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: Excelcare at Lewes LLC **DATE SURVEY COMPLETED:** February 13, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 02/10/25 - 02/13/25 Census: 124 Sample: 46 Supplemental Sample: 13		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 13, 2025: F550, F600, F602, F609, F610, F684, F686, F689, F690, F700, F760 and F880.	Cross Refer to approved POC for CMS-2567-L.	April 14, 2025

Provider's Signature _____ Title _____ Date 5-9-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085034	A. BUILDING _____ B. WING _____	C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EXCELCARE AT LEWES LLC	301 OCEAN VIEW BLVD LEWES, DE 19958

(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
E 000	Initial Comments A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 02/10/25 through 02/13/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 02/10/25-02/13/25 Census: 124 Sample: 46 Supplemental Sample: 13	F 000		
F 550 SS=D	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	F 550		4/14/25

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

Electronically Signed | 03/07/2025

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 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.

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F 550	Continued From page 1 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. §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, interviews, and record review, the facility failed to ensure that one residents (Resident (R)79) in the sample of 46 received care and services in a manner and environment that maintained dignified dining experience. Findings include: Review of R79's "Admission Record" located under the "Profile" tab in the Electronic Medical	F 550	A. Once the facility became aware, R79□s bed linens were changed. B. All residents have the potential to be affected. C.1.) The root cause analysis (RCA) determined that the aide was passing food and did not want to breach infection control practices. 2.) The staff developer/designee will re-educate CNAs and licensed nurses on changing linens before serving meal trays.	

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F 550	Continued From page 2 Record (EMR) revealed R79 was admitted on 02/21/23 with diagnoses that included generalized osteoarthritis and chronic obstructive pulmonary disease. Review of the quarterly "Minimum Data Set (MDS)" located under the "MDS" tab with an Assessment Reference Date (ARD) of 11/04/24 revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15 which indicated R79 was cognitively intact. Review of the "Care Plan" located under the "Care Plan" tab dated 11/13/24 revealed R79 was to have assistance with activities of daily living (ADL) as needed due to identified self-care deficit. Observation and interview on 02/11/25 at 08:38 AM, R79 was seated in his wheelchair at the foot of his bed. The resident's bed linens were soiled with a large brown stain visible to anyone entering the room and the room was very odorous. The resident's covered breakfast tray was on the overbed table next to the bed. R79 stated, "I just want to lay down and look at my bed. They expect me to eat breakfast, and my bed is like that. They said they would change my bed, but they haven't been back. Interview on 02/11/25 at 8:43 AM, Registered Nurse (RN3) stated he would have someone change R79's bed linens. A second request was made at 8:57 AM before the bed was changed. When asked, at 9:15 AM, why the bed was not changed for 14 minutes, RN3 stated, "they were passing trays, didn't want them to be sitting." Interview on 02/13/25 at 4:47 PM, the Director of	F 550	3.) Now the Direct care staff will be trained to change soiled linens before beginning meal service. 4.) The DON/designee will conduct weekly meal service audits on each of the three (3) units and review fifteen (15) random rooms over the units to monitor compliance with changing linens before meal service begins. D. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is achieved for three consecutive months.	

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F 550	Continued From page 3 Nurses (DON) and Assistant Director of Nurses (ADON) said the bed linens should have been changed before providing R79 his breakfast.	F 550		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, interviews, and review of facility policy, the facility failed to ensure one of three residents (Resident (R) 21) reviewed for abuse was free from abuse in the sample of 46 residents. This failure had the potential for psychosocial impairment from being verbally abused by a staff member. Findings include: A review of the facility reported incident revealed that on 11/26/24 at approximately 9:00 AM, the Social worker witnessed the involved staff (medical records clerk) having a verbal exchange with the resident in an argumentative tone and	F 600	A. The employee no longer works at the facility. B. All residents have the potential to be affected. C. 1.) The RCA determined that the staff member could have benefited from additional de-escalation strategies when dealing with a confrontational resident.2.) The staff developer will educate staff across all departments on de-escalation strategies. 3.) This will be included in new-hire orientation and annual mandatory training. 4.) The NHA/designee will audit employee files after new hire orientation to monitor	4/14/25

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F 600	Continued From page 4 when the involved staff was advised to walk away from the altercation, the staff member turned around and confronted the R21 and used profanity. Review of R21's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/26/24 revealed an admission date of 05/17/17 and a "Brief Interview for Mental Status (BIMS)"score of 15 out of 15 indicating R21 was cognitively intact. On 02/13/25 at 12:10 PM during an interview R21 stated that he had already talked with someone from the state about this incident. Interview on 02/12/25 at 01:04 PM, the Assistant Director of Nurses (ADON) stated that she only remembered the incident occurring. On 02/13/25 at 1:44 PM during an interview the Social Service Director (SSD) stated that she did not actually witness the event but heard raised voices and the accused resident used profanity towards staff. Does not recall if the accused staff used profanity towards the resident. Interview on 02/13/25 at 2:00 PM, the Administrator stated that when the incident happened the medical records staff was immediately removed from the situation, escorted out of the building, and terminated. Review of the facility's policy titled, "Freedom from Abuse, Neglect and Reporting of Alleged Violations," reviewed 06/15/2024, indicated, "The facility will not use verbal ...Verbal/Written Abuse is defined as the use of oral ...that willfully includes disparaging and derogatory terms to	F 600	for evidence of de-escalation training. NHA will audit fifty (50) % of all new hire files as orientation is completed. D. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is achieved for three consecutive months	

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F 600	Continued From page 5 residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability ...The facility will develop and operationalize policies and procedures for screening and training employees. protection of residents and for the prevention, identification, investigation, and reporting of abuse ...The purpose is to assure that the facility is doing all that is within its control to prevent occurrences."	F 600		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on document review, record review, interview, and policy review, the facility failed to ensure residents were free from misappropriation for one of one resident (Resident (R) 177) reviewed for misappropriation. Specifically, Licensed Practical Nurse (LPN) 3 took Resident (R)177's Percocet (pain medication) from the medication cart. The facility's failure to safeguard medication placed all residents at risk for their medications to be misappropriated. Findings include: Review of the facility's investigation summary revealed, "On 12/4/24, [Licensed Practical Nurse	F 602	A. LPN3 no longer works at the facility. B. All residents that are prescribed narcotics have the potential to be affected. C. 1.) The RCA determined that the Percocet was mistakenly placed in the even cart due to the narcotics sheet lacking a designated space to identify odd and even carts for the Henlopen Unit. 2.) The narcotic sheet has been revised, all previous versions removed, to include a section specifying whether the medication was added to the odd or even cart. 3.) The staff developer/designee will educate licensed nurses on the revised narcotics	4/14/25

