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: Regal Heights Healthcare & Rehab Center **DATE SURVEY COMPLETED:** February 10, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced complaint survey was conducted at this facility from February 5, 2025, through February 10, 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 was one hundred and sixty-four (164). The investigative sample totaled twenty-eight (28) residents.	-Please Cross reference to the CMS 2567-L Survey completed February 10, 2025: Responses posted on EPOC: CMS f-Tags Listed in the left Column 2025: F658, F689, F695, F697, F842, F908	3/7/2025
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 10, 2025: F658, F689, F695, F697, F842, F908.		

Provider's Signature Sarah Thompson Title Administrator Date 3-5-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

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F 000	INITIAL COMMENTS An unannounced complaint survey was conducted at this facility from February 5, 2025 through February 10, 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 was one hundred and sixty-four (164). The investigative sample totaled twenty-eight (28) residents. Abbreviation/definitions used in this report are as follows: ADLs - activities of daily living; ADON - Assistant Director of Nursing; BIMS - Brief Inventory of Mental Status/assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions). 8-12: Moderately impaired (decisions poor; cues/supervision required). 13-15: Cognitively intact (decisions consistent/reasonable); CAD - Coronary Artery Disease, a condition where the arteries that supply blood to the heart become narrowed or blocked; cm - centimeters; CVA - cerebral vascular accident, stroke; DON - Director of Nursing; Dementia - chronic condition with symptoms including problems with memory, thinking, social; EMR - electronic medical record; EMS - Emergency medical services; EMT - emergency medical technician; ESBL - extended spectrum beta-lactamase, a MDRO bacteria that required Enhanced Barrier	F 000		

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

Electronically Signed | 02/20/2025

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F 000	Continued From page 1 Precautions; Enhanced Barrier Precautions (EBP) - an infection control intervention designed to reduce transmission of multidrug- resistant organisms (MDROs) in nursing homes. EBP involves the use of gowns and gloves during high-contact resident care activities for residents known to be colonized or infected with MDRO as well as for those residents at increased risk of MDRO acquistion; F- Fahrenheit, scale for measuring temperatures; FNE - Forensic Nurse Examiner; Hemiplegia - a neurological condition that causes weakness on one side of the body; HTN - hypertension, a condition where the blood pressure in the arteries is persistently elevated above normal levels; hx - history; L - left; LPN - Licensed Practical Nurse; MDRO - multi-drug resistant organisms; MDS assessment- Minimum Data Set- a federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/medicaid nursing homes that evaluates functional capabilities and health needs; MD - Medical Director; mg - milligrams; NHA - Nursing Home Administrator; NP - Nurse Practitioner; NRS - Numeric Rating Scale Use this tool is used to assess pain intensity for older adults who are able to self-report. 0 = no pain, 1-3 = mild pain, 4-6 = moderate pain, 7-10 = severe pain; 02 - Oxygen; Oxygen Levels - Normal ranges - 94% to 100%; PAINAD Scale - Pain Assessment in Advanced Dementia, behavior tool is used to assess pain in older adults who have dementia or other cognitive	F 000		

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F 000	Continued From page 2 impairment and are unable to reliably communicate their pain; PPE - personal protective equipment; pt - patient; PVD - a condition where the arteries or veins become narrowed or blocked, reducing blood flow to the limbs; R - right; RN - Registered Nurse; R/T - related to; s/s - signs/ symptoms.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (R15, R19, R20) out of seven residents reviewed for falls, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of practice by failing to have a registered nurse (RN) complete and document an RN post- fall assessment . Findings include: "Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024 ... RN (registered nurse) ...post-fall assessment and documentation ...". 1. Review of R15's clinical record revealed: 3/31/18 - R15 was admitted to the facility with diagnoses, including but not limited to, stroke and	F 658	A. Resident R15 and R20 no longer reside at this facility. R19 continues to reside at the facility. The facility is unable to correct this deficient practice, as it is past the time of the occurrence. B. Residents having falls at the facility have the potential to be affected by this same deficient practice. Staff educator or designee will inservice all licensed staff of the necessity of having a Registered nurse do the post fall assessment. C. Root Cause Analysis indicates that the	3/7/25

