/25 - R150 was readmitted to the facility with	F0635	F635 Admission Physician Orders for Immediate Care A. R150 no longer resides in the facility, the facility is unable to correct deficient practice for R150. B. Newly admitted residents with wounds have the potential to be affected. An initial audit of residents still residing in the facility with wounds admitted since November 1, 2025 will be completed to ensure wound treatment orders are in place. C. Root cause analysis noted to be licensed nursing staff failed to ensure wound care orders were entered on admission for the resident with wounds, it was determined that the interagency discharge orders did not have wound treatment orders listed, as well as the nurse that completed the admission/readmission nursing collection tool did not identify wounds therefore did not contact the physician for wound treatment orders and the second day skin observation tool completed by the wound care nurse did not identify the wounds. RN	01/09/2026

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F0635 SS = D	Continued from page 7 diagnoses including diabetes mellitus, congestive heart failure, and epilepsy. 9/19/25 - A readmission Wounds Assessment Report for R150 completed by P1 (NP) documented treatment orders for four wounds, noted as present on admission. 9/22/25 3:30 PM - Review of R150's clinical record revealed no current orders for wound care. 9/24/25 2:15 PM - During an interview, the Surveyor asked E14 (RN) if R150 had treatment orders for wound care since he was readmitted on 9/19/25. E14 stated, "I don't see the orders, but I have been doing his wound care and dressing changes." 9/24/25 3:00 PM - During an interview E14 (RN) stated, "Orders were put in today for dressing changes to begin tomorrow." 9/26/25 2:49 PM - Findings were reviewed with E1 (NHA). 9/29/25 1:25 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0635	Continued from page 7 Supervisor reviews and enters the admission orders listed on the hospital interagency discharge orders, two nurses review the physician orders that have been entered into the electronic clinical record, the admission orders are then reviewed by Clinical Leadership at the next clinical meeting. The Staff Development Coordinator/designee will educate licensed nurses to ensure wounds are identified on admission/readmission, the facility has implemented that 2 licensed nurses will complete the skin evaluation on the day of admission and on the second day skin evaluation to ensure wounds are identified and that wound care orders are entered the day of admission. Clinical review will be completed by Nursing Leadership in the clinical meeting. D. Unit Managers/designee will audit newly admitted/readmitted residents with wounds to ensure wound treatment orders are entered on admission. These audits will be completed daily x5 days, then weekly x3 weeks, then monthly x2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance : 1/9/2026	
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.	F0641	F641 Accuracy of Assessments A. R16 currently resides in the facility, MDS Section L (Oral/Dental Status) was modified on 9/23/2025 to reflect accurate oral/dental status. B. Residents currently residing in the facility with oral/dental issues have the potential to be affected by this practice. Regional Director of Clinical Reimbursement/designee will complete an audit on MDS assessments completed Since November 1, 2025, to ensure residents with oral/dental issues were coded correctly. C. Root cause noted to be related to MDS Coordinator not reviewing the medical records for the patient thoroughly regarding resident's dental issues or completing an MDS quarterly assessment accurately. An audit of other like patients reflected medical records were reviewed and MDS was coded accurately. The Regional Director of Clinical Reimbursement/designee will educate MDS Coordinators on accurate coding instructions for section L in the MDS. Education of MDS Coordinators includes reviewing the medical record, the dental recommendations/consult, including nursing,	01/09/2026

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F0641 SS = D	Continued from page 8 §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (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 observation, interview and record review, it was determined that for one (R16) out of one resident reviewed for dental services, the facility failed to accurately code R16's dental assessments for two MDS (Minimum Data Sets) review periods. Findings include: Cross refer F791 Review of R16's clinical records revealed: 2/11/25 – R16's quarterly MDS section L (Oral/Dental Status) revealed that R16 had no mouth or facial pain, discomfort or difficulty chewing. 3/23/25 – A Dental Report of Consultation recommended R16 "... To return to restore cavities, [sic] teeth that are extensively decayed and root tips would need to be extracted in the future if symptoms or swelling begin." 5/14/25 – R16's quarterly MDS section L revealed no mouth or facial pain, discomfort or difficulty chewing. 8/12/25 – R16's Annual MDS section L revealed no cavities or broken natural teeth, inflamed or bleeding gums, loose natural teeth, mouth or facial pain, or discomfort or difficulty with chewing. 9/23/25 2:45 PM - During an interview, E28 (RN MDS) stated that she was the one who coded and completed R16's 8/12/25 quarterly MDS. E28 confirmed that she did not physically assess R16's teeth. Furthermore, E28 stated that she was not aware of the dental consult note and P3's [Dentist] finding of R16's decayed dental cavities and root tips that were recommended for extraction. P3 stated, "I did not personally check	F0641	Continued from page 8 physician, dietary, and speech language pathologist notes, and any available information on dental history or problems. Dental problems may include poor fitting dentures, dental caries, edentulous, mouth sores, tumors and/or pain with food consumption D. The Director of Nursing/Designee will audit completed MDS Assessment of residents currently receiving dental care from the list that was provided to the dental provider and new MDS Assessments to ensure Section L is coded correctly. These audits will be completed weekly x4 weeks, then monthly x 2 months focusing on Section L for accuracy compared to supporting documentation to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 1/9/2026	

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F0641 SS = D	Continued from page 9 [R16's] teeth. I only saw this consult now. I was not made aware of any dental issues by the nursing staff". 9/29/25 1:25 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0641		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R10) out of two residents reviewed for PASARR review, the facility failed to refer the resident for a PASSAR screening following a newly evident condition and qualifying medications. Findings include: The facility clinical guidelines for PASARR [undated] indicated, "While admitted if a resident has a change in condition, a PASARR evaluation may be required if there is a significant change in the individual's mental or physical health status since their last evaluation, or if the facility suspects the individual may have a serious mental illness, intellectual disability or related condition not previously identified." Review of R10's clinical record revealed: 6/13/25 - A PASARR Level I was completed for R10 that	F0644	F644 Coordination of PASARR and Assessments **** A. R10's PASSAR was completed to reflect changes to medications to include antipsychotic and antianxiety medication orders received on 7/27/2025 and 10/15/2025. B. Residents with changes that require the PASSAR screening process since November 1, 2025 will be audited to ensure a new PASSAR screening has been completed. C. Root cause noted to be Social Services did not complete the PASSAR per the screening process due to the facility's failure to identify new orders for psychotropic medications during the clinical meeting. The facility Leadership failed to follow the process of reviewing the Point Click Care dashboard to identify and discuss new/changes in qualifying medications specifically related to the need to review the PASAAR, causing the social services department to not complete a PASAAR as indicated. The facility is now incorporating the need to specifically discuss new/changes in qualifying medication for Social Services to determine when a new PASAAR is required, this process is as well discussed at the weekly high-risk meeting that includes communicating new qualifying orders that may require an updated PASAAR from Social Services. The Regional Director of Clinical Services re-educated the Leadership team on the process of morning clinical meeting and the High-Risk Meeting to include specifically addressing the need to evaluate and initiate a new PASAAR as needed related to new/changes in qualifying medications. The Regional Social Work & Discharge Planning Specialist/designee will educate social services staff on the PASSAR screening process following any newly evident condition and qualifying medications. The Social Services Director will be responsible for ensuring PASARRs are completed. D. Social Services Director/designee will audit residents with new orders for psychotropic medications that require a new PASSAR screening and will have one completed. These audits will be completed weekly x4 weeks, then monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for	01/09/2026