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F 602	Continued From page 6 (LPN)5's name] received 2 blister packs of Percocet packs from the pharmacy around 5AM. [LPN5] then handed the 2 packs of Percocet off to [Registered Nurse (RN)5's name] who was responsible for two carts on the unit (referred to as the odd and even carts). Both cards were mistakenly placed on the even cart, causing a discrepancy, the even cart had three cards of Percocet and the odd cart had two cards of Percocet. An adjustment was made and both carts had 2 cards of Percocet. On 12/4/24 at 7PM [LPN3's name] arrived for her shift and the narcotics were counted and recorded as correct. On 12/5/24 at 7AM [LPN3] signed over the even cart to [LPN12's name] with 2 cards of Percocet. The odd cart was signed over to [LPN13] and [LPN3] left the building. [LPN 13] discovered [R177's] blister pack on the odd cart had two tablets remaining. She contacted the pharmacy and confirmed 60 tablets of Percocet were delivered on 12/04/24. The investigation began, one of R177's blister pack of Percocet was found containing 30 tabs and the other was missing. [LPN3] left the building and did not return calls or return to the facility. She was unable to be reached by the facility. The Director of Nursing (DON) notified Regional about the incident and started an investigation. The police department was notified, and the incident was reported to the state. [LPN3] did not respond to the facility calls or the police who went to her house to inquire about the missing medications." Review of R177's undated "Face Sheet" located in the resident's electronic medical record (EMR) under the "Face Sheet" tab indicated that R177's was admitted to the facility on 11/27/24 and was discharged on 12/09/24.	F 602	sheet. 4.) The DON/designee will conduct weekly audits of all narcotic sheets on the Henlopen for compliance. D. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. Finally, the facility will conduct a monthly audit until 100% compliance is maintained. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is achieved for three consecutive months.	

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F 602	Continued From page 7 Review of R177's physician's orders revealed orders for Percocet two tablets 10/325 milligram (mg) every six hours for pain. During an interview on 02/12/25 at 9:51 AM, the Assistant Director of Nursing (ADON) stated the facility's investigation determined LPN3 was responsible for taking R177's Percocet pain medication. The ADON said all nursing staff were interviewed and drug tested. The ADON stated that R177 did not miss any doses of his medication due to the drug diversion. During an interview with the Administrator on 0212/25 at 1:48 PM, she stated LPN3 was arrested for the misappropriation of R177's medications. The Administrator provided an email from the detective investigating the incident indicating that LPN3 was arrested. Interview on 02/12/25 at 10:52 AM, the DON was asked if there was any document the nurses sign that they are to not take residents' medications. The DON stated the nurses sign the facility's Abuse policy. Review of the facility's policy titled, "Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation" dated 02/01/23 indicated, " ...Definitions ...Misappropriation of Patient Property: the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a patient's belongings or money without the patient's consent."	F 602		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4)	F 609		4/14/25

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F 609	Continued From page 8 §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and policy review, the facility failed to implement policies and procedures for the reporting of abuse to the State Survey Agency (SSA) for one of five residents (Resident (R) 77) reviewed for abuse out of a total sample of 46 residents. These failures had the potential to contribute to continued abuse in the facility for this resident and other residents.	F 609	A. 1.) Once identified as an allegation of abuse, the State Survey Agency was notified. 2.) The ADON and DON were re-educated on abuse policies, including reporting and investigating allegations involving cognitively impaired residents. B. 1.) All cognitively impaired residents have the potential to be affected. 2.)	

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F 609	Continued From page 9 Findings include: Review of the facility's policy titled, "Reporting of Reasonable Suspicion of a Crime & Alleged Violations" provided by the facility and dated 06/15/24 indicated, "The facility will develop and operationalize policies and procedures for ...reporting of abuse, neglect, mistreatment, and misappropriation of property ...Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment ...are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials, including to the State Survey Agency ..." Review of R77's "Admission Record" located in the Electronic Medical Record (EMR) under the "Profile" tab indicated she was admitted to the facility on 01/13/25. Review of R77's Admission "Minimum Data Set (MDS)" assessment under the "MDS" tab in the EMR with an Assessment Reference Date (ARD) of 01/17/25 included a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15 which indicated she was moderately cognitively impaired. Review of R322's "Admission Record" located in the EMR under the "Profile" tab indicated she was admitted to the facility on 02/05/25. Review of R322's Admission "MDS" assessment	F 609	Review of all resident interviews conducted over the past 90 days regarding alleged abuse will be completed to determine if any allegations need to be reported to the State Survey Agency. Reports and investigations will be conducted according to regulation. C. 1.) The RCA determined that the staff conducting the investigation failed to recognize the Resident's statement as an allegation of abuse. 2.) The staff developer/designee will re-educate staff across all departments on abuse policies, including reporting allegations involving cognitively impaired residents.3.) Training on cognitively impaired resident abuse reporting will now be included in new-hire orientation and annual mandatory education. 4.) The NHA/designee will audit within two hours of notice all supervisor reported events that could be interpreted as abuse and taken to determine if an allegation needs to be reported to the State Survey Agency. Additionally, all grievances will be reviewed in daily stand-up to determine if there are trends requiring further education. 100% of all such reports will be reviewed as they occur, with a weekly review determining compliance. Reportable events will be made in accordance with regulations. D. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is achieved for three consecutive months.	

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F 609	Continued From page 10 under the "MDS" tab in the EMR was in progress and incomplete. Review of a facility's investigation dated 02/07/25 of R322's incident indicated R77 reported to the Assistant Director of Nurses (ADON) that she was afraid of a female staff member with a hairband and long, black hair. During an interview on 02/10/25 at 2:38 PM, R77 stated that sometimes staff are rude, but she was not afraid of any staff, and she had no concerns about abuse or neglect. During an interview on 02/13/25 at 5:19 PM, the Director of Nurses (DON), was asked about a witness statement dated 02/07/25 written by the ADON regarding R77's statement about being afraid of a staff with long black hair wearing a headband. The DON stated that R77 was confused, and the allegation was not reported to the SSA or investigated. Additionally, the DON stated that the facility was still working on the five-day report and felt that R77's statement would be investigated during the five-day investigation time period. During an interview on 02/13/25 at 6:10 PM, the ADON provided a revised statement from her interview with R77 which indicated the resident was confused, not consistent with her description of staff members or the time of day/shifts that staff worked. The statement indicated, " ...Resident recently changed room to move closer to nursing station for closer observation and stated did not feel safe 'because moved here yesterday'. [sic] Revisited resident later at the day [sic], resident did not recall conversation from earlier, no statements of being unsafe." The	F 609		