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F 658	Continued From page 3 difficulty walking. 4/28/24 5:40 AM - E12 (LPN) documented in R15's EMR (electronic medical record), "While standing at the med cart, a loud thump could be heard ...she [R15] could be seen laying on the floor, the supervisor was then called to the room to assess the resident. The resident was assessed and vitals were taken ...". 4/28/24 6:30 AM - E12 (LPN) documented in R15's EMR, "left with EMS (emergency medical services)." Review of R15's EMR progress notes after the 4/28/24 fall lacked evidence of any documentation by a registered nurse (RN) of the State required "post-fall assessment". 2. Review of R19's clinical record revealed: 6/7/24 - R19 was admitted to the facility with diagnoses, including but not limited to, dementia and difficulty walking. 2/3/25 8:08 PM - E13 (LPN) documented in R19's EMR, " ... while doing night medication pass when I heard a loud noise coming from [R19]'s room. Upon arrival resident was noted on the floor close to the doorway with wheelchair behind him. Resident [R19] states 'I was trying to get into my cart (wheelchair) and I fell.' House supervisor notified. Resident assessed for pain and injuries, Vital signs taken ...". Review of R19's EMR progress notes after the 2/3/25 fall lacked evidence of any documentation by a registered nurse (RN) of the State required "post-fall assessment".	F 658	facility failed to meet the Delaware Board of Nursing Scope of practice by not having a registered nurse complete and document an RN post-fall assessment. Facility did not realize that it was not sufficient for the LPN to note that the RN assessed resident, therefore the RN did not write a progress note. DON/Designee will audit residents who have fallen in morning clinical meeting to ensure that post fall evaluations and documentation were performed by a Registered Nurse. D. Administrator/designee will audit residents who have fallen daily to ensure that post fall evaluations and documentation were performed by a registered nurse. Audits will be completed daily for one week until we consistently reach 100% success over the next 3 weeks. Audits will continue three times a week until 100% success over another 3 weeks, and then continue monitoring once a week until 100% success over another 3 weeks. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or	

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F 658	Continued From page 4 3. Review of R20's clinical record revealed: 1/7/25 - R20 was admitted to the facility with diagnoses, including but not limited to, dementia and difficulty walking. 1/20/25 1:27 PM - E3 (LPN) documented in R20's EMR, "Nurse contacted nephew. He was informed that resident had a fall and was taken to the hospital. NP was also made aware that the resident was taken to the hospital." Review of R20's EMR progress notes after the 1/20/25 fall lacked evidence of any documentation by a registered nurse (RN) of the State required "post-fall assessment". 2/10/25 12:03 PM - During an interview, E9 (Corporate Risk Manager) stated, "The facility incident report is not part of the resident's EMR. They are an internal document. They do not appear in the resident's progress notes or chart."' 2/10/25 - 1:30 PM - During an interview, E1 (NHA) confirmed that the facility did not have documentation from an RN regarding R15's 4/28/24 fall, R19's 2/3/25 fall and R20's 1/20/25 fall. 2/10/25 2:23 PM - Findings were reviewed during exit conference with E1 (NHA), E2 (DON), E6 (ADON), E9 (Corporate Risk Manager) and E8 (Corporate IP/SP).	F 658	recommendation. See attached F658 supporting documentation	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		