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F0644 SS = D	Continued from page 10 documented the resident had no mental health diagnoses, received no mental health medications and that no further screening was required. 7/25/25 - R10 was admitted to the facility. 7/27/25 - A physician's order was written for R10 to receive quetiapine, an antipsychotic medication at bedtime for psychosis. 7/31/25 - An admission MDS assessment documented that R10 had a psychotic disorder and was currently receiving antipsychotic medication, antidepressant medication and received forty-five minutes of psychological therapy one day. 9/15/25 - 10/15/25 - A physician's order was written for R10 to receive lorazepam, an anti-anxiety medication for agitation, anxiety, and psychosis as needed. 9/22/25 12:02 PM - During an interview, E41 (SSD) confirmed that a referral for PASARR screening had not been made for R10. 9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0644	Continued from page 10 review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of completion: 1/9/2026	
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 one (R11) out of three sampled residents reviewed for ADLs (Activities of Daily Living), the facility failed to ensure each dependent resident received the necessary services to promote adequate nutrition. Findings include: Cross refer F692 Review of R11's clinical records revealed: 5/8/25 – R11 was re-admitted to the facility with diagnoses including malnutrition.	F0677	F677 ADL Care Provided for Dependent Residents A. R11 was assisted with her meal by E5. E33 was educated regarding the need to assist residents with meals as needed. The Unit Manager assisted R11with her meal. B. Residents currently residing in the facility that require assistance with feeding have the potential to be affected by this practice. An initial audit was completed to identify residents that require assistance with feeding. C. Root cause noted to be E33 failed to assist R11 with her meal. When the DON spoke with E33 regarding her not assisting the resident with her meal, E33 mentioned that she misunderstood the surveyor's request and left the room and was unsure of what to do. E33 received a 1:1 education regarding assisting residents with their meals in a timely manner and requesting assistance from unit manager if she is unsure of surveyor's requests. The Staff Development Coordinator/designee will educate clinical staff regarding feeding residents that require assistance with eating meals.	01/09/2026

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F0677 SS = D	Continued from page 11 9/10/25 – An OT (Occupational Therapy) Evaluation documented that R11 was dependent with eating. 9/10/25 - A facility nutrition assessment documented that R11 required full assistance with feeding. 9/26/25 12:45 PM – A facility staff person was observed entering R11's room and placed R11's food tray on the overbed table standing against the wall. The staff left the room. 9/26/25 12:46 PM – Another facility staff person, E33 (CNA), was observed entering R11's room and attempted to shut the door. This Surveyor followed the CNA and told E33 that Surveyor will do R11's lunch observation. E33 told this Surveyor that she was going to feed R11 her lunch, pointing at R11. 9/26/25 12:46 through 12:55PM – As the Surveyor entered the room and asked permission from R11 to do a lunch observation, E33 left the room and did not return. The Surveyor waited and noted the wait time for facility staff to respond and attend to R11's lunch. 9/26/25 12:50 PM – When the Surveyor asked if R11 was alright, R11 stated, "I am very hungry." 9/26/25 12:55 PM – E5 (LPN, UM) was observed entering the room, moved the overbed food table across R11's bed and set up R11's food tray. E5 removed the plate cover and uncovered the magic cup and cranberry juice and offered the food for R11 to eat. The Surveyor notified E5 of E33 entering and leaving the room at 12:45 PM. 9/26/25 1:30 PM – In an interview, E5 stated that E33 should have attended to R11 and assisted her with her lunch instead of leaving the room in haste. 9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0677	Continued from page 11 D. Unit Manager/designee will observe residents that require assistance with being fed meals are being assisted by staff. These audits will be completed daily x 5 days, then weekly x3 weeks, then monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 1/9/2026	
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	F0679	F679 Activities Meet Interest/Needs Each Resident A. R54 person-centered activity program was updated 12/10/2025. B. Residents currently residing in the facility have the potential to be affected. Current residents' activity care plans have been reviewed and updated to reflect person-centered activity care plans with measurable objectives and timeframes. C. Root cause noted to be the Activity Director did not	01/09/2026

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F0679 SS = D	Continued from page 12 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 observation, interview and record review, it was determined that for one (R54) out of one resident reviewed for activities, the facility failed to provide an ongoing person-centered activity program for R54, who chooses to remain in her room all day. Findings include: Review of R54's clinical record revealed: 3/9/25 – The annual MDS assessment documented that R54 had moderate difficulty of hearing (speaker has to increase volume and speak distinctly), had impaired vision (sees large print, but not regular print in newspapers/books), BIMS score of 14 (cognitively intact), had active diagnoses that included but were not limited to dementia and bilateral hearing loss, and activity preferences were as follows: -to be around pets are very important; -to have books/newspapers/magazines to read and to listen to music the resident liked were somewhat important; -to do things with groups of people and to go outside for fresh air when the weather is good and to participate in religious services were not very important; and -to keep up with the news was not important at all. 3/15/25 revised – R54's activity care plan was: "SELF-DIRECTED ACTIVITIES/FRIENDLY VISITS: [R54'S name] prefers to participate in self-directed activities and friendly visits such as animals/pets (dogs, poodles); arts/crafts (past, crocheting, knitting, cross stitch); children/intergenerational (past, extended family); cooking/baking (snacks); current events/news (past, watch); exercise/physical (past, active); gardening/plants (plants, flowers); movies (past, mystery); community involvement (past, career); music (easy listening); outdoor activities; parties/socials (celebrations); puzzles/word games (past, career). Goal: [R54] will report satisfaction with her	F0679	Continued from page 12 have a full understanding of the process to complete a person-centered care plan for activities. The Regional Activity Director/designee will educate the Activity Director to ensure each resident has a person-centered care plan with measurable objectives and timeframes, and that activities performed are captured in the activity log and care plan. D. The Director of Nursing/designee will audit 10% of residents' activity care plans to ensure they are person-centered with measurable objectives and timeframes and activities are captured in the activity log and care plan. These audits will be completed weekly x4 weeks, then monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 1/9/2026	

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F0679 SS = D	Continued from page 13 self-directed activities and friendly visits throughout the review period. Interventions: -facilitate video calls with family (initiated 9/7/23);... -provide friendly visits in the room or location that is the residents (sic) preference as needed (revised 6/27/25)...". 7/18/25 7:26 AM – An activity assessment documented the following "Scope of Activity Participation 1. Does the patient wish to participate in activities while in the center? YES... 4. Does the patient wish 1:1 (one to one) with staff? YES 5. Does patient like self-directed activities (i.e. reading, puzzles, etc.)? YES...". Review of R54's monthly documented "Friendly Visits & 1:1" were as follows: -for July 2025, there were 13 documented 1:1 visits with R54 out of 31 days; -for August 2025, there were 13 documented 1:1 visits with R54 out of 31 days; and -from September 1-22, 2025, there were 10 documented 1:1 visits with R54 out of 22 days. It should be noted that the above documented visits did not specify the time spent with R54 for each visit nor which activity person was involved in the visit. Observations during the survey revealed: 9/18/25 1:30 PM – Observation of R54 revealed that the resident remained in bed since this morning. The surveyor spoke with R54, who talked passionately about animals, how the resident trained the animals, and how her parents brought the resident to the facility. R54 was showing the surveyor her paperwork that she had	F0679		

