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

DHSS - DHCQ
261 Chapman Road Suite 200
Newark, DE 19702

STATE SURVEY REPORT

NAME OF FACILITY: Complete Care At Silver Lake LLC **DATE SURVEY COMPLETED:**
January 23, 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: 01/20/25 to 01/23/25 Survey Census: 111 Sample Size: 32	Cross Refer to the CMS 2567-L survey completed January 23, 2025: F000, F552, F600, F609, F623, F625, F660, F689, F742, F804, F812, F880 and F881. The plan of correction for these deficiencies was submitted through the ePOC system on 2/17/25.	3/6/2025
3201	Supplemental Residents: 9		
3201.1.0	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.2	**Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:**		

Provider's Signature Steven F Smith Title Nursing Home Administrator Date 2-17-2025

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085027	A. BUILDING _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SILVER LAKE LLC	1080 SILVER LAKE BLVD DOVER, DE 19904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An Emergency Preparedness 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 to be in substantial compliance with 42 CFR 483.73. Survey Dates: 01/20/25 to 01/23/25 Survey Census: 111 Sample Size: 32 Supplemental Residents: 9	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: 01/20/25 to 01/23/25 Survey Census: 111 Sample Size: 32 Supplemental Residents: 9	F 000		
F 552 SS=D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.	F 552		3/6/25

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

Electronically Signed | 02/17/2025

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 552	Continued From page 1 §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure one of one resident (Resident (R) 113) reviewed for communication out of a total sample of 32 was communicated with in a language the resident could understand. R113 was Spanish speaking only, and the lack of providing communication in the resident's language could potentially cause frustration and possible unmet care needs. Findings include: Review of facility's policy titled, "Communicating with Persons with Limited English Proficiency," dated 03/14/23, revealed "It is the policy of this facility take reasonable steps to ensure that persons with Limited English Proficiency (LEP) have meaningful access and an equal opportunity to participate in our services, activities, programs, and other benefits. The purpose of this policy is to ensure meaningful communication with LEP residents." Review of R113's "Admission Record," located under the "Profile" tab of the electronic medical	F 552	F552 Right to be Informed/Make Treatment Decisions (1) The administrator immediately visited R113 with nursing staff to facilitate a call with the language line. A Spanish speaking interpreter was able to speak with the resident and determine that the resident was not in pain, did not want a snack, and did not voice any immediate needs or concerns. No negative resident outcome has been reported because of the deficient practicc. (2) Current residents with limited English proficiency have the potential to be affected by the deficient practice. DON or designee will perform an audit of all current residents with limited English proficiency to determine if current methods of communication are effective or if additional methods need to be added. After the initial audit to identify any residents who are not proficient in English, DON or designee will ensure that each of these residents are care planned for	

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F 552	Continued From page 2 record (EMR), revealed R72 was admitted on 12/16/24 with diagnoses of unspecified fracture of right femur, repeated falls, and dementia. Review of R113's admission "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab and with an Assessment Reference Date (ARD) of 12/22/24, revealed the resident was unable to complete the interview, was rarely understood, and was severely cognitively impaired. It was recorded that R113 required maximum assistance with mobility and was dependent on toileting and hygiene. Review of R113's "Recreation Comprehensive Assessment," located in the EMR under the "Assessment" tab and dated 12/22/24, revealed, "[Resident name] speaks Spanish. Her answers in Spanish are not always appropriate r/t [related to] cog[nitive] impairment. Prefers tv cartoons and classic Spanish music. [Resident name] may benefit from accommodations for communication." Review of R113's "Progress Notes," located in the EMR under the "Progress Notes" tab, dated 12/18/24, and documented by nursing staff, revealed, ". . . [R113] speaks Spanish. Reason for visit: The resident is being evaluated today for a new admission . . . Staff Spanish to English interpreter utilized during exam . . ." During a continuous observation on 01/21/25 at 9:06 AM until 10:14 AM, R113 was observed sitting in her Geri-chair at the nurses' station, swinging her legs out of her chair, and speaking in Spanish. Throughout the observation, Registered Nurse (RN) 4 was observed three times assisting R113 by placing her legs back into	F 552	communication and have appropriate interventions in place to meet their communication needs. (3) The root cause of the deficient practice is that the language line signs with the phone numbers were not easily accessible by staff. On 1/21/25, immediately after the observation was made that the signs were not easily accessible, new signs with the language line phone number and instructions for contacting an interpreter were made larger, laminated, and placed in visible areas at each nurses□ station. Reeducation on the language line began on 1/22/25. NPE or designee will reeducate nursing, rehab, and social services on the location of the new signs and the procedure for contacting the language line. (4) To ensure that language line services are properly utilized, DON or designee will conduct random audits of residents with limited English proficiency weekly x 4 for one month, then biweekly x 2 for one month, then monthly x 1 for one month or until 100% compliance is achieved. Results of all audits will be presented monthly by administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F 552	Continued From page 3	F 552		

the chair. RN4 only spoke to R113 in English. The Social Services Director (SSD) walked by R113 twice and did not approach the resident, and the Director of Nursing (DON) walked by R113 once and did not approach the resident. Certified Nurse Aide (CNA) 6 approached R113, attempted to adjust R113's legs in her chair, and spoke to her in English.