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F 689	Continued From page 5 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other related documents, it was determined that for one (R10) out of nine residents reviewed for accidents, the facility failed to provide R10 adequate supervision and assistance to prevent burns. This resulted in harm to R10 as he sustained second-degree burns over 15-20 % of his body surface area. This is being brought forward as past non-compliance with an alleged date of compliance of 10/13/24. Findings include: 2/18/19 - R10 was admitted to the facility with diagnoses, including but not limited to, Alzheimer's disease. 3/1/22 - R10's care plan documented, "[R10] has impaired verbal communication R/T (related to) cognitive loss ... Interventions: ... Assess resident's non-verbal behaviors, such as facial expressions, body language, grimacing and increased restlessness ... Face resident when communicating ...". 9/5/24 2:48 PM -E17 (Psych NP) documented in R10's EMR in a Psychiatric Periodic Evaluation note, " ...72 year old male ...[R10] is noted with severe cognitive impairment and non-verbal throughout ... Mental Status Evaluation - Sensorium: alert, Orientation: person, Speech: non-verbal, Affect: dull, ...".	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 6 9/13/24 -R10's MDS revealed a BIMS score of 0, which is reflective of severe cognitive impairment. 10/3/24 5:05 PM - E19 (LPN) documented in R10's EMR in a health status note, "Called to shower room by assigned CNA [E20], same [E20] stated 'after giving resident shower and drying him off, he noticed that resident skin (sic) became very red.' This nurse [E19] noticed redness and skin peeling on resident (sic) face, neck, forehead, chest and upper upper (sic) left shoulder, this writer immediately called supervisor on duty. Resident taken to his room. No s/s (signs/symptoms) of pain noted. Vs (vital signs) obtained 133/57, 78, 97.6, 20, 96%. NP [E16] made aware. New order obtained to send resident to ER (emergency room) for evaluation, apply (sic) cold towels and wash rags to affected area, responsible party wife [F1] made aware. resident left facility @ 5:38 PM via 911 on stretcher." 10/3/24 5:33 PM - In R10's prehospital care report, C2 (EMT) documented, "At 5:33 PM, the patient [R10] was found lying in bed alert, but mental status was unable to be performed due to patient being nonverbal at baseline ... Skin- red with multiple burns. Nurse reported to EMS crew that the patient's skin was red and peeling. Upon further assessment, it was noted that the patient had multiple first-degree burns on his body along with second -degree burns. The first first-degree burns were all over his body to include the chest, abdomen and head. The second-degree burns were again found in multiple areas differentiating in size with some blisters noted both open and closed. The nurse stated that the pt (patient) came out of the shower this way, and that the aid	F 689		

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F 689	Continued From page 7 (sic) took him into the shower to clean him up and when he got out of the shower and back in bed they noted his skin red all over with some areas peeling and blistering. She stated the water must have been to (sic) hot ...The nurse was unable to tell us how this happened other than it happened in the shower when the aid (sic) took him to give a shower, and she was unable to say if he [R10] was left in there unattended or not. As baseline this patient is a full care patient and is unable to care for himself, is nonverbal and unable to follow direct commands at baseline ...Med report was called to [hospital] to request forensic nurse and trauma eval (evaluation) ...". 10/3/24 approx. 5:35 PM - Per the facility's abateman plan, "At approximately 5:35 PM, [E4, Maintenance director] checked the temperature of the hot water. [E4] noted the temperature to be above 120 degrees and attempted an adjustment first and the temperature did not change. [E4] then immediately shut off the hot water to the building." 10/3/24 6:12 PM - C4 (hospital FNE RN) documented on R10's hospital forensic examination, "pt (patient) nonverbal at baseline, unable to provide any details of events. Per wife [F1], pt with hx (history) (sic) dementia, non-ambulatory and totally dependent on facility staff for care. Areas of second degrees burns with blistering notable on exam. Unknown duration of thermal exposure." The hospital FNE nurse documented R10's burns with photographs and written descriptions as follows. DSC_0001 (face picture) was described as "generalized superficial burn to head/face." DSC_0002 (left ear/cheek picture) was described	F 689		

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F 689	Continued From page 8 as "partial thickness burn with area of blisters" and measured a "5 cm X 4 cm area of superficial partial thickness burn to L (left) cheek." DSC_0003 and DSC_0004 (right ear/cheek picture) were described as" 2 cm X 2 cm area of superficial partial thickness burn." DSC_0005 and DSC_0006 (top of head pictures) were described as "area of redness." DSC_0007, DSC_0008, DSC_0009, DSC_0010, DSC_0012, DSC_0018 (left clavicle/chest/neck pictures) were described as "superficial burn generalized to neck, chest and abdomen with sparing noted to skin folds, area of 2 cm X 3 cm partial thickness burn to L chest." DSC_0011 (right inner upper arm picture) was described as "superficial burn." DSC_0013, DSC_0014, DSC_0016, DSC_0019, DSC_0020, DSC_0021 (bilateral shoulders/back pictures) were described as "generalized superficial burn to upper back with 4 cm X 4 Cm area of partial thickness burn to upper L back and 4 cm X 2 cm partial thickness burn to R (right) upper back." DSC_0017 and DSC_0023 (nose pictures) were described as "circular partial thickness burn." DSC_0015, DSC_0022 (right/left ears pictures) were described as "superficial burns behind R ear and L ear." 10/3/24 6:43 PM - In the ED (Emergency Department) Teaching Physician Record, C1 (hospital emergency room physician) documented, "72 year old male arriving per EMS for evaluation of second -degree burns. Patient has a history of CVA (stroke), is bedbound at baseline, nonverbal at baseline, and all his ADLs (activities of daily living) are provided by nursing home staff. Per nursing home, patient was found in the shower with reddened skin to face, chest and shoulders and upper back ...roughly 15 to 20% surface area burns ... However, secondary	F 689		