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F0679 SS = D	Continued from page 14 collected, which were all of the resident's previous meal tickets. During this time, the surveyor observed R54 did not have a roommate, no television, no music on in the room or pictures on the walls. The surveyor did observe a newspaper in the resident's trashcan and two stuffed animals sitting on tables that were out of reach of the resident in bed. 9/22/25 – Continuous morning observation on the Arcadia (locked dementia) unit revealed that at 11:00 AM, the surveyor observed E31 (AA) stop briefly at R54's room and gave the resident a cookie. R54 was talking to E31 and E31 stated, "I will talk to you later" and exited the resident's room. At 11:14 AM, the surveyor observed E31 stop at resident's door and said, "I heard you would like to have another cookie." R54 started talking to her and E31 said that she would be back this afternoon and moved to the next room to give out snacks. At 11:56 AM, the surveyor observed E31 re-enter the locked unit with a tall green plant on her rolling chair and she was pushing the chair down the hallway to the dining/activity room. At 12:40 PM, the surveyor observed E31 exit the locked dementia unit with the tall green plant on her rolling chair. E31 did not stop at R54's room. Review of the Arcadia's September 2025 Activity Calendar had the following morning activities on 9/22/25: 10:00 Daily Meet & Greet, 10:30 Morning Snack, 11:15 Outdoors with [E31]. Review of R54's September 2025 Event Calendar Report documented that R54 was invited and attended 10:00 Daily Meet and Greet and the 9:30 Music Thru the Halls All Day; and was invited to 11:15 AM Outdoors with [E31]. The activity documentation contradicted what the surveyor observed on the morning of 9/22/25. 9/29/25 9:00 AM – During an interview, E12 (DOR) confirmed that R54 likes pets, especially dogs. E12 confirmed that pet visits are not on the activity calendar. When asked where are R54's pet visits being captured, E12 confirmed that they are not being documented. E12 confirmed that R54 does not want a television in her room. The surveyor asked about the	F0679		

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F0679 SS = D	Continued from page 15 activity note that documented a family call back in July 2025. E12 showed the surveyor that R54 was on a specific resident list for weekly family calls and the list was located in E12's office. Confirmed that the family calls were not being captured in R54's activity log nor in R54's care plan. Reviewed R54's care plan with E12 and discussed that it was not person-centered with measurable objectives and timeframes. 9/29/25 1:25 PM - Finding was reviewed with during the exit conference with E1 (NHA), E2 (DON), and E3 (Corporate Nurse).	F0679		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that for one (R54) out of three residents reviewed for pressure ulcers, the facility failed to ensure that R54's low air loss mattress device was plugged in, turned on and functioning as a preventative intervention and per an active physician order. Findings include: 6/5/25 3:15 PM - R54 had a physician's order for "Alternating air loss mattress check placement and function every shift for fragile skin." 7/25/25 - The quarterly MDS assessment documented that R54 was at risk for pressure ulcers.	F0686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer A. R54's low air loss mattress was plugged in on 9/23/2025 and the device turned on and displayed a green light. B. Residents currently residing in the facility that have an order for a Low Air Loss Mattress have the potential to be affected. An initial audit of all residents with Low Air Loss Mattresses was completed, and all were plugged in and functioning. C. Root cause noted to be the staff's failure to follow the physician's order to check placement and function of the alternating air mattress, by not observing to ensure the mattress was plugged in, the green light was on, and the mattress was functioning properly. The Staff Development Coordinator/designee will educate clinical staff regarding the use of Low Air Loss Mattresses to ensure the mattress is plugged in, turned on and functioning as a preventative intervention per an active physician order. The Assistant Director of Nursing and/or Unit Managers will verify the functionality of a low air loss mattress when it is put in place by checking the mattress for functionality and documenting it in the clinical record in a progress note. D. Unit Managers/designee will observe random residents with Low Air Loss Mattresses to ensure they are plugged in and functioning, observation audits will be completed daily x 5 days, then weekly x3 weeks, then monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 1/9/2026	01/09/2026

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F0686 SS = D	Continued from page 16 Observations during the survey revealed: 9/22/25 9:45 AM - Observed R54 asleep in bed, laying on her left side facing the hallway, and her low air loss device was not turned on. 9/22/25 1:28 PM - Observed R54 asleep in bed, laying on her left side facing the hallway, and her low air loss device was not turned on. 9/23/25 9:27 AM - Observation with E43 (LPN) revealed that R54's low air loss mattress device was not plugged into the wall outlet located behind R54's head of the bed. Once the device was plugged into the wall outlet, the device turned on and displayed a green light. R54 confirmed the finding and stated that R54 does not get out of bed. Review of the September 2025 eTAR (electronic Treatment Administration Record) revealed that on 9/22/25 into 9/23/25: -the 7:00 AM to 3:00 PM nurse, E44 (LPN), did not sign off the physician-ordered preventative treatment and left it blank; -the 3:00 PM to 11:00 PM nurse, E45 (LPN), signed off the treatment as completed; and -the 11:00 PM to 7:00 AM nurse, E39 (LPN), signed off the treatment as completed. 9/26/25 3:30 PM - Finding was reviewed with E1 (NHA) and E2 (DON). The facility failed to ensure R54, a resident at risk for pressure ulcers, received physician-ordered preventative treatment every shift for fragile skin. 9/29/25 1:25 PM - Finding was reviewed with during the exit conference with E1 (NHA), E2 (DON), and E3 (Corporate Nurse).	F0686		
F0691 SS = D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f)	F0691	F691 Colostomy, Urostomy, or Ileostomy Care A. R149 no longer resides in the facility.	01/09/2026

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F0691 SS = D	Continued from page 17 §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R149) out of nine residents reviewed for activities of daily living the facility failed to ensure documentation regarding urostomy and pelvic drain output was recorded as ordered. Findings include: Review of R149's clinical record revealed: 7/22/25 - R149 was admitted to the facility with a history of bladder cancer and recent urinary tract infection, pelvic infection a urostomy and pelvic drain. 7/22/25 - A physician's order was written for R149's pelvic drains to be emptied and the drainage amounts to be recorded. 7/22/25 - A care plan was created for R149's care of urostomy that included the intervention to empty the urostomy drainage bag and change it as needed and record the amount [ML's]. 7/23/25 - A care plan was created for R149's care of pelvic drains that included the intervention to empty the pelvic drain as ordered. 7/29/25 - A physician's order was written for R149 that directed staff to empty the urostomy drainage bag and record the amount every shift. August 2025 - Review of R149's TAR lacked evidence that staff documented the amount drained from R149's urostomy; the slots were blank on the following dates: 8/3 7:15 AM 8/4 11:15 PM 8/6 3:15 PM 8/8 3:15 PM 8/13 3:15 PM	F0691	Continued from page 17 B. Residents currently residing in the facility with drains that have an order to record the amount of drainage have the potential to be affected. An initial audit of residents with drainage devices that require recording output has been completed. C. Root cause noted to be staff failed to document output from the urostomy and pelvic drain in the clinical record per physician order, related to the licensed nurse's failure to document additional information in the electronic medical record when unable to collect the drainage related to leaking or the C.N.A. emptying the urostomy and not informing the nurse of the amount . The Staff Development Coordinator/designee will educate licensed nursing staff to document drainage output per physician orders in the electronic clinical record or document if no drainage was collected and the reason why, CNA's will be educated to inform the licensed nurse of the amount of drainage emptied so the nurse can document the amount in the clinical record. D. Unit Managers/Designee will audit the electronic medical records of residents with drains requiring documentation of output weekly to ensure documentation is completed. These audits will be completed daily x 5 days, then weekly x3 weeks, then monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 1/9/2026	