During an interview on 01/21/25 at 9:06 AM, CNA6 stated staff used the translation line or the resident's family member to speak to R113. She stated there were also staff that spoke Spanish so occasionally they would get them to help. She stated usually R113 just slept and was "never like this [restless and agitated]."

During an interview on 01/21/25 at 9:11 AM, RN8 and RN4 stated R113 had no safety awareness and was a fall risk. They stated the family member encouraged them to call. RN8 stated, "We can use the language line, and we have some staff that speak Spanish."

During an interview on 01/22/25 at 8:52 AM, the DON and the Administrator stated the care plan should have been followed, the language line should have been contacted, and a snack should have been offered to R113. The Administrator stated that he had placed a sign at each nurses' station with the language line number to ensure staff could call when necessary. He stated prior to this it had been difficult to see the numbers. The sign was observed at each station.

During an interview on 01/23/25 at 8:40 AM, the SSD stated that since R113 had a communication barrier, staff would usually contact R113's family member and use the language line. She stated

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F 552	Continued From page 4 she had walked by the resident twice on 01/21/25 and noticed she was agitated. The SSD stated she did not stop because she saw the nurses working with her and she did not want to interrupt what they were doing. She stated she was responsible for developing care plans for resident communication. During an interview on 01/23/25 at 12:21 PM, the DON stated when the SSD walked by staff talking with R113 in English, she should have asked staff what they had done to help R113 and offered her assistance.	F 552		
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 observation, interview, record review, and policy review, the facility failed to ensure two residents (Resident (R) 24 and R82) of 32 sampled residents were free from physical abuse from R90, when R90 punched R24 and R82. The	F 600	F600 Freedom from Abuse and Neglect (1) R24 and R90 had an altercation, and both were immediately separated and placed on 30-minute checks. R90 was	3/6/25

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F 600	Continued From page 5 abuse caused by R90 had the potential to cause harm to all current residents throughout the facility. Findings include: Review of the facility's policy titled, "Abuse, Neglect, Exploitation" Policy and Procedure," dated 09/12/24, revealed, "The facility strictly prohibits abuse, mistreatment, neglect, or exploitation of all resident, or misappropriate of resident property . . . The facility will protect residents from harm during an investigation by: immediately removing the alleged perpetrator from resident care areas . . ." 1. Review of R24's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R24 was admitted on 02/02/21 with diagnoses that included chronic obstructive pulmonary disease and delusional disorders. Review of R24's quarterly "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab and with an Assessment Reference Date (ARD) of 11/20/24, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of nine out of 15, indicating R24 was moderately cognitively impaired. Review of R24's "Progress Note," located under the "Progress Note" tab of the EMR and dated 08/31/24, revealed, ". . . CNA reported to nurse that she observed [R90] punching [R24] in [the] courtyard. [R90] informed writer that he was trying to get [R24] out of his way but does not remember hitting him. [R90] mentioned that [R24] did not hit him. [R90] refused skin assessment.	F 600	also moved to a different hallway to be away from R24. R90 was placed in a private room, and monitored for approximately two weeks, with no further aggression observed. R90 was then moved into a semi-private room with R82. Soon after the room change, R90 and R82 began having interpersonal conflict and R90 had struck R82. After R90 had struck R82, he was immediately removed from the room and sent to Meadow Wood behavioral health. R82 was immediately assessed for injury and sent to the ER. R82 returned to the facility the same day. R82 had received psyche services and social services, including a psychological assessment and trauma informed care assessment. Upon R90□s return, the facility placed R90 in a private room on one-to-one supervision. R90 remains on one-to-one supervision and there have been no further altercations since. (2) Current residents have the potential to be affected by this deficient practice. DON or designee will conduct a review of current residents to identify any behaviors that may trigger an altercation. (3) The root cause of the deficient practice is that the facility failed to have appropriate interventions in place for early signs of frustration, tension, triggers or undesirable behaviors exhibited by R90, R82, and R24. NPE or designee will educate all staff on identifying residents who exhibit frustration, triggers, tension or undesirable behaviors in residents and reporting those observations to nursing	