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F 609	Continued From page 11 document was initially unsigned and undated. The ADON then provided documentation indicating that her interview with R77 was on 02/07/25 between 4:00 PM and 5:00 PM. The ADON confirmed that she had not reported the allegation to the Abuse Coordinator due to the resident being confused. During an interview on 02/13/25 at 7:00 PM, the Administrator confirmed that R77's allegation of being fearful of a staff member on 02/07/25 had not been reported to her but should have been. The Administrator confirmed that any resident, regardless of cognition status reporting fear of a staff member should always be reported to the Abuse Coordinator/Administrator to be investigated and reported to the SSA.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 610		4/14/25

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F 610	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on interviews, record reviews, and policy review, the facility failed to complete a thorough investigation into an allegation of staff to resident abuse for one of five residents (Resident (R) 77) reviewed for an allegation of abuse out of a total sample of 46 residents. The failure to conduct a thorough investigation had the potential to place other residents at risk for abuse. Findings include: Review of the facility's policy titled, "Reporting of Reasonable Suspicion of a Crime & Alleged Violations" revised 06/15/24 revealed, " ...In response to allegations of abuse ...or mistreatment, the facility will: a. Have evidence that all alleged violations are thoroughly investigated ...c. Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law ...The administrator, Director of Nursing (DON) or Designee will be responsible for obtaining all statements/forms from staff member and will also be responsible for the investigation and documentation of final findings ..." Review of R77's "Admission Record" located in the Electronic Medical Record (EMR) under the "Profile" tab indicated she was admitted to the facility on 01/13/25. Review of R77's Admission "Minimum Data Set (MDS)" assessment under the "MDS" tab in the EMR with an Assessment Reference Date (ARD) of 01/17/25 included a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15 which	F 610	A. 1.) Once identified as an allegation of abuse, the State Survey Agency was notified. 2.) The ADON and DON were re-educated on abuse policies, including reporting and investigating allegations involving cognitively impaired residents. B. 1.) All cognitively impaired residents have the potential to be affected. 2.) A review of all resident interviews conducted over the past 90 days regarding alleged abuse will be completed to determine if any allegations need to be reported to the State Survey Agency. Reports and investigations will be conducted according to regulation. C. 1.) The RCA determined that the investigator failed to recognize the Resident's statement as an allegation of abuse. 2.) The staff developer/designee will re-educate staff across all departments on abuse policies, including reporting allegations involving cognitively impaired residents. 3.) Training on cognitively impaired resident abuse reporting will now be included in new hire orientation and annual mandatory education. 4.) The NHA/designee will audit all residents□ statements within two hours of being taken to determine if an allegation needs to be reported to the State Survey Agency. Additionally, all grievances will be reviewed in daily stand-up to determine if there are trends requiring further education. 100% of all such reports will be reviewed as they occur, with a weekly review determining compliance. Reportable events will be	

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F 610	Continued From page 13 indicated she was moderately cognitively impaired. Review of R322's "Admission Record" located in the EMR under the "Profile" tab indicated she was admitted to the facility on 02/05/25. Review of R322's Admission "MDS" assessment under the "MDS" tab in the EMR was in progress and incomplete. Review of a facility's investigation into R322's allegation of abuse revealed that on 02/07/25, R77 reported to the Assistant Director of Nurses (ADON) that she was afraid of a female staff member with a hairband and long, black hair. During an interview on 02/10/25 at 2:38 PM, R77 stated that sometimes staff are rude, but she was not afraid of any staff, and she had no concerns about abuse or neglect. During an interview on 02/13/25 at 5:19 PM, the DON was asked about R77's statement on 02/07/25 to the ADON related to R77 being afraid of a staff with long black hair wearing a headband. The DON stated that R77 was confused, and the allegation was not reported or investigated. Additionally, the DON stated that the facility was still working on the five-day report regarding the other resident in the facility and felt that R77's statement would be investigated during the five-day investigation time period. During an interview on 02/13/25 at 6:10 PM, the ADON confirmed that she had not investigated the allegation due to the resident being confused. The ADON did not confirm or deny that she should have investigated the allegation.	F 610	made in accordance with regulations. Reports will be made in accordance with regulations. This audit will be in tandem with F609. D. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. Finally, the facility will conduct a monthly audit until 100% compliance is maintained. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is achieved for three consecutive months.	

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F 610	Continued From page 14 During an interview on 02/13/25 at 7:00 PM, the Administrator confirmed that R77's allegation of being fearful of a staff member that she reported to the ADON on 02/07/25 had not been reported to her but should have been. The Administrator confirmed that any resident, regardless of cognition status reporting fear of a staff member should always be reported to her/Abuse Coordinator and that a thorough investigation should have been conducted.	F 610		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to provide treatment to a wound in accordance with the physician's order and revise the care plan to reflect the change of wound treatment for one of six residents reviewed for quality of care (Resident (R) 17) in the sample of 46 residents. The failure created the potential to cause a negative outcome to the healing of R17's wound. Findings include: Review of the "Admission Record" located in R17's electronic medical record (EMR) under the	F 684	A. R17□s treatments are now being administered as ordered. B. 1.) All residents with wound treatment orders have the potential to be affected. 2.) A full-house audit of residents with wound treatments will be conducted to monitor for compliance. Treatments will be completed as needed. C. 1.) The RCA determined that the nurse did not input the order incorrectly in the Treatment Administration Record. 2.) The staff developer/designee will conduct a return demonstration with licensed nurses on how to input treatment orders in PCC.	4/14/25

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F 684	Continued From page 15 "Profile" tab indicated the resident was admitted on 10/07/22 with diagnoses including acquired absence of right and left legs above the knees, peripheral vascular disease, and type 2 diabetes mellitus with diabetic neuropathy. Review of the quarterly "Minimum Data Set (MDS)" located in the "EMR" under the "MDS" tab with an Assessment Reference Date (ARD) of 11/20/24 revealed a "Brief Interview for Mental Status (BIMS)" score of 13 out of 15 which indicated the resident was cognitively intact. During an observation and interview on 02/10/25 at 10:53 AM, R17 stated, "I have this spot on my stump that I think was caused by the table [overbed table] hitting it. Now I think it's infected. It's supposed to be changed every other day." R17 uncovered his left stump which revealed a bandage dated "2/7" with a "B" next to the date. R17 stated "Yeah, they came in on Friday and changed it, but not over the weekend." During an interview on 02/10/25 at 11:02 AM, Licensed Practical Nurse (LPN9) confirmed that the date on the bandage was "2/7" with a "B" next to the date. LPN9 reviewed R17's physician orders and stated, "It should have been changed yesterday, 02/09/25. It's supposed to be changed every other day. It was changed by the wound care team on Friday." Review of the "Physician Orders" located under the "Orders" tab in the "EMR" revealed the following physician orders: 02/07/25, "Clean L [left] AKA [above knee amputation] with NSS [normal saline solution], apply Silvasorb Alginate every other day."	F 684	3.) Now the facility will have licensed nurses do return demonstrations on inputting order entries as part of new hire orientation. 4.) The DON/designee will conduct return demonstrations for five treatments to monitor for compliance. The audit will include five (5) wound treatments over the three (3) separate neighborhoods, prioritizing newest treatments first, weekly. With compliance measured over the four weeks in the month. D. The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. Finally, the facility will conduct a monthly audit until 100% compliance is maintained. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is achieved for three consecutive months.	