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F0691 SS = D	Continued from page 18 8/18 7:15 AM 8/19 7:15 AM August 2025 - Review of R149's TAR lacked evidence that staff documented the amount drained from R149's pelvic drains; the slots were blank on the following dates: 8/3 7:15 AM 8/4 11:15 PM 8/13 3:15 PM 9/24/2512:38 PM - During an interview, E40 (LPN) confirmed the findings. E40 stated, "I believe the CNAs were allowed to drain them. If they drained the urostomy without telling me, they emptied it, I wouldn't know the amount to record." 9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0691		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.	F0692	F692 Nutrition/Hydration Status **** A1. R11 no longer resides in the facility. R11's weight was obtained on 10/1/2025. A2. R11 no longer resides in the facility. The dietary director educated the kitchen staff related to double portions and scooping instructions on 9/28/2025. A3. R143 no longer resides in the facility, and the deficient practice could not be corrected. B1. Residents currently residing in the facility that have orders for weight monitoring have the potential to be affected. B2. Residents currently residing in the facility that have diet orders requiring double portions have the potential to be affected. B3. Residents currently residing in the facility that are at risk for dehydration have the potential to be affected. C1. Root cause noted to be the facility failed to follow the Weight Monitoring and Tracking Policy for R11 related to monthly weights not being obtained and the lack of a full-time dietician to ensure residents	01/09/2026

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WILMINGTON NURSING & REHABILITATION CENTER	700 FOULK ROAD , WILMINGTON, Delaware, 19803

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F0692 SS = D	Continued from page 19 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that for two (R11 and R143) out of three sampled residents reviewed for nutrition, the facility failed to maintain acceptable parameters of nutrition and/or hydration. Findings include: Cross refer F677 1.Review of R11's clinical records revealed: A facility policy titled, "Weight Monitoring and Tracking", dated 1/29/24, documented, "Procedure…2. Patients will be weighed on admission/re-admission and weekly x 4 weeks thereafter, or until the Interdisciplinary Team determines weight is stable, then monthly thereafter 6. Weekly weights should continue greater than 4 weeks if one or more of the following criteria are met: Significant unplanned weight change, Identified trends in weight change…Patients < (less) 100 pounds…8. The team will notify the provider and responsible party of significant weight changes…" A. Weight Monitoring 5/8/25 – R11 was re-admitted to the facility with diagnoses including chronic wounds, diabetes, dementia, acute kidney injury and moderate protein calorie malnutrition. 5/8/25 – An OT (Occupational Therapy) evaluation documented that R11 was dependent with eating. 5/9/25 – R11 was care planned for risk for protein calorie malnutrition and interventions included limited to obtain weights as ordered. 5/12/25 – A nutrition assessment documented R11's most recent weight, obtained on 5/7/25, at 80.8 lbs. 5/13/25 – A physician encounter note documented, "Patient requires assistance with ADLs … staff working to encourage p.o. (by mouth) intake and maintain hydration and continue to monitor…" 6/1/25 4:03 PM – A nurse progress note documented, "[R11] …(sic) 0-25 percent of her meal today…pocketing food in her mouth…" 6/3/25 – A physician's 30 – Day visit encounter note for R11 documented, "… Patient with dysphagia pureed	F0692	Continued from page 19 weights are obtained as ordered and the policy was being followed. The facility now has a full-time dietician in place. Staff Development Coordinator/designee will educate the clinical staff and dietician on the Weight Monitoring and Tracking Policy. C2. Root cause noted to be facility failed to provide diet portions as ordered related to the kitchen staff's lack of knowledge related to lack of previous comprehensive education regarding the process for scooping double portions. On 9/28/2025 the kitchen staff was educated by the Dietary Director on double portions and scooping instructions. The Dietary Director/designee will re-educate the kitchen staff on double portions and scooping instructions. C3. Root cause noted to be facility failed to follow the Hydration Policy and failed to document fluid intake in the electronic medical record in POC related to staff's lack of knowledge related to not using the proper section of POC documentation for fluid intake. Staff Development Coordinator/designee will educate the clinical nursing, therapy staff and activity staff on the Hydration Policy and will educate the clinical staff on the proper process for documenting fluid intake in POC. D1. The Dietician/designee will audit that weight monitoring of residents with Congestive Heart Failure that have orders for weight monitoring, residents receiving dialysis and new admissions is being completed per the facility policy. These audits will be completed daily x5 days, then weekly x3 weeks, then monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. D2. The Dietary Director/designee will audit that proper diet portions are being served as ordered. These audits will be completed daily x5 days, then weekly x 3 weeks, then monthly x2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. D3. Unit Managers/designee will randomly audit 10 residents with a BIMS of 12 or less that the facility Hydration Policy is being followed, and that fluid	

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F0692 SS = D	Continued from page 20 texture diet with nectar thick liquids and typically relies on staff ..." 6/3/25 – R11 had an order for monthly weights. The order was discontinued on an unknown date. 6/12/25 7:31 PM – A nurse progress note documented, "[R11] continues with poor p.o. (per orem or by mouth) intake." 6/23/25 – A physician's encounter note documented, "Wt (weight): 80.8 lbs (from 5/7/25 record)...nursing reports ...decreased appetite over the weekend... ill initiate hypodermoclysis... staff to encourage p.o. intake and continue to monitor clinically...". 6/24/25 – R11's nutrition assessment by E34 (RD) documented R11's most recent weight at 80.8 lbs. per record dated 5/7/25. 6/30/25 – R11's annual MDS assessment revealed that R11's cognition was moderately impaired, R11 was dependent with eating and required the assistance of 2 or more helpers to complete the activity. R11 was on a mechanically altered diabetic diet. There was a lack of information on R11's weight during the review period. 7/1/25 – A physician's encounter note documented, "Wt: 80.8 lbs (from 5/7/25 record) ... Acute kidney injury...I am told that p.o. intake has improved and staff working with the resident." 9/8/25 – R11 had a physician's order for monthly weights. 9/28/25 – A review of R11's weights revealed the following: - 5/7/25 – 80.8 lbs. - 7/3/25 – 62.0 lbs. 9/29/25 11:20 AM – In an interview, E2 (DON) stated that E34 (RD) works part time and E2 thinks that E34 assessed R11 in person when completing the nutritional assessments and notes. E2 further confirmed that they (facility) don't have R11's June 2025 weight information. "We could not find it". When asked if R11's weight was monitored when it started to decline after 5/7/25, E2 responded and confirmed, "No". 9/29/25 11/30 AM – In an interview, E10 (RN MDS) stated that, E27 (RN MDS) completed the nutritional status of R11's 6/30/25 quarterly MDS. E10 further stated that	F0692	Continued from page 20 intake is being documented in the electronic clinical record in POC. These audits will be completed daily x 5 days, then weekly x3 weeks, then monthly x2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 1/9/2026	