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F 600	Continued From page 6 Skin tear observed at back of [R24] left hand [bruising around area] and skin tear on right side of forearm. Denies pain. Moves all extremities. No further injury observed. Neurological checks initiated . . ." During an attempted interview on 01/20/25 at 1:00 PM, R24 refused to speak about the incident. 2. Review of R82's "Admission Record," located under the "Profile" tab of the EMR, revealed R82 was initially admitted on 08/18/24 and was readmitted on 12/23/24 with diagnoses that included dehydration and type 2 diabetes. Review of R82's quarterly "MDS," located in the EMR under the "MDS" tab and with an ARD of 12/30/24, revealed the resident had a "BIMS" score of 15 out of 15, indicating R82 was cognitively intact. Review of R82's "Care Plan," located under the "Care Plan" tab in the EMR and dated 01/02/25, revealed, "Resident is/has potential to be verbally aggressive." The goal was "resident will demonstrate effective coping skills through the review date." Interventions included, ". . . Administer medication as ordered, assess and anticipate resident's needs and assess resident's understanding of the situation . . ." Review of R82's "After Visit Summary," dated 09/17/24 and provided by the facility, revealed ". . . [R82] was evaluated in the emergency room . . . Reason for visit: Facial Injury . . . Diagnoses: Orbital contusion, left, initial encounter, Assault, Contusion of lip, initial encounter, conjunctival hemorrhage of left eye . . ."	F 600	leadership. Included in the education will be a focus on specific interventions that nursing and administration can utilize for person-specific behaviors involving early signs of frustration, tension, triggers, or undesirable behaviors. The goal will be to identify early signs that could lead to physical altercations and put interventions in place to prevent resident to resident abuse from occurring. (4) DON or designee will review behavior documentation and ensure proper interventions are in place weekly x 4, biweekly x 1 month, then monthly x 1 month or until 100% compliance is achieved. Results of all audits will be presented monthly by DON or designee for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F 600	Continued From page 7	F 600		

During an interview on 01/20/25 at 1:50 PM, R82 stated he was laying in his bed with the television on. He stated R90 asked him to turn off the television and he said no. R82 stated R90 said he would "come over and turn it off." R82 stated he did not turn it off so R90 came over and threw the overbed table on the bed and then R90 jumped on top of him while he was in bed and started punching him. R82 said R90 then ran out into the hall and started telling staff what he had done.

3. Review of R90's "Admission Record," located under the "Profile" tab of the EMR, revealed R90 was initially admitted on 03/30/23 with diagnoses that included vascular disease and bipolar disorder.

Review of R90's quarterly "MDS," located in the EMR under the "MDS" tab and with an ARD of 01/06/25, revealed the resident had a "BIMS" score of 15 out of 15, indicating R90 was cognitively intact.

Review of R90's "Care Plan," located in the EMR under the "Care Plan" tab and initiated on 08/31/24, revealed, "The resident is/has potential to be physically aggressive r/t (related to) poor impulse control." The goal was for the resident "not to harm self or others through the review date." Interventions included, ". . . administer medications as ordered, give the resident as many choices as possible, psychiatric/psychogeriatric consult as indicated and resident to have 1:1 supervision from 7:00 AM to 11:00 PM . . ."

During an interview on 01/20/25 at 10:30 AM, R90 stated he was depressed and was not sure

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F 600	Continued From page 8	F 600		

why he had someone in his room all the time. R90 was asked about the incidents involving R24 and R82. R90 stated he did not remember any incidents.

During an interview on 01/20/25 at 1:30 PM, Certified Nurse Aide (CNA) 6 stated that she knew R90 had one to one supervision several times since he readmitted to the facility in October. She stated he would be on one-to-one supervision and then off again. CNA6 stated she thought this was his last time and stated, "If he hits anyone else, then he will be discharged."

During an interview on 01/21/25 at 9:17 AM, Registered Nurse (RN) 8 stated R90 was always on one-to-one supervision, and the staff providing the supervision should always be with him. RN8 stated the first incident with R90 was when R90 hit R24 because he was going too slow outside. She stated the one-to-one supervision was from 7:00 AM until 11:00 PM and then he had a motion sensor alarm that was plugged in at the desk.

During an interview on 01/21/25 at 6:55 PM, the Administrator stated that R90 punched R24 on 08/30/24 as they were going outside to the smoking area, and after that, R90 was placed on 30-minute checks and was moved to a private room. He stated there were no incidents so he was moved to a semi-private room with R82 but remained on 30-minute checks. He stated on 09/17/24, R90 punched R82 after they were in an altercation about R82's television. The Administrator stated R82 went to the emergency room and R90 went to a behavioral health hospital. He stated when R90 returned on 09/24/24, he was moved into a private room and was placed on one-to-one supervision.