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F 689	Continued From page 9 burns are very mild in nature and do not suspect he would require transfer to burn center at this time ...". 10/4/24 6:30 AM - E21 (LPN) documented in R10's EMR, "Late entry. Resident [R10] arrived back to facility from hospital at 4:17 AM via stretcher, vital signs WNL (within normal limits) 126/73, O2 98%, HR 101, temp 97.4. Residents (sic) show no nonverbal signs of pain or discomfort, was able to take meds as needed without any issues, no new skin issues outside burns to face and shoulders. Orders to not remove bandage until follow-up with [physician] at the burn center in 1-2 days. Resident is in room resting in bed, with call bell in reach, bed in lowest position." 2/6/25 2:39 PM - During an interview, E19 (LPN) stated, "There were two CNAs who showered [R10]. [E20 (CNA)] was orienting [E22 (CNA)], who was a new hire. They were with him the hole time. I was not in the shower room during the shower. I was called into the shower room to perform a skin check. His [R10] skin was red in the face and even his arm. His chest and shoulder was peeling ... [R10] was in a reclining shower chair with the seat having a hole so the water drained. I think the water was malfunctioning, going hot then cold." 2/7/25 10:38 AM - During a telephone interview, F1 stated, " ... I never said it was intentional ...maybe negligent but not intentional ... My husband is able to move his head back and forth and he does very occasionally moan or groan but you don't know why he is doing it. He would not be able to groan when hot water hit him."	F 689		

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F 689	Continued From page 10 2/7/25 11:25 AM - During a telephone interview, E20 (CNA) stated, " ... It was me and another aide [E22] that I was orienting. She [E22] was there the whole time. I checked the temperature of the water twice once with my gloved hand and then on my bare wrist. The water was fine when we started the shower. We started with his head to wash his hair. He was in a reclining shampoo chair so we could tilt him back and just wash his head first. He uses a special shampoo. So I wet his hair, then I put the shower head the grab bar and the wall spraying the wall, while I lathered up his hair. I washed the shampoo out of his hair. I don't remember if I checked the water temp again before washing the shampoo out. I noticed the redness when I was drying him. So I sent [E22] to get the nurse to do a skin check. Once he was back in bed, [E19 LPN] was busy putting cool towels on him so I left the room." 2/7/25 12:49 PM - During an interview, E4 (Maintenance Director) stated, "We don't know the actual temperature of the hot water when the mixing valve was defective, because the thermometer on the thermostat only goes to 120 degrees. All I can say is it was greater than 120 degrees." E4 also clarified that the temperatures were in degrees Fahrenheit. The facility did the following as a result of this incident: - 10/3/24 at approximately 5:15 PM - E2 (DON) put all showers/baths on hold within the facility. - 10/3/24 at 5:35 PM- E4 (Maintenance Director) checked the hot water temperature and once confirmed it was out of range, E4 shut down the hot water supply in the facility. - 10/3/24 6:00 PM - E4 replaced the problematic mixing valve to the hot water heating system.	F 689		

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(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
F 689	Continued From page 11 - 10/3/24 during 3 - 11 PM shift, E2 (DON) started educating the direct care staff regarding testing the water temperature prior to patient care and the risk factors of the elderly for receiving burns. Education of the entire direct staff continued until 10/13/24, when all staff had been educated. - 10/4 24 at 12:01 PM - E5 (Corporate facilities manager) and [plumbing contractor] technician were on site to check the operation of the facility water mixing valve. No issues were found with the water temperature. The old mixing valve cartridge was examined and found to have sediment stuck in the valve body/spring, which affected its function. This service call lasted 3 hours. -10/4/24 2 PM - A risk management meeting was conducted with the Medical Director regarding this incident. - The facility installed water temperature safety gauges on all shower heads in the facility that notify the resident and the care provider by the color of gauge light whether the water temperature is in a safe temperature range. - Additionally, E1 (NHA) and E4 (maintenance director) monitored the facility's water temperature daily on all units for 2 consecutive weeks, then weekly for 3 weeks and then monthly to confirm 100% compliance with the water temperatures being less than 110 degrees F. - These audit logs were presented at the QAPI steering committee meetings. The date of abatement completion was 10/13/24 at 3:30 PM. The surveyor confirmed these interventions were completed during the survey with review of trainings logs,document review and interview. 2/10/25 2:23 PM - Findings were reviewed during	F 689		