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F 684	Continued From page 16 Review of the "Treatment Administration record (TAR)" located in the "EMR" under the "Orders" tab revealed the treatment was provided on 02/07/25 and not on 02/09/25 as ordered. Review of the "Progress Notes," located under the "Clinical" tab in the "EMR" revealed a "scab on his left stump" was identified on 1/28/25. R17 was added to wound rounds. On 01/29/25, the "Nurse Practitioner (NP) assessed the new wound/scab on left stump ... It is inflamed around the scab with scant amount of drainage noted. Wound care team consulted." R17 was seen by the Wound care team on 01/31/25 with new orders for doxycycline with treatment as "bacitracin and dry dressing daily." A "Progress Note" on 02/07/25 indicated, the Wound Care Physician (WCP) changed the treatment to NSS (normal saline solution), Silvasorb Alginate every other day." Review of R17's "Care Plan" dated 12/02/24 located in the "EMR" under the "Care Plan" tab noted, "Potential for further complications from PVD (peripheral vascular disease): has L (left) AKA (above knee amputation) (right) AKA. The approaches did not include the change of treatment dated 02/07/25. During an interview on 02/13/25 at 4:44 PM, both the Director of Nurses (DON) and Assistant Director of Nurses (ADON) confirmed the physician ordered treatment should have been completed on 02/09/25 and that the care plan should have reflected the current treatment intervention.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		4/14/25

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F 686	Continued From page 17 §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 observations, record review and interviews, the facility failed to ensure one (Resident (R) R46) of two residents reviewed for pressure sores in the sample of 46 residents was provided with all planned interventions related to an existing pressure sore. This failure created the potential for the resident to experience further unnecessary skin breakdown. Findings include: Review of R46's undated "Admission Record" dated 02/13/25 in the Electronic Medical Record (EMR) under the "Summary" tab indicated admitted to the facility on 11/23/18 with diagnoses including dementia and type 2 diabetes. Review of R46's significant change "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/13/24 in the EMR under the "MDS" tab revealed a "Brief Interview for Mental	F 686	A.) R46 now has an air mattress. B.) 1.) All residents with air mattress orders have the potential to be affected. 2.) A full whole house audit of residents that have an air-mattress order will be completed to review for compliance. Corrections will be made as needed. C.) 1.) The RCA determined that a change in the Maintenance Director resulted in a lack of access to TELS and he was unable to see the request in the system. 2.) The Maintenance Director now has access to TELS. 3.) TELS access will now be included when hiring a new Maintenance Director. 4.) The NHA/designee will audit all new air mattress orders weekly for compliance. D.) The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is achieved for three consecutive months.	

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F 686	Continued From page 18 Status (BIMS)" score of nine out of 15, which indicated the resident was moderately cognitively impaired. The assessment indicated the resident was at risk for developing pressure ulcers but did not have any current pressure ulcers at the time of the assessment. The assessment indicated a pressure reducing mattress was being used on the resident's bed. Review of R46's "comprehensive physicians orders" dated 02/13/25 in the EMR under the "Orders" tab indicated orders, order dated 02/08/25 that indicated, cleanse left heel wound with normal saline solution. Apply calcium alginate and bordered gauze daily. An order dated 02/08/25, that indicated the resident was to receive the following treatment: cleanse left buttock with normal saline solution, apply zinc, cover with bordered gauze, change daily and as needed. The order did not indicate the application of a low air loss mattress to the resident's bed. Review of R46's "Skin Integrity Care Plan," dated 02/07/25 in the EMR under the "Care Plan" tab revealed the resident had a stage 2 pressure sore to her left buttock and a deep tissue injury to her right heel. The "care plan" indicated the resident was at risk for further skin breakdown and indicated preventative skin measures, including a pressure reducing mattress on the resident's bed, were to be implement as ordered. The care plan did not indicate the application of a low air loss mattress to the resident's bed. Review of R46's "Health Status Note" dated 02/074/25 in the EMR under the "Notes" tab revealed, "Resident seen by [Facility's Wound Care Physician (WCP)] for wound rounds ... Air Mattress order placed in TELLS (the facility's	F 686		

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F 686	Continued From page 19 maintenance request system)." Observations of R46 lying in bed in her room on 02/10/25 at 4:34 PM, on 02/11/25 at 9:01 AM 1:09 PM, 3:10 PM, and 3:46 PM, and on 02/12/25 at 8:30 AM and 9:45 AM revealed no low air loss mattress applied to the resident's bed. R46 was lying on a regular pressure reducing mattress. During an observation of the resident along with Unit Manager (UM1) on 02/12/25 at 1:16 PM, UM1 confirmed a low air loss mattress was not applied to R46's bed. UM1 stated the WCP had ordered a low air loss mattress for the resident during wound rounds conducted the previous week to prevent potential worsening of the resident's wounds and stated she had placed the order for the mattress into the facility's TELS system that day (02/07/25). During an interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 02/13/25 at 4:30 PM, the ADON confirmed the resident's low air loss mattress was expected to have been ordered timely and would typically have been expected to have been placed on the resident's bed on the same day.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		4/14/25