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F 600	Continued From page 9 During an interview on 01/22/25 at 8:52 AM, the Director of Nursing (DON) and the Administrator stated R90 should always have one-to-one supervision from 7:00 AM until 11:00 PM and then he had a motion sensor alarm from 11:00 PM until 7:00 AM. The Administrator and the DON stated there had been no further incidents.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		3/6/25

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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 609	Continued From page 10 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and facility policy review, the facility failed to report an allegation of abuse within two hours to the state agency for one of seven residents (Resident (R) 71) reviewed for abuse out of 32 sampled residents. This had the potential to affect all the residents in the facility who were at risk of abuse. Findings include: Review of R71's undated "Face Sheet" located under the "Profile" tab in the electronic medical record (EMR) revealed R71 was admitted to the facility on 07/13/22 with the diagnoses of diabetes mellitus, transient ischemic attack (TIA), and major depressive disorder. Review of R71's quarterly "Minimum Data Set (MDS)" located under the "MDS" tab in the EMR with an "Assessment Reference Date (ARD)" of 08/17/24 revealed a "Brief Interview for Mental Status (BIMS)" score of five out of 15 which indicated R71 was severely cognitively impaired. Review of R71's "Care Plan" located under the "Care Plan" tab in the EMR, dated 10/17/22, revealed "The resident has a behavior problem: agitation, cursing, using derogatory language and expressing frustration/anger at others [sic]." The interventions that were in place included "Anticipate and meet the resident's needs. Divert attention by giving resident alternative objects and/or activites [sic]. Familiarize with belongings/surroundings. Listen to and attempt to calm. Psych [psychiatric] eval [evaluation] with [name of psychiatric services]. Remove resident	F 609	F609 Reporting of Alleged Violations (1) Upon discovery, the allegation of emotional abuse was immediately reported to the Division of Healthcare Quality. The alleged perpetrator (nurse) was placed on administrative leave. The nurse who did not report the alleged emotional abuse timely was also placed on administrative leave. The results of the 5-day investigation showed that the allegation of emotional abuse was unable to be validated. Both staff members were cleared to return to work with education on abuse recognition and reporting. No negative resident outcome has been reported because of the deficient practice. (2) Current residents have the potential to be affected by the deficient practice. The administrator or designee will conduct a review of all grievances over the past 60 days to determine if any possible abuse allegations were reported timely. (3) The root cause of the deficient practice is the need for reeducation on abuse recognition and reporting. The nurse practice educator (NPE) or designee will reeducate all staff on recognizing and reporting abuse. A competency audit tool will be developed that assesses staff knowledge and understanding of recognizing and reporting abuse.	

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	085027	A. BUILDING _____ B. WING _____	C 01/23/2025

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F 609	Continued From page 11 from environment. UA CNS [urinalysis culture and sensitivity]." R71 was also care planned for "false accusations toward staff i.e. stating staff is providing care." Review of R71's "Nursing Progress Note" located under the "Progress Note" tab in the EMR, revealed a noted dated 09/12/24 at 9:10 PM which stated, "Monitor behaviors r/t [related to] agitation, cursing, using derogatory language and expressing frustration/anger at others. Every shift [sic] Was a behavior observed? Yes [sic] Resident was disrespectful to nurse using derogatory language when administering medication. Resident states he will not take any medications until he speaks to the doctor. And asked us to get out of his room with CNA [Certified Nursing Assistant] as witness." During a phone interview on 01/23/25 at 10:14 AM, Registered Nurse (RN) 5 stated, "I went into the room because his [R71] call light was on. He [R71] was requesting shoulder rub to his shoulder and that was when he [R71] told me the nurse came in to give me my medicines and he [R71] refused it. Then the nurse gave him the middle finger. There was an aide in the room with the nurse so with the past behaviors I didn't think this was abuse. I talked to the nurse and the aide about it. The nurse said she didn't do that, and the aide said the same thing to me." RN5 was asked who she reported this to, and RN5 stated, "I didn't until the DON [Director of Nursing] asked me about it and I told her [DON] what I knew." RN5 was asked if there was a report of abuse whether it be any kind of abuse, what was the reporting time frame for her [RN5] to report. RN5 stated, "I would report this immediately to my supervisor. But in this situation of the resident	F 609	(4) Administrator or designee will conduct random competency audits on a minimum of ten staff by quizzing staff and evaluating their answers to ensure they are competent in abuse recognition and reporting requirements. These audits will be conducted weekly x 4 for one month, biweekly x 1 for one month, then monthly x 1 for one month or until 100% compliance is achieved. Results of all audits will be presented by the administrator or designee monthly for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F 609	Continued From page 12	F 609		

cursing and refusing his meds in the past, I didn't think it was abuse and I didn't report it."