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F0692 SS = D	Continued from page 21 there was no information on R11's weight during the review period. E10 also confirmed and stated, "A reweight should have been done for R11 since the last weight on record which was 80.8 lbs on 5/7/25 was taken more than 30 days prior to the assessment reference date." R11 had a 23.3% weight loss in 57 days, from 5/7/25 through 7/3/25. The facility policy was not adhered to when weights were not obtained for R11 when she weighed below 80.8 lbs at readmission through 7/3/25. R11's weight was not obtained after the nutrition assessment was completed on 6/24/25 by E34 (RD), who documented R11's weight at 80.8 lbs based on the 5/7/25 record. In addition, R11's weight was not obtained when R11's previous recorded weight was obtained more than 30 days prior to E27 (MDS Coordinator) assessment reference date. B. Diet Order 6/28/20 – R11's original admission to the facility with diagnoses including difficulty swallowing following a stroke. 10/8/24 – R11 had a physician's order for dysphagia pureed texture, nectar thick liquid consistency, no straws, double entrée and divided plate. This order was discontinued on an unknown date. 5/8/25 – R11 had a physician's order for diabetic diet dysphagia (difficulty swallowing) mechanically altered, pureed texture (require change in texture of food or liquids ex. pureed food, thickened liquids), nectar thick liquid consistency, "VEGETARIAN – NO BEEF/NO EGGS/NO POULTRY/NO PORK". Said physician's order was discontinued on an unknown date. 8/12/25 – A dietary weight change note documented, "[R11] has experienced a weight change. She continues to receive a Regular (sic), dysphagia puree with NTL (nectar thick liquid) w/ (with) VEGETARIAN – NO BEEF/ NO EGGS/ NO POULTRY/ NO PORK. Current intake is now mostly 0-50% of meals. [R11] is also receiving Magic cup TID (three times a day) in which she consumes mostly 100%..." 8/19/25 1:23 PM – A nurse progress note documented, "This nurse … (dietitian), and (NP), had a conversation with [FM2, R11's daughter] with concerns of hydration and nutrition informed [sic] her resident presents with lack of desire to eating [sic] or drink. The dietitian went over possible nutrition considerations such as artificial nutrition (sic) the NP went over current	F0692		

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F0692 SS = D	Continued from page 22 code status (sic) the resident's daughter said she needs time to make the decisions and she will talk to [R11] tomorrow on a video call and follow up next week." 9/8/25 – R11 was readmitted to the facility with diagnoses including UTI (urinary tract infection) and low blood sugar. 9/8/25 – R11 had a physician's order for regular diet, dysphagia pureed texture, nectar thick liquid consistency. 9/10/25 – R11 had a physician's order for magic cup three times a day with all meals related to severe protein calorie malnutrition. Said physician's order was discontinued on an unknown date. 9/15/25 – R11's quarterly MDS assessment revealed that R11's cognition was severely impaired, had poor appetite nearly every day during the review period, was dependent with eating and required the assistance of 2 or more people to complete the activity. R11 had a 5% or more weight loss in the last month or loss of 10% or more in the last 6 months. R11 was also on a mechanically altered diet. 9/26/25 12:55 PM – During lunch observation, R11's food tray was observed to contain the following: a single serving of regular pureed vegetable on a divided plate, a cup of nectar thickened cranberry juice and magic cup. 9/26/25 1:00 PM – A review of R11's meal ticket tray notes/instructions revealed, "double entrée vegetarian no meat no eggs … water nectar 80z and magic cup". 9/26/25 1:05 PM – When asked to clarify R11's dietary orders, E5 (LPN/UM) stated that R11 was vegetarian. E5 also confirmed that R11's divided plate contained single serving of the pureed vegetable. E5 left R11's room to clarify the orders with the kitchen staff. 9/29/25 11:25 AM – When asked to clarify the conflicting active physician dietary orders regarding R11's portion serving size and vegetarian status as indicated in R11's meal tickets, E9 (RD) stated that R11 was to get a double a portion size and that kitchen staff will be educated on double portions and scooping instructions. 9/29/25 11:27 AM – In a follow up interview regarding R11's vegetarian status, E9 stated that she had a meeting with R11's daughter [FM2]. E9 "… The daughter	F0692		

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F0692 SS = D	Continued from page 23 was okay not to withhold R11's protein restrictions due to her very poor appetite and poor oral intake." E9 stated that R11's dietary orders will be clarified with the kitchen staff, and the meal ticket instructions will be updated. 9/29/25 1:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse). 9/29/25 1:25 PM - Findings were reviewed with E1, E2 and E3 during the exit conference. 2. Review of R143's clinical record revealed: 1/3/25 - A quarterly MDS assessment documented that R143 was severely cognitively impaired and dependent for eating. 1/23/23 [last updated 2/28/24] - A care plan for risk of dehydration was created for R143. The goal of the care plan was to maintain adequate hydration. Additionally, a care plan for risk of constipation was created that included the intervention to encourge and assist as needed to consume fluids between meals. Lastly, a care plan for weight changes related to cognition was created that included an intervention to encourage and assist as needed to consume foods and/or supplements and fluids offered. January 2025 - Review of CNA documentation of PRN fluid intake lacked evidence that R143 was offered fluids or consumed fluids for seventeen day shifts, twenty-two evening shifts and twenty-four night shifts. February 2025 - Review of CNA documentation of PRN fluid intake lacked evidence that R143 was offered or consumed fluids for thirteen day shifts, sixteen evening shifts, and sixteen-night shifts. March 2025 - Review of CNA documentation of PRN fluid intake lacked evidence that R143 was offered or consumed fluids for eleven day shifts, three evening shifts, and three night shifts. 9/26/25 11:41 AM - During an interview, E50 (CNA) stated that residents should be offered fluids, "At least once [a shift] with the water cups" and that intake of offered fluids is documented, "On the task point of care, even if it's zero." 9/26/25 11:44 AM - During an interview, E49 (CNA) stated that residents should be offered fluids, "Throughout the day" and that offering and consumption	F0692		

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F0692 SS = D	Continued from page 24 is documented, "In the computer." 9/26/25 11:45 AM - During an interview, E32 (CNA) stated that residents should be offered fluids, "Three times a day" and the resident response to being offered additional fluids is documented, "on the computer." 9/26/25 12:05 PM - During an interview, E5 (LPN) and the unit manager confirmed the finding and stated that fluids should be offered, "At least twice a shift, meals and as needed." E5 confirmed that fluids offered and consumed are to be documented on the point of care documentation by the CNAs. 9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0692		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R1) out of one resident reviewed for dialysis, the facility failed to provide dialysis related care and services to meet the needs of the resident when pre-dialysis information was not completed on the dialysis communication form. Additionally, some dialysis communication forms were absent from the medical record. Findings include: Review of R1's clinical record revealed: 9/3/25 - R1 was admitted to the facility with multiple diagnoses including end-stage renal disease requiring dialysis. 9/3/25 - A physician's order was written for R1 to receive dialysis three times a week. September 2025 - Review of R1's Dialysis communication forms lacked completion of pre-dialysis information for R1 including meals, medications, change of condition and a signature of the person completing the form.	F0698	F698 Dialysis A. R1 no longer resides in the facility, unable to correct the deficient practice for R1. B. Residents that currently reside in the facility that require dialysis have the potential to be affected by this practice. An initial audit has been completed for current residents receiving dialysis in the facility. C. Root cause noted to be failure of licensed nursing staff to follow the process to complete all appropriate sections on the dialysis communication form prior to the scheduled pick-up time to ensure paperwork is ready prior to transport and the license nurse not completing the information on the dialysis communication form upon return from dialysis. Staff Development Coordinator/Designee will re-educate the licensed nursing staff on the process and timely completion of each applicable section on the dialysis communication forms prior to and after dialysis, education will include that two licensed nurses need to sign the dialysis communication form to verify completeness prior to and after dialysis. C1. Two licensed nurses will sign the dialysis communication form to verify completeness prior to the resident leaving the facility for dialysis. C. Two licensed nurses will sign the dialysis communication form to verify completeness after it is received, reviewed and placed in the appropriate filing location. D. Unit Managers/Designee will audit dialysis communication forms to ensure they are accurately	01/09/2026