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F 689	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, the facility failed to prevent an injury during incontinence care for two of eight residents (Resident (R) 171 and R170) reviewed for accidents out of a total sample of 46 residents. Specifically, the facility failed to utilize a mechanical lift for assistance out of bed for R170 and failed to properly assist R171 with bed mobility during incontinence care which according to the care plan required the assistance of two staff members. This failure resultedR171 sustaining a laceration to her forehead when she rolled off the bed during incontinence care. Additionally, R170 sustained a skin tear to the abdomen during incontinence care related to improper transfer. Findings include: 1. Review of R171's "Admission Record" located in the Electronic Medical Record (EMR) under the "Resident" tab indicated she was admitted to the facility on 08/28/17 with diagnosis of cerebral infarction. Review of R171's "Care Plan" located in the EMR under the "Care Plan" tab initiated 09/01/20 included two-person assistance with bed mobility and was incontinent of bowel and bladder. Review of R171's quarterly "Minimum Data Set (MDS)" located in the EMR under the "MDS" tab did not include a "Brief Interview for Mental Status (BIMS)" score due to the resident not being able to participate. R171 was noted to have impairment to all extremities and was dependent with all activities of daily living (ADL) including	F 689	A.) 1.) R171 now requires assistance from two staff members for bed mobility. 2.) R170 no longer resides in the facility. B.) 1.) All residents requiring a mechanical lift or assistance from two staff members for bed mobility may be affected. 2.) A facility-wide audit will be conducted to assess residents' bed mobility and transfer needs, ensuring accurate documentation in PCC, EMAR, and TAR. Corrections will be made as necessary. C.) 1.) The RCA determined that transfer status and bed mobility information should be more accessible to staff. 2.) The facility now includes transfer status and bed mobility details in POC, EMAR, and TAR. 3.) The DON/designee will audit all new and updated transfer status orders to monitor for inclusion in POC, EMAR, and TAR, reviewing compliance weekly to determine addition focus of training. Weekly audits will be combined into monthly to determine compliance success. D.) The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. Finally, the facility will conduct a monthly audit until 100% compliance is maintained. The results of the audits will be reviewed in	

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F 689	Continued From page 21 incontinent care and bed mobility. Review of R171's"fall investigation" provided by the facility revealed the resident sustained a fall on 06/06/24 at 9:40 PM while being provided incontinence care by Certified Nursing Assistant (CNA1). The resident was noted to have rolled off the bed and sustained a laceration to the left forehead with active bleeding. R171 was transported to the Emergency Department (ED) for evaluation and treatment. No sutures were required. A computed tomography (CT) scan was performed of the head and was negative. The resident returned to the facility on 06/07/24 with no new orders. The facility investigation confirmed that CNA1 was immediately suspended pending investigation and was terminated on 06/07/24 for failing to follow the resident's plan of care which indicated that two staff were to be present during bed mobility. Review of CNA1's "Witness Statement" dated 06/06/24 and provided by the facility indicated, "I walked into the room with [CNA2], [R171] had a bm [bowel movement] and was very sweaty. [CNA2] left to get a sheet. I continued to clean R171, her feet rolled out of the bed and her head followed. I tried my best to hold her up. She fell, I stepped into the hall and called for CNA2 because she was the only person I seen (sic). When she came to the room I asked her to get [Licensed Practical Nurse (LPN)1]." Review of CNA2's "Witness Statement" dated 06/06/24 and provided by the facility stated, "I [CNA2] was @ [at] the nurse station talking to [LPN1] when [CNA1] called my name to come to room ...when I walked in I saw [R171]on the floor bleeding from the left side of her face. I [CNA2]	F 689	monthly QA&A meetings until 100% compliance is maintained for three consecutive months.	

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F 689	Continued From page 22 immediately called [LPN1]to come fast and that [R171]was on the floor ...." Review of LPN1's "Witness Statement" provided by the facility stated, "This writer was sitting at the desk when [CNA1] rushed out of [R171's room] and asked to call [CNA2] the other aid. Writer did so. [CNA2] went to rm [room] and came out calling for writer. As writer came to rm, [R171] was observed lying down on the floor, face down, bleeding from the side of the left side of the head." During an interview on 02/13/25 at 2:25 PM, LPN1 stated that CNA1 came out of R171's room and called for CNA2 to come to the room to assist her. CNA2 then saw R171 on the floor bleeding from the head and called for LPN1. LPN1 immediately assessed R171, notified her supervisor and called 911 (Emergency Services). R171 was to have two-person assistance with all ADL care due to contractures. R171 went to the ED and returned with a bandage wrapped around her head. LPN1 confirmed that R171 should have had two CNAs providing care to her and she did not know why CNA1 gave care by herself. During an interview on 02/13/25 at 10:18 AM, the Assistant Director of Nurses (ADON) confirmed that R171 was dependent on staff for all ADL care. It was determined that CNA1 didn't follow the protocol for two-person assistance and should have. 2. Review of R170's "Admission Record," dated 02/13/25 in the EMR under the "Admissions" tab, indicated the resident was admitted to the facility on 01/16/24 with diagnoses including schizophrenia, morbid obesity, and congestive	F 689		

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F 689	Continued From page 23 heart failure. Review of R170's significant change "MDS" with an ARD of 08/29/24 in the EMR under the "MDS" tab revealed a "BIMS" score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident did not transfer/move from a sitting to standing position from her bed or any other surface due to her medical condition or safety concerns. The assessment indicated the resident was totally dependent on staff to transfer in and out of her bed to a wheelchair and required extensive assistance from staff to move about in her bed. Review of R170's "comprehensive care plan" dated 09/17/24 in the EMR under the "Care Plan" tab indicated the resident's mobility status as assistance of two staff with use of Hoyer lift for transfers to and from bed and assistance of two staff for movement within bed. The "care plan" indicated the resident was non-ambulatory. Review of R170's "Fall Risk Evaluation" dated 09/24/24 and found under the "Assessment" tab in the EMR, revealed a score of 18, which indicated the resident was at risk for falls. The "assessment" indicated the resident's ambulation/elimination status as bedbound/incontinent. The "assessment" indicated the resident's gait/balance as "Not able to perform function." Review of R170's "Health Status Note" dated 09/25/24 in the EMR under the "Notes" tab revealed, "Resident was lowered to the floor during transfer from her bed, acquired small skin tear to the L [left] lateral abdomen, was assisted back to bed via Hoyer lift and x [time[4 staff	F 689		

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F 689	Continued From page 24 assist, resident recently readmitted to facility and therapy to evaluate and confirm transfer status." Review of the facility's investigation related to R170's 09/25/25 fall revealed R170 was lowered to the floor when she became weak and was unable to stand while Certified Nursing Assistant (CNA6) and CNA7 assisted the resident to stand next to her bed to provide ADL/Peri-care. The "investigation" revealed four unidentified staff members, and the use of a Hoyer lift were required to transfer the resident back to her bed and indicated the resident received a skin tear to her abdomen during the incident. Interview with the Director of Nursing (DON) on 02/13/25 at 4:33 PM, she stated her expectation was the resident's plan of care was to be followed by staff related to any resident care.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;	F 690		4/14/25