During an interview on 01/23/25 at 11:57 AM, the DON stated, "[R71] reported to the day shift nurse [Licensed Practical Nurse (LPN) 1] on 09/13/24, the nurse the night before had given him the middle finger after he had refused to take his medications. During the investigation of this allegation, it was discovered that [RN5] was told by [R71] of this incident occurring on 09/12/24 after the incident occurred with the night nurse giving him [R71] the middle finger." The DON began reviewing the statement from RN5 and stated, "[RN5] talked with the resident, the night nurse and the CNA because the night nurse had taken the CNA into the resident's room with her. They both reported that the night nurse left the resident's room with one cup of pills in one hand and a cup of water in the other hand. The night nurse and the CNA confirmed [R71] was being verbally abusive towards them telling them to get out." The DON was asked when staff should report any kinds of alleged abuse. The DON stated, "They are to report this to me immediately and then we have two hours to report it to state."

During an interview on 01/23/25 at 6:10 PM, the Administrator stated, "We have drilled down to our managers and staff, they are to report any allegation of abuse immediately even if there is a witness, no matter if there is a history of the residents or what they do. So, we can report this to the state within two hours."

Review of the facility's policy titled, "Abuse, Neglect, Exploitation," dated 09/14/24, revealed "Notify the appropriate agencies ... In the case of abuse or serious bodily injury, no later than 2 [sic]

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F 609	Continued From page 13 hours after discovery or forming the suspicion ..."	F 609		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;	F 623		3/6/25

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F 623	Continued From page 14 (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 623		

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F 623	Continued From page 15 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide written notification of a hospital transfer to the resident and responsible party (RP) for one of five residents (Resident (R) 62) reviewed for hospitalization of 32 sample residents. The failure had the potential to affect the residents and/or their representatives concerning the reason for the transfer and the resident's appeal rights. Findings include: Review of the facility's policy titled, "Transfer or Discharge Notice," updated 01/19 and provided by the facility, revealed "3. The resident and/or representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge..."	F 623	F623 Notice Requirements Before Transfer/Discharge Before her transfer to the hospital on 9/9/24, nursing staff reviewed the transfer paperwork with R62 and R62 signed the bed hold notice form, which was attached to the transfer packet. This paperwork was then given to EMS to give to the hospital so that the hospital could give the copies of the transfer paperwork to the resident. R62 stated she never received a copy of the transfer or bed hold notice paperwork. R62 has since been provided with a copy of the transfer/bed hold notice paperwork. There has been no reported negative resident outcome because of this deficient practice.	

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F 623	Continued From page 16 Review of R62's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 12/30/24 located in the "MDS" tab of the electronic medical record (EMR), revealed an admission date of 06/23/23 and a "Brief Interview for Mental Status (BIMS)" score of 14 out of 15 which indicated R62's cognition was intact, and had diagnoses of diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. Review of R62's General note, dated 09/09/24 and located in the EMR under the "Progress Note" tab, revealed "Resident sent to [name] hospital. Report called to [name] by [company] nurse per her request. Resident transported via stretcher with EMS [emergency medical services]. Resident was sent with cell phone, tablet, art book, colored pencils, headphones, wallet. Bed hold notice signed and sent with patient. Left message with emergency contact. Awaiting return call." Review of R62's "Medication Administration Note," dated 09/10/24 and located in the EMR under the "Progress Note" tab, revealed R62 was "hospitalized." Review of R62's "Transfer Form," dated 09/09/24 and located in the EMR under the "Assessment" tab, revealed the reason for the transfer was due to a "low K [potassium] 2.1" and R62's [family member] was telephoned about the transfer to the hospital and the reason for the transfer." Nothing was documented that written notice was provided to R62 and/or R62's family member. Review of R62's "Notice of Hospital Transfer,"	F 623	Current residents who have had a hospital transfer have potential to be affected by this deficient practice. DON or designee will review all hospital transfers for current residents over the past 60 days to determine if the transfer notice was documented to be provided. Residents who lack documentation to show the transfer notice as being provided will receive a copy of the transfer notice. The root cause of this deficient practice is that a copy of the transfer paperwork was neither given directly to R62, nor sent to her responsible party. The NPE or designee will educate licensed nursing staff on the transfer or discharge notice policy with an emphasis on providing a copy of the discharge notice to the resident and responsible party. Administrator or designee will conduct random audits of hospital transfers to ensure that the resident and/or responsible party was provided a copy of the discharge transfer notice. The cadence of the random audits will be weekly x 4 for one month, biweekly x 2 for one month, then monthly x 1 for one month or until 100% compliance is achieved. Results of all audits will be presented by the administrator or designee monthly for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F 623	Continued From page 17	F 623		