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	085006	A. BUILDING _____ B. WING _____	C 02/10/2025

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F 689	Continued From page 12 exit conference with E1 (NHA), E2 (DON), E6 (ADON), E9 (Corporate Risk Manager) and E8 (Corporate IP/SP).	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of other facility documents as indicated, it was determined that the facility failed to ensure that one (R14) out of one resident was provided respiratory care consistent with physician's orders. Findings include: 6/6/22 - R14 was admitted to the facility with multiple diagnoses, including Chronic Obstructive Pulmonary Disease (COPD), and dysphonia (difficult speech). R14's admission MDS documented R14's speech clarity as being "no speech, absence of spoken words". On 6/7/24 the following progress notes were written: 10:37 AM - E14 (LPN) wrote that at 10:30 AM R14 "wrote a note was complaining of having a	F 695	A. Resident R14 continues to reside at the facility. The facility is unable to correct this deficient practice, as it is past the time of occurrence. R14 has a current PRN nebulizer treatment ordered for shortness of breath and wheezing. B. Residents who have a sudden onset of shortness of breath and who have PRN nebulizer treatment orders have the potential to be affected by this same deficient practice. Staff Educator or Designee will in-service licensed staff to ensure that when a resident is having difficulty breathing that their PRN Nebulizer/inhaler treatment is given to assist the resident in resolution of their breathing difficulties.	3/7/25

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F 695	Continued From page 13 hard time breathing" and that E14 and E15 (RN) assessed ["R14's] oxygen level to be in the low 70's, with an elevated heart rate of 104. We got her to calm down so she could control her breathing which worked her 02 started increasing to low 80's, reached out to NP to obtain a stat chest x-ray and some oxygen." 10:51AM - E14 wrote that R14 "was still having a hard time breathing, after taking a listen to her he (sic) is wheezing and her 02 is still in the 70's ... . She is being sent out to the hospital, due to respiratory distress." 2/6/25 10:15 AM - A review of the Electronic medical record (EMR) for R14's medication orders revealed the following respiratory medications were ordered for R14 on 6/7/22: -Trelegy Ellipta, inhale by mouth daily one time a day for COPD; -albuterol sulfate, 1 puff inhale orally every 6 hours as needed for SOB (shortness of breath). 2/6/25 10:20 AM - A review of R14's EMR June 2024 medication administration record (MAR) revealed that on 6/7/24, the day that R14 experienced respiratory distress, R14 was never administered the as needed for shortness of breath medication abuterol during the time she experienced respiratory distress. The albuterol medication was never administered to R14 prior to the time that she was sent to the hospital emergently for respiratory distress. 2/6/25 2:45 PM - During an interview, E14 confirmed that Albuterol was not administered to R14 during the time that R14 experienced respiratory distress on 6/7/24	F 695	Staff in servicing will include documenting in the progress notes the respiratory assessment that was done, such as confusion, overall appearance of resident, lung sounds, pulse ox, and any cyanotic features. C. Root Cause analysis indicates that when R14 started having difficulty breathing, staff calmed resident down, applied O2 and obtained a chest xray order but failed to follow resident's physician order by not giving resident her prn Inhaler treatment prior to sending resident to the hospital. Nurse E14 noted resident to be in respiratory distress and asked unit manager E15 to assess resident. E14 did not look at residents' medication to see if there was a PRN order was available for use. E15 Assessed resident and acted to what was happening at the moment and did not look to see if there was PRN medication to use. E15 contacted NP after calming resident down and applying oxygen. Nursing did not follow the PRN medication for a first line treatment for SOB. DON/Designee will audit any resident who has difficulty in breathing that the resident was provided respiratory care consistent with physician orders. Any current residents	