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F 690	Continued From page 25 (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to ensure two Residents (R) R28 and R65) out of three residents reviewed for urinary function/catheters had appropriate orders in place related to the use of their indwelling urinary catheters in the sample of 46 residents. This failure created the potential for the residents to go without appropriate catheter related care. Findings include: Review of R65's "Admission Record," dated 02/13/25 in the Electronic Medical Record (EMR) under the "Admissions" tab indicated the resident was admitted to the facility on 03/14/24 with diagnoses included quadriplegia following a spinal cord injury and urinary retention. Review of R65's admission "Minimum Data Set	F 690	A.) 1.) R28 now has routine catheter care orders. 2.) R65 now has routine catheter care orders. B.) 1.) All residents with catheters may be affected. 2.) A facility-wide audit will be conducted to urine catheter to monitor care orders are in place. Orders will be obtained as needed. C.) 1.) The RCA determined that the facility lacked a standardized order set for routine catheter care. 2.) A standardized order set for routine catheter care has been created, and the staff developer will educate licensed nurses accordingly. 3.) The DON/designee will audit all new Foley catheter orders weekly. The audit will monitor that routine catheter care becomes properly documented with a 100% weekly compliance review, when all	

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F 690	Continued From page 26 (MDS) Assessment" with an Assessment Reference Date (ARD) of 11/05/24 and in the EMR under the "MDS" tab, revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident had an indwelling urinary catheter in place in his bladder. Review of R65's "Order Summary Report," dated 02/13/25 in the EMR under the "Orders" tab indicated no orders for the resident's use of his urinary catheter or related to routine care of the catheter. Review of R65's "Medication Administration Record (MAR)" and "Treatment Administration Record (TAR)" dated 02/01/25 through 02/13/25 and found in the EMR under the Orders Tab, indicated nothing to show the provision of routine catheter related care had been provided for the resident during that time period. Review of R65's comprehensive care plan, most recently dated 01/10/25 and found in the EMR under the "Care Plan" Tab, indicated the resident had a suprapubic catheter in place in his bladder and indicated the catheter was to be changed every four weeks at the resident's urology office. During an interview with the Director of Nursing (DON) and the Assistant DON (ADON) on 02/13/25 at 4:27 PM, both stated their expectation was there would be physician's orders for the use and routine care of any resident's indwelling urinary catheter. 2. Review of the "Admission Record" located under the "Profile" tab in the EMR revealed R28	F 690	four (4) weeks are completed with 100% compliance the month will be considered in compliance. D.) The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. Finally, the facility will conduct a monthly audit until 100% compliance is maintained. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is maintained for three consecutive months.	

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F 690	Continued From page 27 was admitted on 10/24/23 with diagnoses acute kidney failure, and neuromuscular dysfunction of bladder. Review of the quarterly "MDS" located under the "MDS" tab in the with an ARD of 01/07/25 revealed a "BIMS" score of 15 out of 15 which indicated R28 was cognitively intact. During an interview on 02/11/25 at 8:44 AM, R28 stated, "They're overdue by a month, at least, for changing my catheter. Probably six weeks." Review of the December 2024, January 2025, and February 2025 "Physician Orders" located under the "Orders" tab in the EMR revealed an order for "Urinary Catheter - 18F30 cc bulb" dated 11/28/24. There were no orders for catheter care. Review of the December 2024, January 2025, and February 2025 "MAR and TAR" revealed no orders for catheter care. During an interview on 02/12/25 at 4:43 PM, the ADON stated, "I'll have to check on the catheter care, why it's not on the orders." During an interview on 02/12/25 at 5:39 PM, the ADON stated, "(R28's) catheter was last changed 11/24 when sent to the hospital for a UTI (urinary tract infection). We (facility) have a policy that it (catheter) is not to be changed every month, only when symptomatic. The orders didn't transfer over from 11/24, I don't know why." 2. Review of the "Admission Record" located under the "Profile" tab in the EMR revealed R28 was admitted on 10/24/23 with diagnoses acute kidney failure, and neuromuscular dysfunction of	F 690		

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F 690	Continued From page 28 bladder. Review of the quarterly "MDS" located under the "MDS" tab in the with an ARD of 01/07/25 revealed a "BIMS" score of 15 out of 15 which indicated R28 was cognitively intact. During an interview on 02/11/25 at 8:44 AM, R28 stated, "They're overdue by a month, at least, for changing my catheter. Probably six weeks." Review of the December 2024, January 2025, and February 2025 "Physician Orders" located under the "Orders" tab in the EMR revealed an order for "Urinary Catheter - 18F30 cc bulb" dated 11/28/24. There were no orders for catheter care. Review of the December 2024, January 2025, and February 2025 "MAR and TAR" revealed no orders for catheter care. During an interview on 02/12/25 at 4:43 PM, the ADON stated, "I'll have to check on the catheter care, why it's not on the orders." During an interview on 02/12/25 at 5:39 PM, the ADON stated, "(R28's) catheter was last changed 11/24 when sent to the hospital for a UTI (urinary tract infection). We (facility) have a policy that it (catheter) is not to be changed every month, only when symptomatic. The orders didn't transfer over from 11/24, I don't know why."	F 690		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If	F 700		4/14/25

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F 700	Continued From page 29 a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on policy review, record review, observation, and interviews, the facility failed to ensure one (Resident (R) R65) out of seven residents reviewed for accidents in the sample of 46 resident was appropriate for the use of side rails on his bed. This failure created the potential for the resident to be injured related to potentially unnecessary side rails installed and in use on his beds. Findings include: Review of the facility's policy titled, "Bed Rails/Grab Rails " dated 05/03/24 indicated, "The facility will attempt to use appropriate alternatives prior to installing a side or bed rail ...The use of side rails will require a physicians order; ...The use of bed rails will be included in the residents'	F 700	A.) R65□s bedrails have been removed. B.) 1.) All residents with bedrails may be affected. 2.) A facility-wide audit will be conducted to review side rail assessments, orders, and devices. Adjustments will be made as needed based on residents□ assessments. Pharmacist consults not required. C.) 1.) The RCA determined that a resident returned from the hospital in an isolation bed equipped with side rails instead of their assigned bed. 2.) The facility will remove side rails from all unoccupied beds and will not place side rails on a resident's bed until a side rail assessment is completed. 3.) The DON/designee will conduct weekly audits of empty beds to monitor that rails are	

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F 700	Continued From page 30 plan of care ...The nursing department will evaluate the resident for the use of bed/side rails upon admission, readmission, quarterly and as needed." Review of R65's "Admission Record," dated 02/13/25 and found in the Electronic Medical Record (EMR) under the "Admissions" tab, indicated the resident was admitted to the facility on 03/14/24 with diagnoses including quadriplegia following a spinal cord injury. Review of R65's admission "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 11/05/24 in the EMR under the "MDS" tab revealed a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated that the resident was totally dependent upon staff to move about in his bed and to transfer in and out of his bed. The assessment did not indicate side rails were in use for R65. Review of R65's "Order Summary Report" dated 02/13/25 in the EMR under the "Orders" tab, indicated no orders for the resident's use of side rails on his bed. Review of R65's "comprehensive care plan", most recently dated 11/06/24 in the EMR under the "Care Plan" tab indicated the resident was quadriplegic and was unable to move any of his extremities independently. The care plan indicated the resident was completely dependent upon staff to complete all of his Activities of Daily Living (ADLs), including moving about in his bed. The care plan revealed nothing to indicate the resident's use of side rails.	F 700	removed from all unoccupied beds. Additionally, all new admissions and readmissions will be audited weekly to monitor that side rail assessments align with the devices used. The weekly audit will be reviewed for compliance with related IDT to assure compliance in empty rooms to determine weekly compliance. Four (4) 100% compliant weeks will signify a compliance successful month. D.) The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. Finally, the facility will conduct a monthly audit until 100% compliance is maintained. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is maintained for three consecutive months.	