dated 09/09/24 and provided by the facility, revealed "A copy of this notice is being provided to the following persons and organizations: 1. You and/or your representative, guardian, or any other individual known to have acted as your agent and/or representative, 2. Notice to your local Ombudsman ...Please ask your nurse to notify me if you do not agree with your discharge so that I can meet with you to discuss your options. I want to ensure that you are comfortable with your discharge plan and ensure that complete [facility name] provides you with your options for continued care if needed." There was no documentation indicating the form was provided to R62.

During an interview on 01/22/25 at 9:39 AM, R62 was asked if she had gone to the hospital. R62 stated, "Yes, several times, last time was few months ago." R62 was asked if she had been given any papers for her transfer to the hospital for her recent hospitalization. R62 stated, "No" she had not been given a transfer paper.

During an interview on 01/22/25 at 10:06 AM, the Assistant Director of Nursing (ADON) was asked if R62 received a written transfer notice when R62 was transferred to the hospital on 09/09/24. The ADON stated R62 was not provided with a paper copy of the transfer notice.

During an interview on 01/22/25 at 10:23 AM, the Director of Nursing (DON) provided a hard copy of the transfer notice when R62 was sent to the hospital. The DON stated the notice was placed in the transfer packet that was given to EMS to give to the hospital. The hospital then should have given the copy of the notice to R62. The DON could not verify that a written copy of the

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F 623	Continued From page 18 notice was provided to R62. The DON confirmed R62 was her own representative.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to provide written notification of the bed hold policy to the resident	F 625	F625 Notice of Bed-Hold Policy and Return	3/6/25

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F 625	Continued From page 19 and responsible party (RP) for one of five residents (Resident (R62) reviewed for hospitalization of 32 sample residents. The failure had the potential to affect the residents planning on returning to the facility. Findings include: Review of the facility's policy titled, "Bed-Hold and Returns," updated 10/19, revealed "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." Review of R62's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 12/30/24, located in the "MDS" tab of the electronic medical record (EMR), revealed an admission date of 06/23/23 and a "Brief Interview for Mental Status (BIMS)" of 14 out of 15, indicating R62's cognition was intact, and had diagnoses of diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. Review of R62's General note, dated 09/09/24 and located in the EMR under the "Progress Note" tab, revealed "Resident sent to [name] hospital. Report called to [name] by [company] nurse per her request. Resident transported via stretcher with EMS [emergency medical services]. Resident was sent with cell phone, tablet, art book, colored pencils, headphones, wallet. Bed hold notice signed and sent with patient. Left message with emergency contact. Awaiting return call." Review of R62's "Medication Administration Note," dated 09/10/24 and located in the EMR under the "Progress Note" tab, revealed R62 was	F 625	(1) Before her transfer to the hospital on 9/9/24, nursing staff reviewed the transfer paperwork with R62 and R62 signed the bed hold notice form, which was attached to the transfer packet. This paperwork was then given to EMS to give to the hospital so that the hospital could give the copies of the transfer/bed hold paperwork to the resident. R62 stated she never received a copy of the transfer or bed hold notice paperwork. R62 has since been provided with a copy of the transfer/bed hold notice paperwork. There has been no reported negative resident outcome because of this deficient practice. (2) Current residents who have had a hospital transfer have potential to be affected by this deficient practice. DON or designee will review all hospital transfers for current residents over the past 60 days to determine if the bed hold notice was documented to be provided. Residents who lack documentation to show the bed hold notice as being provided will receive a copy of the bed hold notice. (3) The root cause of this deficient practice is that a copy of the transfer / bed hold paperwork was neither given directly to R62, nor sent to the party responsible. The NPE or designee will educate licensed nursing staff on the bed hold notice policy with an emphasis on providing a copy of the discharge and bed hold notice to the resident and responsible party. (4) The administrator or designee will	