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F0698 SS = D	Continued from page 25 9/15 - Pre-dialysis communication form documentation incomplete; only R1's blood pressure and pulse were documented. 9/17 - Pre-dialysis communication form documentation incomplete, only R1's blood pressure, pulse and a staff signature were documented. 9/19 - Pre-dialysis communication form documentation blank. 9/22 - Pre-dialysis communication form documentation blank. 9/22/25 - Review of R1's dialysis communication forms lacked evidence of forms for dialysis visits on 9/5/25, 9/10/25, and 9/12/25. 9/23/25 10:18 AM - During an interview, E46 (MR) confirmed that R1's dialysis communication forms for dialysis visits on 9/5/25, 9/10/25 and 9/12/25 were unable to be located by the facility. 9/23/25 11:59 AM - During an interview, E48 (LPN) confirmed that residents assigned nurses should complete the resident's dialysis communication form. Additionally, E48 stated, "We make sure [R1] has medicine. We do vitals. The nurse gets food from the kitchen. He has a yellow folder and we give to transportation." 9/23/25 12:05 PM - During an interview, E47 (RN) and the unit manager on R1's unit confirmed the finding. 9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0698	Continued from page 25 completed. These audits will be completed daily x5 days, then weekly x3 weeks, then monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 1/9/2026	
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §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- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F0757	F757 Drug Regimen is Free from Unnecessary Drugs A. R6 currently resides in the facility; behavior monitoring orders were initiated on 9/26/2025. Side effect monitoring orders were in place since 7/15/2025 and documentation was being completed on the Medication Administration Record. The Assistant Director of Nursing was educated on the proper follow-up of Pharmacy Medical Record Reviews. B. Residents currently residing in the facility that require medication monitoring have the potential to be affected. An initial audit was completed of Medication Record Reviews from November 1, 2025, through present to ensure they were completed and addressed as per	01/09/2026

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F0757 SS = D	Continued from page 26 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R6) out of five residents reviewed for unnecessary medication review the facility failed to act upon a recommendation documented in the residents MRR. Findings include: The facility policy on MRR last updated, 8/2020, indicated "Recommendations are acted upon and documented by the facility staff and/or the prescriber. Review of R6's clinical record revealed: 4/24/25 - was initially admitted to the facility. 5/1/24 -7/15/24 - Was discharged from the facility due to being hospitalized. 7/15/25 - R6 was re-admitted to the facility with multiple diagnoses including dementia, anxiety, and major depressive disorder with psychotic symptoms. 7/15/25 - An admission MDS assessment documented that R6 was receiving antipsychotic medications. 7/15/25 - A care plan for use of antipsychotic medications was created for R6 with an intervention to monitor behaviors. 7/15/25 - An MRR documented that R6's antipsychotic "requires monitoring"; the recommendation was signed by R6's physician on 7/18/25. 7/16/25 - A physician's order was written for R6 to receive an antipsychotic medication twice a day for	F0757	Continued from page 26 pharmacy/physician recommendations. Residents currently residing in the facility have monitoring orders in place. C. Root cause was related to the Assistant Director of Nursing's review of the Medication Record Review noting that side effect monitoring orders were in place, which were ordered on 7/15/2025 at 2316. The Assistant Director of Nursing determined that the monitoring order that was in place addressed the Medication Record Review section "Intervention: Initiate or increase medication monitoring", not that the resident needed behavior monitoring orders. Behavior monitoring orders were added to the resident's clinical record on 9/26/2025. Staff Development Coordinator/designee will educate the Clinical Leadership Nursing team responsible for the follow-up of the Medication Record Review to ensure follow-up is completed per the pharmacy recommendation and the physicians' response to the pharmacy recommendations. D. Director of Nursing/designee will audit Medication Record Reviews from the pharmacy to ensure completion per pharmacy/physician recommendations and required monitoring orders are in place. These audits will be completed daily x 5 days, then weekly x 3 weeks, then monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 1/9/2026	

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F0757 SS = D	Continued from page 27 psychosis. 9/26/25 12:01 PM - During an interview, E5 (LPN) confirmed the finding. E5 stated, "Usually there is something based off of meds that should come up every shift. I don't see it but she should have it. Sometimes it will fall off possibly from when she left then came back." 9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0757		
F0770 SS = D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R149) out of one resident reviewed for change in condition, the facility failed to ensure ordered labs were completed timely. Findings include: The facility policy on laboratory and diagnostic testing last updated 1/29/24 indicated, "Laboratory, radiology and other diagnostic services are provided to the center by way of written contractual agreements. The contracted service vendor is to provide services to the center that ensure safe and effective patient testing and timely delivery of results." Review of R149's clinical record revealed: 7/22/25 - R149 was admitted to the facility with a urostomy tube. 7/28/25 - A physician's order was written for R149 to receive urinalysis culture and sensitivity testing for recurrent UTIs and blood in the urine. 7/28/25 8:59 pm - A progress note in R149's clinical	F0770	F770 Laboratory Services A. R149 no longer resides in the facility; the facility is unable to correct the deficient practice for R149. B. Residents currently residing in the facility with an order for a UA C&S have the potential to be affected. C. Root cause noted to be that the licensed nursing staff failed to follow the lab tracking process to ensure labs were completed in a timely manner. The licensed nurse failed to collect the specimen in a timely manner, and it was not available for pick up by the lab on the morning of 7/29/2025, which resulted in the remainder of the lab tracking process not to be followed. An initial audit of orders dated 11/1/2025 through 12/8/2025 for UA C&S was completed to ensure labs were completed in a timely manner. Staff Development Coordinator will educate licensed nursing staff and Clinical Leadership related to lab collection and tracking process to include shift to shift nursing communication of any needed specimens that need to be obtained. D. Director of Nursing/designee will audit lab orders for UA C&S to ensure completion per physician orders. These audits will be completed daily x 5 days, then weekly x 3 weeks, then monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 1/9/2026	01/09/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/04/2025

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F0770 SS = D	Continued from page 28 record documented, "resident noted with some reddish urine in her urostomy bag. [MD] notified new order for urinalysis culture and sensitivity to rule out UTI." 7/29/25 - Review of the facility lab tracking form documented that R149's UA/C&S was to be collected that day. 7/30/25 - R149's lab results report documented that the UA/C&S was collected. Review of progress notes lacked clarification on why the urine sample was not collected on 7/28/25. 7/31/25 - A physician's order was written for R149 to receive an antibiotic medication for treatment of a UTI. 9/24/25 12:45 PM - During an interview, E41 (RN) and the unit manager on R149's unit confirmed that R149's urinalysis labs were not obtained timely. E41 stated, "The doctor puts the order in and then we put it right to the lab book and most are done overnight shift. We put it in the book but usually during the same shift." 9/29/25 1:25 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0770		
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services;	F0791	F791 Routine/Emergency Dental Srvcs in NF A. R16 currently resides in the facility, the dentist visited the facility on 10/1/2025 but the resident was not available to be seen, but was seen on 10/5/2025 for cavity restoration with resins completed. The resident also had follow-up with the dentist completed on 11/2/2025 and is being followed for potential dentures, resident was seen again on by dentist on 12/9/2025 and is receiving treatment to prepare for upper dentures. B. Residents currently residing in the facility that require dental services have the potentlal to be affected. An initial audit of residents requiring dental services has been completed. C. Root cause noted to be that the facility failed to provide dental services per the facility process related to not appropriately monitoring the dental consults recommendations. The facility did not place R16 on the dental visit prior to 10/1/2025 as the LPN Unit Manager interpreted the dental consult as the resident only required follow-up if symptoms or swelling began, and the resident did not notify the facility staff of pain or discomfort or the inability to eat food anytime after the dental visit on	01/09/2026