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F 695	Continued From page 14 2/10/25 2:23 PM - Findings were reviewed during the exit conference with E1(NHA), E2 (DON), E6 (ADON), E9 (Corporate Risk Manager) and E8 (Corporate IP/SP).	F 695	with a history of respiratory distress or shortness of breath will be ordered nebulizer treatments as a first line treatment for SOB. During morning clinical meeting, IDT will review residents clinical documentation to monitor for any respiratory distress that occurred during the previous day to ensure proper PRN medications were administered as ordered. The IDT will monitor all PRN respiratory medications for effectiveness during the previous day. D. Administrator/designee will audit residents who have had difficulty in breathing to ensure that the resident was provided respiratory care consistent with physician orders. Audits will be completed daily for one week until we consistently reach 100% success over the next 3 weeks. Audits will continue three times a week until 100% success over 3 weeks, and then continue monitoring once a week until 100% success over another 3 weeks. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or	

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F 695	Continued From page 15	F 695	recommendation. see attched F695 supporting documentation	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require 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 interview and record review, it was determined that for one (R12) out of one residents sampled for pain management, the facility failed to monitor the resident's pain to the extent possible in accordance with the comprehensive assessment and care plan, and current professional standards of practice. Findings include: 4/4/22 - R12 admitted to the facility with a diagnosis of dementia. 2/5/25 - a review of R12's care plan dated 4/4/22 reveals that staff should assess for verbal or non-verbal signs and symptoms of pain. A review of R12's Quarterly Minimum Data Set (MDS) dated 5/3/24 revealed a Brief Interview for Mental Status (BIMS)could not be conducted because the resident is rarely/never understood. The same MDS identifies R12's Speech Clarity: Unclear speech - slurred or mumbled words; Ability to express ideas and wants: Rarely/never understood; Ability to Understand others:	F 697	A. R12 no longer resides at the facility. The facility is unable to correct this deficient practice, as itis past the time of occurrence. B. Residents who require a non-verbal assessment of pain have the potential to be affected by this same deficient practice. Staff Educator or Designee will in-service license staff to ensure that when a resident is non-verbal or rarely/never understood that a non-verbal pain assessment needs to be conducted. C. Root Cause Analysis indicates that the nurse conducting the pain assessment used an inappropriate pain scale for a resident who is rarely/never understood. A numerical pain scale was used instead of a non-verbal pain	3/7/25

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F 697	Continued From page 16 Rarely/never understands. 8/29/24 - R12 admitted to hospice. 9/22/24 - At approximately 7:20 PM, nurse aides providing care reported to the charge nurse swelling and bruising to resident's right knee as well as a skin tear. The charge nurse reported this to the nursing supervisor. R12 was administered 650 milligrams of as needed Tylenol. 9/22/24 9:47 PM and 10:41 PM - resident's pain level was assessed utilizing a numerical pain scale and documented as 4/10, moderate pain, even though R12's speech clarity was rated as "Unclear" and her ability to understand others was "Rarely/never understands." A numerical pain scale requires the ability to self-report their pain. 9/23/24 - 7:17 AM Record review revealed R12 "continues (sic) monitoring for a skin tear to left lower leg. Resident is in bed with her eyes closed with no apparent distress at this time." Vital signs recorded: blood pressure 123/74, temperature 97.8, and pulse 69. 9/23/24 11:13 AM - Resident's pain was assessed and rated at 8/10 (severe pain) and 5 milligrams of morphine sulfate was administered orally, even though there is no evidence that a non-verbal assessment of pain was performed. 9/23/24 - An x-ray was obtained at approximately 11:23 AM that revealed a distal femur fracture. Family, hospice, and provider informed, and resident was transferred to a higher level of care.	F 697	scale. The nurse did not fully understand the process for assessing pain for a cognitively impaired resident and therefore did not use the PAINAD scale. All nursing staff has since been educated on use of proper pain scale to use. DON/Designee will audit pain assessments with residents who are non-verbal or rarely/never understood to ensure that a non-verbal pain assessment was used. D. Administrator/designee will audit residents who are non-verbal or rarely/never understood to ensure that a non-verbal pain assessment was used. Audits will be completed daily for one week until we consistently reach 100% success over the next 3 weeks. Audits will continue three times a week until 100% success over 3 weeks, and then continue monitoring once a week until 100% success over another 3 weeks. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. see attached F697 supporting documentation	