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F 625	Continued From page 20 "hospitalized." Review of R62's "Bed Hold Notice," dated 09/09/24 and provided by the facility, revealed "The notice is presented to you because of the following: Admission to the hospital. The notice fulfils requirements to remind you of this facility's bed hold policy (see attached). Please read carefully and indicate whether or not you wish to reserve your room." The notice was signed by R62 but did not indicate the form was provided to R62. During an interview on 01/22/25 at 9:39 AM, R62 was asked if she had gone to the hospital. R62 stated, "Yes, several times, last time was few months ago." R62 was asked if she had been given any papers for a bed hold for her recent hospitalization. R62 stated, "No" she had not been given a bed hold paper. During an interview on 01/22/25 at 10:06 AM, the Assistant Director of Nursing (ADON) was asked if R62 received a written bed hold notice when R62 was transferred to the hospital on 09/09/24. The ADON stated R62 was provided with a paper copy of the bed hold which was uploaded in the EMR. The ADON then reviewed the EMR, and no bed hold notice was found. During an interview on 01/22/25 at 10:23 AM, the Director of Nursing (DON) provided a hard copy of the bed hold with R62's signature, dated 09/09/24, when R62 was sent to the hospital. The DON stated the notice was placed in the transfer packet that was given to the EMS to give to the hospital. The hospital then should have given the copy of the notice to R62. The DON could not verify that a written copy of the notice was	F 625	conduct random audits of hospital transfers to ensure that the resident and/or responsible party was provided a copy of the bed hold notice. The cadence of the random audits will be weekly x 4 for one month, biweekly x 2 for one month, then monthly x 1 for one month or until 100% compliance is achieved. Results of all audits will be presented by the administrator or designee monthly for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F 625	Continued From page 21 provided to R62. The DON confirmed R62 was her own representative.	F 625		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked	F 660		3/6/25

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F 660	Continued From page 22 about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.	F 660		

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F 660	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to develop and implement an effective discharge care plan for two of two residents (Resident (R) 46 and R82) reviewed for discharge planning out of a total sample of 32. Specifically, the facility failed to have an individualized discharge care plan in place. This failure had the potential to cause confusion and unmet care needs. Findings include: Review of the facility's undated policy titled, "Care Plans, Comprehensive Person-Centered," revealed, "the Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident." 1. Review of R46's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R46 was admitted on 06/28/24 with diagnoses that included type two diabetes and an acquired absence of right leg below the knee. It was recorded R46 required setup assistance with eating and oral hygiene and was dependent on staff for all other activities of daily living (ADLs). Review of R46's "Care Plan," located under the "Care Plan" tab in the EMR and dated 01/07/25, revealed there was no discharge care plan for the resident. During an interview on 01/20/25 at 3:28 PM, R46 stated she had attended a care conference, but	F 660	F660 Discharge Planning Process (1) Upon identification of this deficient practice, discharge care plans were established for both residents. R82 has since been discharged from the facility. (2) Current residents have the potential to be affected by this deficient practice. An initial audit will be conducted by the administrator or designee to determine that each resident who has an anticipated discharge and/or desires to discharge from the facility has a discharge care plan in place. (3) The root cause of this deficient practice is that Social Services staff did not input discharge care plans in the patients□ electronic medical record. Administrator or designee will educate social services staff on the discharge planning process policy with an emphasis on ensuring that residents who have an anticipated discharge and/or desire to discharge from the facility have a discharge care plan in place. (4) To ensure continued success, the administrator or designee will conduct random audits of new admissions with anticipated discharge and/or desire to discharge from the facility to ensure they have discharge care plans in place. The cadence of these audits will occur weekly x 1 for one month, biweekly x 2 for one month, and monthly x 1 for one month.	

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F 660	Continued From page 24 she did not feel like she knew what was going on. She stated she was worried that once she received her prosthetic leg, she would not know what to do and who would be helping her. During an interview on 01/23/25 at 8:40 AM, the Social Services Director (SSD) stated upon admission that she had talked to R46 about her discharge plan but had not included that information in R46's EMR. She stated she did not know she needed to have a discharge care plan in place. She stated she would "definitely try to help her [R46]." 2. Review of R82's "Admission Record," located under the "Profile" tab of the EMR, revealed R82 was initially admitted on 08/18/24 and was readmitted on 12/23/24 with diagnoses that included dehydration and type two diabetes. Review of R82's quarterly "MDS," located under the "MDS" tab in the EMR and with an ARD of 12/30/24, revealed the resident had a "BIMS" score of 15 out of 15, which indicated R82 was cognitively intact. It was recorded that R82 required moderate assistance with all ADLs. Review of R82's "Care Plan," located under the "Care Plan" tab in the EMR and dated 01/07/25, revealed there was no discharge care plan for the resident. During an interview on 01/20/25 at 1:50 PM, R82 stated he wanted to discharge from the facility and possibly go to an Assisted Living Facility, but he needed help to do that. He stated he had a stroke and was unable to take care of himself. He stated the social worker had not been much help as far as discharge planning.	F 660	Results of all audits will be presented by the administrator or designee monthly for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F 660	Continued From page 25 During an interview on 01/23/25 at 8:40 AM, the SSD stated she had just started working with R82, and he had shared a lot of information with her on 01/21/25 about his concerns related to his discharge from the facility. She stated she did not know she needed to have a discharge care plan in place. During an interview on 01/23/25 at 12:21 PM, the Director of Nursing (DON) stated the SSD should be involved in discharge planning and creating a discharge care plan for R46 and R82.	F 660		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to provide supervision to prevent residents from sustaining injuries from falls and/or a burn from hot water for three (Residents (R) 40, R96, and R38) of eight sampled residents reviewed for accidents out of a total sample of 32. R40 was assessed to require two staff members for bed mobility; however, the resident was repositioned by one staff member and slid out of bed, which resulted in actual harm of bilateral femur fractures. R96 suffered actual harm of second	F 689	F689 Free of Accident Hazards/Supervision/Devices (1) The facility had completed staff training, and performance improvement plans were initiated and completed, sufficient to show past noncompliance for the accidents involving R40 and R96. The bedside table for R38 was removed from the room immediately and foam protectors were placed on the perimeter of the bedside table for safety.	3/6/25