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F0791 SS = D	Continued from page 29 §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that for one (R16) out of one resident reviewed for dental services, the facility failed to promptly provide routine and emergency dental care for R16 when he was recommended for follow up visits to restore his cavities and extract his extensively decayed root tips after his dental exam on 3/23/25. Findings include: The facility's policy titled, "Dental Service Needs" dated 1/29/25 documented, "... Procedure ... 2. Nursing will collaborate with the Social Services Department to identify and secure designated and/ or centered contracted community available resources for dental services. 3. Nursing will... assist the patient in making appointments ... " Review of R16's clinical records revealed: Cross refer F641	F0791	Continued from page 29 3/24/2025. R16 did not report concerns until speaking with the state surveyor on 9/18/2025, stating that "I can't remember when I was last seen by the doctor. I don't think I was ever seen. My teeth are loose and are falling off. It is affecting my chewing and eating." R16's recommendations documented on the dental consult dated 3/24/2025 were to return to restore cavities, teeth that are extensively decayed, and root tips would need to be extracted in the future if symptoms or swelling begin. As R16 had not complained, the facility misinterpreted that consult indicated additional treatment was needed at that time. The Staff Development Coordinator/designee will educate licensed nursing staff and Social Services on the facility's policy "Dental Service Needs", and to ensure the recommendations are being followed, making follow-up appointments as needed. The Staff Development Coordinator will educate the Director of Nursing, the Assistance Director of Nursing and the Unit Managers to contact the dental provider for clarification of the dental consult if recommendations are not clear or if clarification is needed related to the dental consult interpretation, or to understand the handwriting or grammar on the consult by contacting the dental provider and document the clarification in the clinical record progress notes. The Social Services Director is the dedicated liaison between dental services being completed without interruption. D. The Director of Nursing/designee will audit residents identified on the list of residents requiring dental services initiated/maintained by the Social Services Director and by quarterly MDS completion completed by the MDS Coordinator requiring dental services to ensure appointments are made and follow-up recommendations are completed. These audits will be completed weekly x 4 weeks, then monthly x 3 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance E. Date of compliance: 1/9/2026	

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F0791 SS = D	Continued from page 30 11/25/22 – R16 was admitted to the facility. 8/26/24 – A care plan was developed for R16 related to his independence with oral care and R16's goal was to be free from dental complications through the review period. R16's interventions included to perform oral exams as needed and to refer to a dentist as indicated. 3/23/25 – A report of consultation from (dental office) documented, "Recommendations: Return to restore cavities, teeth that are extensively decayed and root tips would need to be extracted in the future if symptoms or swelling begin." 5/14/25 – R16's quarterly MDS assessment revealed that R16 had an intact cognition and had no dental issues. 9/18/25 1:20 PM – During an interview, R16 stated, "...I can't remember when I was last seen by the doctor. I don't think I was ever seen. My teeth are loose and are falling off; it's affecting my chewing and eating." 9/18/25 1:30 PM - The Surveyor observed R16's chipped off and decayed teeth. 9/23/25 10:20 AM – In an interview, E5 (LPN UM) stated that she did not hear from resident [R16] complaining of dental issues. E5 confirmed that R16 was not seen by P3 [dentist] sooner after the March 2025 recommendation. E5 added that "... She [R16] is included in the list of residents scheduled to be seen by P3 anytime these days for the six month follow up visit." 9/29/25 1:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E3 (Corporate Nurse). 9/29/25 1:25 PM - Findings were reviewed with E1, E2 and E3 during the exit conference.	F0791		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880	F880 Infection Prevention & Control A1. R35's room was disinfected with an appropriate cleaning solution on 9/22/2025. The resident does not currently reside in the facility. A2. Orders for enhanced barrier precautions were entered on 9/26/2025 for wounds for R150. R150's PICC line was inserted on 9/20/2025 and had Enhanced Barrier Precautions in place from 9/22/2025 through 9/26/2025 for the indwelling medical device. The resident does not currently reside in the facility. A3. The full sharps container was removed and replaced with an empty sharp's container on 9/25/2025.	01/09/2026

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F0880 SS = E	Continued from page 31 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880	Continued from page 31 B1. Residents currently residing in the facility with diagnosis of C. difficile have the potential to be affected. An initial audit of residents residing in the facility has been completed, and there are no other residents identified positive for C. difficile. B2. Residents currently residing in the facility that require enhanced barrier precautions for indwelling medical devices and wounds have the potential to be affected. An initial audit of residents residing in the facility with indwelling medical devices and/or wounds has been completed, and orders updated as needed. B3. Residents currently residing in the facility have the potential to be affected by this practice. An initial audit of sharp's containers was completed during survey and replaced as needed. C1. Root cause analysis is related to the facility staff E26, E35, and E38 failing to follow proper cleaning procedures and hand hygiene procedures for a resident with C. Difficile due to lack of knowledge of staff involved. The Staff Development Coordinator will re-educate facility staff regarding the proper cleaning procedures for residents infected with C. difficile, the education included proper hand hygiene and proper cleaning of surfaces. Environmental staff will be educated regarding the process for terminal cleaning of a C. diff resident's room. Resident care will be monitored when a resident has C. Diff during infection control rounds daily by the Infection Preventionist/designee and daily rounds by the Unit Managers, these rounds will include ensuring proper signage is in place, and observation of proper hand hygiene and proper cleaning of surfaces. The Environmental Services Director will observe Environmental Services staff to ensure that proper terminal cleaning procedures are being followed for resident's with C. diff. C2. Root cause analysis was related to the facility failing to follow the Policy related to Enhanced Barrier Precautions. The licensed nursing staff for R150 failed to enter the order for Enhanced barrier precautions when the line was inserted on 9/20/2025, related to lack of knowledge for the need for enhanced barrier precautions related to a PICC line, the order for enhanced barrier precautions were added on 9/22/2025 by the unit manager when it was noted during the daily clinical meeting that the licensed nurse did not initiate the order on 9/20/2025 when the PICC line was inserted. The licensed nursing staff and Nursing Leadership's failure to identify the need for physician	