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F 700	Continued From page 31	F 700		

Review of R65's "Device/Restraint Assessment and Consent Form" dated 01/29/25 in the EMR under the "Assessment" tab, indicated, "¼ side rails to the resident's bed", however there was nothing on the assessment to indicate the rationale for the use of side rails, what alternatives were attempted prior to the implementation of the side rails, or that risks related to the use of the rails had been addressed with the resident prior to implementation of the side rails.

R65 was observed laying in his bed with ¼ side rails raised on both sides of his bed on 02/10/25 at 3:30 PM, on 02/11/25 at 10:06 AM, 1:15 PM, 3:07 PM, and 3:48 PM, and on 02/12/25 at 8:32 AM, 9:52 AM, and 11:53 AM. R 65 was not able to move anything below his neck independently.

During an interview on 02/12/25 at 11:55 AM, R65 confirmed he was not able to move independently and was not able to use the rails on his bed.

During an observation of R65 along with the Assistant Director of Nursing (ADON) on 02/12/25 at 2:46 PM, the ADON confirmed the resident's side rails were raised on both sides of his bed and confirmed the resident was not able to use the side rails at all due to his quadriplegia. She stated the side rails should not have been on the resident's bed.

During an interview with the Director of Nursing (DON) and the ADON on 02/13/25 at 4:27 PM, both stated their expectation was that side rails were to be used only when necessary and physician's orders, a care plan, and a thorough assessment were required related to the use of

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F 700	Continued From page 32 rails prior to use.	F 700		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure one of six sampled residents (Resident (R) 176) whose medications were reviewed was free from significant medication error in the sample of 46 residents. Specifically, R176 was administered Ativan, an anxiolytic medication, and morphine, a narcotic pain medication, without a physician order for the medications. This medication error had the potential to cause the resident to become over sedated and experience respiratory depression. Findings include: Review of the summary provided by the facility revealed on 07/26/24 at approximately 9:35 PM, Registered Nurse (RN)4 started the medication pass for the hall she was assigned to on the evening shift. She took out medications for a hospice resident including 0.5 milligrams (mg) of Ativan and 15 mg of Morphine and proceeded to the room. RN4 did not check R176's armband or ask her name before administering the medications. After R176 swallowed the medication she realized she had given the medication to the wrong resident. She immediately called the supervisor and Director of Nursing (DON) and reported the medication error.	F 760	A.) 1.) The physician was immediately notified about the medication error and Narcan was administered to R176 without a negative effect. 2.) RN4 was re-educated on the 5 rights of medication administration. B.) All residents have the potential to be affected. C.) 1.) The RCA was determined to be that licensed nurse did not follow the 5 rights of medication administration. 2.) The staff developer/designee will re-educate licensed nurses on the 5 rights of administration and conduct three (3) random med-pass observation, one on each neighborhood, weekly. Four (4) weeks of complaint observations will qualify as a compliant month 3.) The pharmacist consultant will conduct routine medication administration observations, quarterly. D.) The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is maintained for three consecutive months in staff developer / designee audits and two (2) consecutive quarters of pharmacy consultant audit.	4/14/25

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	085034	A. BUILDING _____ B. WING _____	C 02/13/2025

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F 760	Continued From page 33	F 760		

RN4 was instructed to stay with R176 and administer Narcan and take vital signs every ten minutes. R176 did not have any adverse effects from the medication error. RN4 was counseled immediately and completed a medication pass competency. She was then allowed to administer medications.

Review of R176's undated "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab, revealed the resident was admitted to the facility on 07/08/24 with diagnoses which included heart failure, anemia, and chronic obstructive pulmonary disease (COPD).

Review of R176's "Medication Administration Record (MAR)" dated 07/2024revealed R176 did not have orders for Ativan or Morphine.

Review of RN4's personnel file revealed RN4 received counseling on 07/26/24 regarding the medication error. She received education on the five rights of medication administration.

During an interview on 02/12/25 at 4:32 PM the Assistant Director of Nursing (ADON) stated R176 was given the wrong medications and the physician was notified immediately. The ADON stated the physician ordered Narcan which was given, and there were no adverse reactions.

During an interview on 02/13/25 at 1:49 PM, the Director of Nursing (DON) stated RN4 called her immediately after she realized she gave the wrong medication to the wrong resident. The DON stated she went to the facility and counseled RN4. She ensured R176 was not having any adverse effects from the medications.

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F 760	Continued From page 34 Review of the facility's policy titled, "Geriatric Pharmacy LLC, Policy and Procedure Manuel," revised March 2022, revealed, ". . . Prepare the medications for one customer at a time only . . . Confirm the medication and dose are correct . . . Verify each medication preparation to ensure the medication is the right drug at the right dose, the right route at the right time, for the right customer . . . Verify the Medication Administration (MAR) reflects the most recent medication order. Facility staff observe the resident for possible medication-related adverse consequences . . . when the following conditions occur . . . Medication error . . . In the event of a significant medication-related error or adverse consequence, immediate action is taken, as necessary, to protect the resident's safety and welfare. Significant is defined as . . . Life threatening . . . The physician's orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed . . ."	F 760		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		4/14/25

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F 880	Continued From page 35 §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	F 880		