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F 697	Continued From page 17 2/7/25 1:45 PM - An interview with E2 (DON) confirmed that when there is an injury of unknown origin, a full assessment must be performed. A full assessment would include a pain assessment utilizing tools appropriate for assessing a resident with severe cognitive deficits who has difficulty understanding and being understood verbally. R12 was care planned for the potential for impaired verbal communication, but the facility failed to utilize a pain monitoring instrument (such as the PAINAD scale, which is a pain measurement tool for people with advanced dementia) that aligned with the communication deficits that were identified in the care plan and the MDS. 2/10/25 2:23 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E6 (ADON), E7 (Corporate Risk Manager) and E8 (Corporate IP/SP).	F 697		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		3/7/25

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F 842	Continued From page 18 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain-	F 842		

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F 842	Continued From page 19 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R1) out of seven residents reviewed for falls, the facility failed to have complete, readily accessible medical records regarding the required post-fall assessment. Findings include: Review of R1's clinical record revealed: 12/10/07 - R1 admitted to facility for CAD (coronary artery disease), HTN (hypertension), PVD (peripheral vascular disease), and right-sided hemiplegia. 10/2/24 - Progress note entered by E11 (RN, charge nurse) at approximately 8:45 PM revealed R1 was found on the floor of his room. He explained to staff that he was removing the footrests from his wheelchair in preparation for going to bed as he does every night. He leaned forward too far and fell out of his chair and onto the floor. R1 has a BIMS of 15 (indicating a resident is cognitively intact), according to his MDS dated July 16, 2024. 10/2/24 8:56 PM - Progress note entered by E11	F 842	A. Resident R1 continues to reside at the facility. The facility is unable to correct this deficient practice, as it is past the time of occurrence. B. Residents having falls at the facility have the potential to be affected by this same deficient practice. Staff educator or designee will in-service all licensed staff of the necessity of having a Registered nurse do the post fall assessment. The post fall assessment by a registered nurse will include documentation for any observed signs or symptoms of pain, swelling, bruising, deformity and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. C. Root Cause Analysis indicates that the facility failed to have complete, readily	

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F 842	Continued From page 20 (RN, charge nurse) states "Resident assessed with small skin tear to right lower leg ...resident denies pain." 2/7/25 - Record review revealed no comprehensive assessment (vital signs, focused assessment, or range of motion) documented in R1's chart. 2/10/25 - Findings were confirmed with E2 (DON). 2/10/25 2:23 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E6 (ADON), E9 (Corporate Risk Manager) and E8 (Corporate IP/SP).	F 842	accessible medical records regarding the required post-fall assessment. Facility failed to have a registered nurse completed and document a RN post assessment. Facility did not realize that it was not sufficient for the LPN to note that the RN assessed resident, therefore the RN did not write a progress note. DON/Designee will audit residents who have fallen in morning clinical meeting to ensure that post fall evaluations and documentation were performed by a Registered Nurse. D. Administrator/designee will audit residents who have fallen daily to ensure that post fall evaluations and documentation were performed by a registered nurse. Audits will be completed daily for one week until we consistently reach 100% success over the next 3 weeks. Audits will continue three times a week until 100% success over 3 weeks, and then continue monitoring once a week until 100% success over another 3 weeks. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for	

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F 842	Continued From page 21	F 842	further evaluation or recommendation. See attached F842 supporting documentation	
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R10) out of twenty-eight residents reviewed for environment, the facility failed to maintain the water supply/patient care equipment was in safe operating condition. Findings include: Facility 's Safety of Water Temperatures policy- "Domestic water in the facility shall be kept within a temperature range of 95-110 degrees to prevent scalding of residents and to maintain temps (temperatures) for infection control and good handwashing practices ... 2. Mixing valves are to be set at 110 degrees to ensure domestic water temperatures are provided to resident rooms, bathroom common area fixtures and shower/tub rooms ... 3. Maintenance staff are responsible for checking thermostats, mixing valves and temperature controls in the facility. 4. Maintenance staff shall conduct daily water temperature checks and record the water temperature in a water temperature log ... 6. Recordings will be taken on each wing or floor, the date, time and location is to be recorded by an employee.7. If at any time water temperature feel excessive to the touch ...staff will report this	F 908	A. Resident R10 continues to reside at the facility. The facility is unable to correct this deficient practice, as it is past the time of occurrence. B. Residents in the facility have potential to be affected by this same deficient practice. Maintenance Director and/or designee will monitor water temperatures daily and document random location samplings on water temp log. Maintenance Director will provide in servicing to maintenance staff taking and documenting daily water temperatures. C. The root cause analysis indicates the mixing valve piston wasn□t able to decrease tempered water by turning the adjustment bolt to lower water temperature. Piston was stuck with isolated foreign matter visible by streak marks inside piston after being removed	3/7/25