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F0880 SS = E	Continued from page 32 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for two (R150 and R35) out of five residents reviewed for infection control, the facility failed to initiate and maintain Enhanced Barrier Precautions (EBP) for contact with a resident with wounds and an indwelling medical device and failed to use appropriate disinfection practices. Also, the facility failed to prevent the risk of exposure to infectious and communicable diseases by not safely disposing a full sharps container. Findings include: An infection prevention and control facility policy titled, "Standards of Practice" dated, 2/6/20, documented, "... Procedure 8 Environmental Cleaning/Disinfection: ... DO NOT USE Alcohol based-disinfectants; alcohol-based disinfectants are not effective against C. difficile and should not be used to disinfect environmental surfaces." Review of R35's clinical records revealed: 9/20/25 – R35 had a physician's order for contact precautions for C-diff (bacterial overgrowth that releases toxins that attack the lining of the intestines). 9/22/25 11:00 AM - The Surveyor observed a notice of contact precaution outside of R35's room. 9/22/25 11:01 AM - During interview, E26 (LPN) stated that R35 tested positive for C-diff the past weekend. 9/22/25 11:02 AM - In an interview, R35 stated, "I have been having diarrhea over the weekend". R35 was observed moving her over bed table and touching her call bell button. R35 was also observed and was heard asking E26 (LPN) to give her the bed control. 9/22/25 11:03 AM – In an interview while in R35's room, E26 was asked what she uses to disinfect high contact	F0880	Continued from page 32 orders on admission for enhanced barrier precautions for wounds. Enhanced barriers precautions were in place for the indwelling medical device (PICC line), until 9/25/2025, the root cause of the enhanced barrier precautions to be discontinued was related to the central supply coordinator mistakenly removing the signage and PPE as her understanding was that the resident no longer had an indwelling medical device, and the licensed nursing staff and Nursing Leadership's failure to ensure that the resident had Enhanced Barrier Precautions remain in place. The Staff Development Coordinator/designee will educate facility staff on the requirements of Enhanced Barrier Precautions. The Infection Preventionist and/or Unit Manager and/or Supervisors are responsible for signage removal, PPE removal and the discontinuation of orders when appropriate and ensuring Enhanced Barrier Precautions are in place as ordered/indicated. C3. Root cause analysis noted that environmental staff lacked knowledge regarding disposing of sharps containers in resident rooms/bathrooms when they become full as there was not a process in place, a process has been developed, Environmental Services is responsible for monitoring, discarding and replacing the sharps containers in resident rooms/bathrooms as needed, the licensed nursing staff are responsible for monitoring, discarding and replacing the sharps containers on medication and treatment carts. The Environmental Services Director educated the environmental services team members on the process for monitoring, discarding and replacing the sharps containers in resident rooms/bathrooms as needed, the Staff Development Coordinator/designee educated the licensed nursing staff on the process for monitoring, discarding and replacing the sharps containers on medication and treatment carts. D1. Staff Development Coordinator/Infection Preventionist/designee will observe clinical and environmental services staff for residents infected with C. difficile to ensure proper cleaning techniques and proper hand hygiene are being followed. The Environmental Services Director will observe the Environmental Services staff to ensure terminal cleaning for resident's infected with C. diff to ensure proper cleaning techniques and hand hygiene are being followed. These audits will be completed daily x5 days, then weekly x3 weeks, then monthly x2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans.	

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F0880 SS = E	Continued from page 33 objects such as doorknobs, bed rails, overbed tables, bed control and call light button. E26 pointed to the anti-bacterial alcohol-based hand sanitizer mounted on the wall. On her way out of E35's room into the hallway, E26 was heard instructing E32 (CNA) to show to the Surveyor the disinfectant being used. 9/22/25 11:04 AM – In an interview, E32 (CNA) told the Surveyor that they (staff) have been using the anti-bacterial hand sanitizer. When the Surveyor asked E32 for the specific germicidal bleach wipes that targets the C-diff spores, E32 walked towards E38 (Central Supply staff), who confirmed that the facility has the germicidal bleach wipes in stock and that she was going to get it from her office. 9/22/25 11:05 AM – E26 and E32 presented to Surveyor an unopened canister of germicidal bleach wipes. E26 told Surveyor she would use it to disinfect R35's room. 2. CDC (Centers for Disease Control and Prevention) guidance dated 6/28/24, states, "Enhanced Barrier Precautions are an infection control intervention designed to reduce the transmission of multidrug resistant organisms (MDROs) in nursing homes. Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices)." The facility policy titled "Enhanced Barrier Precautions (EBPs)" dated 3/26/24 states, "...Procedure...1. [EBP] may be indicated for patients: With chronic wounds (...diabetic ulcers, vascular/arterial ulcers...) 4. Post Enhanced Barrier Precaution signage on the wall outside the patient(s) room. 5. Ensure PPE is available..." Review of R150's clinical record revealed: 8/2/25- R150 was readmitted to the facility with diagnoses including diabetes mellitus, congestive heart failure and epilepsy. 8/11/25 - A Wound Assessment report competed by P1 documented R150 had two venous ulcers and a diabetic foot ulcer. 8/26/25 - R150 was discharged from the facility. 9/16/25 - R150 was readmitted to the facility. 9/19/25 - R150 had a midline catheter placed for	F0880	Continued from page 33 D2. Unit Managers/designee will randomly audit 10 residents with wounds and indwelling medical devices to ensure enhanced barrier precaution orders are in place, appropriate signage is posted and proper PPE is available. These audits will be completed daily x 5 days, then weekly x3 weeks, then monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. D3. Environmental Services Director/designee will randomly audit 20 sharps containers in resident rooms/bathrooms and the Unit Managers/designee will randomly audit medication carts and treatment carts on each unit. These audits will be completed daily x5 days, then weekly x3 weeks, monthly x 2 months to ensure substantial compliance. Results will be provided to the Quality Assurance and Performance Improvement Committee for review and action as appropriate until 100% compliance is met. The Committee will determine the need for further audits and/or action plans. E. Date of compliance: 1/9/2026	

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F0880 SS = E	Continued from page 34 medication administration. 9/22/25 - Enhanced Barrier Precautions (EBP) were ordered for R150 for midline catheter placement. This order was entered two days after R150 had midline catheter placed. 9/22/25 3:19 PM - EBP signage was posted for R150 and PPE supplies were observed. 9/24/25 - R150's midline catheter was removed. 9/25/25 2:30 PM - No EBP signage or PPE supplies were observed for R150. 9/26/25 1:20 PM - No EBP signage or PPE supplies were observed for R150. 9/26/25 1:52 PM - During an interview, The Surveyor asked E11 (IP) if EBP is required for residents that have chronic wounds. E11 stated, "EBP should be in place." 3. The OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard 29 CFR 1910.1030.(d)(4)(iii)(A)(2)(iii), which describes safeguards to prevent needlestick injuries and protect employees from occupational hazards associated with bloodborne pathogens, states, "...containers for sharps shall be routinely replaced and not be allowed to overfill." FDA (U.S. Food and Drug Administration) April 2021 guidance states, "...sharps disposal containers are marked with a line to indicate when about three-fourths (3/4) full...sharps disposal containers in healthcare facilities should be disposed when three fourths (3/4) full..." 9/22/25 2:15 PM - A full sharps container was observed in a residential bathroom in the Memory Care unit. 9/22/25 3:04 PM - E39 (LPN, UM) confirmed the full sharps container in the residential bathroom. During an interview, E39 stated, "The sharps containers are replaced when they are full. I will let someone know the container needs to be changed." 9/24/25 9:16 AM - A full sharps container was observed in the same residential bathroom. 9/25/25 2:25 PM - E5 (LPN, UM) confirmed the full sharps container in the same resident bathroom. E5	F0880		

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F0880 SS = E	Continued from page 35 stated, "I will change it now." 9/29/25 1:25 PM - Findings were reviewed with E1, E2 (DON) and E3 (Corporate Nurse) during the exit conference.	F0880		