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F 880	Continued From page 36 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to implement an effective infection control program to ensure personal protective equipment (PPE) was used for one resident of one resident (Resident (R) 320) who was on contact isolation, and failed to identify COVID from the weekend to weekday for R80 who was not placed on contact isolation in a timely manner to prevent the potential spread of an infection. Findings include: Review of the facility's policy titled, "Enteral Feeding Medication Administration" dated 05/01/24 and provided by the facility stated, " ...Universal precautions and clean technique will be utilized when stopping, starting, flushing, and giving medications through the feeding tube. PPE [personal protective equipment] will be used as needed ...The personal protective equipment worn will vary by task being performed and likelihood of exposure to body fluid ...Enhanced Barrier Precautions will be used in the facility as extra level of protection for some residents in order to prevent the transmission of MDROs	F 880	A.) 1.) LPN2 was re-educated on the Enhanced Barrier Precautions policy, emphasizing that administering medications through a PEG tube is considered "close contact" and requires a gown. 2.) Licensed nurses are now wearing gowns when administering medications to R320. 3.) Upon identification, R80 was placed on contact precautions for 10 days due to COVID. B.) 1.) All residents with enteral feedings who receive medications have the potential to be affected. 2.) All residents with GI symptoms have the potential to be affected. 3.) A whole-house audit will be conducted to review residents with active COVID symptoms for proper precautions. Precautions will be implemented accordingly. C.) 1.) The RCA determined that the licensed nurse did not recognize enteral feeding as close contact requiring a gown. 2.) The RCA also determined that staff failed to recognize GI symptoms as a possible sign of COVID. 3.) The staff	

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F 880	Continued From page 37 [multidrug resistant organisms] infections. Enhanced barrier precautions will be used when providing direct contact or during high-contact care with certain residents ...Resident with feeding tubes ..." Review of the facility's policy titled, "Enhanced Barrier Precautions Policy" dated 05/01/24 stated, " ...Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs ...Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: ...device care or use: ... feeding tube ..." 1.Review of R320's "Admission Record" located in the EMR under the "Profile" tab indicated an original admission date of 02/09/25 with diagnosis of dysphagia following cerebral infarction. Review of R320's "Baseline Care Plan" located in the EMR under the "Care Plan" and dated 02/11/25 indicated, "NPO (nothing by mouth) intake status and PEG tube (percutaneous endoscopic gastrostomy- a tube inserted through the wall of the abdomen directly into the stomach)." Review of R320's "Order Summary Report" located in the EMR under the "Orders" tab included amlodipine (anti-hypertensive medication) via PEG tube, chewable aspirin (medication used to stop blood clots) via PEG tube, apixaban via PEG tube and metoprolol via PEG tube. Review of R320's Review of R320's "Order	F 880	developer/designee will educate licensed nurses on Enhanced Barrier Precautions, including that enteral medication administration is considered close contact and requires a gown. This training will be incorporated into the new-hire orientation for licensed nurses. 4.) The staff developer/designee will reeducate CNAs and licensed nurses on the signs and symptoms of COVID, including GI symptoms. 5.) The DON/designee will observe one enteral feeding medication pass per week to monitor compliance with Enhanced Barrier Precautions, including the use of gloves, gowns, and proper handwashing techniques. 6.) The DON/designee will conduct daily audits of residents with active GI symptoms to monitor that proper precautions are in place. D.) The facility will conduct daily audits until 100% compliance is achieved for three consecutive weeks. Then, the facility will conduct audits three times a week until 100% compliance is achieved for three consecutive weeks. Next, the facility will conduct audits once a week until 100% compliance is achieved for three consecutive weeks. Finally, the facility will conduct a monthly audit until 100% compliance is maintained. The results of the audits will be reviewed in monthly QA&A meetings until 100% compliance is achieved for three consecutive months.	

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F 880	Continued From page 38 Summary Report" located in the EMR under the "Orders" tab included "Enhanced Barrier Precautions r/t [related to] Peg tube every shift for Enhanced Barrier Precaution, don gloves and gown before high contact resident care. Remove gown and gloves and handwash/sanitize hands, before exiting the room or before providing care to another resident in the room" starting 02/10/25. Review of R320's "Progress Notes" located in the EMR under the "Progress Notes" tab indicated R320 had episodes of emesis and loose stool on 02/11/25. Observation on 02/12/25 at 9:36 AM, R320 had a sign on her door indicating that she was on "Contact Precautions" to include, "cleaning hands before entering the room and when leaving the room, put on gloves before room entry, discard gloves before room exit, and put on gown before room entry. Discard gown before room exit." During an observation and interview on 02/12/25 at 9:36 AM Licensed Practical Nurse (LPN)2 performed hand sanitizing, donned gloves, and a surgical mask, then prepared and administered medications via PEG tube. LPN2 did not don a gown prior to administering medications via R320's PEG tube. LPN2 was asked what the facility's policy regarding what PPE to wear when administering medications via PEG tube. LPN2 said that she only needed to wear a mask and gloves. Review of the signage on the door and the orders in the EMR for "Enhanced Barrier Precautions" LPN2stated that it was her understanding that only the nurse aides needed to wear a gown during "close contact" activities. LPN2 stated that she did not consider PEG tube medication administration a "close contact"	F 880		

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F 880	Continued From page 39 activity. Additionally, LPN2 confirmed that R320 had three loose stools on 02/11/25 during the 3:00 PM -11:00 PM shift along with intermittent emesis. During an interview on 02/12/25 at 1:50 PM, the Director of Nursing (DON) confirmed that it was her expectation for nurses to wear a gown, mask, gloves, and eye protection during PEG tube medication administration. 2. Review of the "Admission Record" found in R80's electronic medical record (EMR) under the "Profile" tab noted the resident was admitted on 10/18/22 with diagnoses that included rheumatoid arthritis, chronic pain syndrome, and idiopathic peripheral autonomic neuropathy. Review of the quarterly "Minimum Data Set (MDS)" located under the "MDS" tab in the "EMR" with an assessment reference date (ARD) of 12/09/24 revealed a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 which indicated R80 was cognitively intact. During an observation and interview on 02/10/25 at 11:17 AM, R80 stated, "I'm not feeling well. I was very sick yesterday. I vomited so many times they had to change my entire bed three times." R80 denied having the flu, norovirus, or COVID. There was no signage on the outside of the resident's room to indicate she was in isolation of any kind or proper trash receptacles in the room if on isolation. During an interview on 02/10/25 at 11:46 AM, the Director of Nurses (DON) and Assistant Director of Nurses (ADON) said they were not informed of R80's vomiting on 02/09/25. The DON stated,	F 880		

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F 880	Continued From page 40 "We need to know what happened, why that was not communicated." During an interview on 02/10/25 at 1:07 PM, Certified Nursing Assistant (CNA5) stated, "They (nurses) knew she was sick. She was sick like seven times. Her whole bed and everything changed so many times. No signs went up until you started asking about it." Review of the "Progress Notes" located in the "EMR" under the "Clinical" tab revealed on 02/08/25, R80 was noted to have received medication for a cough. There was no documentation on 02/09/25 that R80 was vomiting. On 02/10/25, the "Progress Note" identified R80 received medication for "loose stool." Review of the "Clinical Physician Orders" located in the "EMR" under the "Orders" tab, dated 02/10/25, revealed R80 was placed on "contact isolation precaution for 10 days, tested positive for COVID."	F 880		