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F 908	Continued From page 22 finding to the immediate supervisor, Maintenance director and NHA. 8. If at any time water temperatures are above 110 degrees, water source/fixture will be shut down immediately ... 10. The length of exposure to warm or hot water, the amount of skin exposed, and the resident's current condition affect whether or not exposure to certain temperatures will cause scalding or burns. Therefore, ongoing resident observation and assessment during prolonged exposure to warm or hot water will help to determine the safety of the situation ...12. If a resident is scalded or burned, nursing staff shall follow pertinent first aid and physician notification protocols and report the injury to his or her direct supervisor." Revision date: December 2009 10/4/24 - The appointment summary/ work order (service call ID 241004-0018) from [plumbing/HVAC/R contractor] stated, " Hot water mixing valve- Symmons MN 7-900NW. Checked over operation of mixing valve that contact [E4, Maintenance director] had recently replaced cartridge in after mixing valve had spike in temperature ... Note: At contact's [E4] request, checked old cartridge to determine why it failed, appears sediment had been stuck in valve body/spring." 2/7/25 12:30 PM - During an interview, E1 (NHA) stated the recordings [of water temperatures) on each floor was not being done prior to 10/3/24. 2/7/25 12:49 PM - During an interview, E4 stated that the maintenance team checks the water temperatures daily in the morning. "On October 3, 2024 during the daily water temperature checks, hot water was in the correct range based on area checked. 1. Mixing valve 109 degrees F	F 908	from city water supply. Maintenance Director followed manufacturer Trouble Shooting Chart to resolve the issue immediately. Maintenance Director removed mixing valve cartridge and replaced immediately. Water temperatures returned to normal indicated on service report from plumbing contractor and by evidence from documented water readings. Facility opted to upgrade their technology and installed a digital mixing valve. New mixing valve□s maintenance guide indicates after 30-60 days of normal operation, facility is to check the performance of the valve, if valve operates properly and there is no evidence of deposits, facility is to establish a periodic maintenance schedule to reinspect this valve at intervals of no greater then every 6-12 months. New valve was installed on 11/26/24. First maintenance inspection was on 1/10/25. Inspection found no evidence of inconsistent performance or any deposits on the internal parts. Facility set the inspections for every 3 months. Facility opted to upgrade shower heads	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 908	Continued From page 23 (Fahrenheit), C wing hydration room 105 degrees F, Water heater 152 degrees F, and Pot sink 105 degrees F." E4 also stated that prior to this incident the mixing valve was checked every three months. Of note, R10 was showered in a different wing's shower room, not C wing. Review of the manufacturer's Parts Breakdown (7-9000) manual, page 10 stated "Maintenance-the cartridge unit contains the entire valve control mechanism. For non-interrupted service, keep a spare cartridge on hand. Temp Control Valve control mechanism must be kept clean and free from deposits and any foreign matter build-up that will be present in many water systems ... If inspection determines that your water system causes deposits and foreign matter build-up monthly, then valve should be cleaned monthly ..." The facility was lacked evidence of the monthly mixing valve cartridge inspections prior to 10/3/24. 2/10/25 2:23 PM - Findings were reviewed during exit conference with E1 (NHA), E2 (DON), E6 (ADON), E9 (Corporate Risk Manager) and E8 (Corporate IP/SP).	F 908	with water temperature gauges. Staff educator educated staff on use of temperature gauges. D. Maintenance Director/designee will inspect (valve) to ensure equipment is maintained in a safe operating condition. It was determined after initial inspection that the valve is in safe working order per manufacturer guidelines. Inspections have been set for every 3 months. Inspections will continue every three months indefinitely. Results of the inspections will be brought to the QAPI steering committee for 3 consecutive reviews or as needed for further evaluation or recommendation. see attached F908 supporting documentation	