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F 689	Continued From page 26 degree burns when water, which had been heated in the microwave for three to four minutes, spilled on her. R38 suffered a fractured femur, and facility staff failed to implement identified interventions to prevent further falls and injury The deficient practices caused residents to experience a decrease in quality of life and quality of care problems. Findings include: Review of the facility's policy titled, "Incidents and Accidents," updated 03/14/23, revealed, "It is the policy of this facility for staff to utilize [electronic medical record program] Risk Management Portal to report, investigate, and review any accidents or incidents that occur or allegedly occur, on facility property and may involve or allegedly involve a resident . . . Assuring that appropriate and immediate interventions are implemented and corrective actions are taken to prevent recurrences and improve the management of resident care . . ." A Fall policy and/or program addressing prevention and intervention was requested and not provided. Review of the facility's policy titled, "Microwave Safety," updated 03/29/22, revealed, "To allow resident food and/or beverages to be reheated via microwave while remaining safe within the facility . . . Heat food/ beverages in 30 second increments until appropriate temperature is reached. 145 degrees F [Fahrenheit] 5. Stir food items during microwave heating to ensure even heat distribution. 6. Use a sanitized thermometer (using a sanitizer wipe safe for food service) to check for safe temperatures prior to service . . .	F 689	(2) Current residents with fall mat interventions have the potential to be affected by the deficient practice. The facility will conduct an initial audit on current residents to ensure that there are no obstructions resulting in the fall mat intervention being ineffective. (3) The facility determined that current staff need reeducation on proper placement and function of fall mats, with an emphasis that no objects are to be placed on top of the fall mats so that the fall mats are clear of obstruction. NPE or designee will provide reeducation for current staff on the proper placement and function of fall mats with an emphasis on ensuring the fall mats are unobstructed. (4) DON or designee will conduct random audits ensuring that fall mats are clear of obstruction weekly x 1 for one month, biweekly x 2 for one month, and monthly x 1 for one month. Results of all audits will be presented by DON or designee monthly for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F 689	Continued From page 27 10. Supervise/assist resident at risks for burns or who need help to eat (as their care plan directs) to maintain their safety and dignity." 1. Review of R40's undated "Face Sheet," located under the "Profile" tab in the electronic medical record (EMR), revealed R40 was readmitted to the facility on 09/18/24 with diagnoses of pneumonitis due to inhalation of food and vomit, metabolic encephalopathy, and muscle wasting and atrophy of multiple sites. Review of R40's "Lift, Transfer, Reposition" assessment, dated 09/18/24 and located under the "Assessment" tab in the EMR, revealed R40 required two staff for repositioning in bed. Review of R40's annual "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab and with an "Assessment Reference Date (ARD)" of 09/21/24, revealed R40 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated the resident was cognitively intact. R40 was also coded as being dependent on staff in bed mobility. Review of R40's "Care Plan," located under the "Care Plan" tab in the EMR and dated 09/19/24 revealed, "The resident uses side rails to maximize independence with turning and repositioning in bed." Review of the facility's self-reported incident, dated 10/04/24 and provided by the facility, revealed R40 fell out of her bed when being turned by Certified Nursing Assistant (CNA)3 during incontinence care. The report read, ". . . Resident had a witnessed fall this morning 10-04-24 at 7:00 am. Resident was being	F 689		

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provided incontinence care and while rolled on her side residents legs started to slide off the bed. Resident then completely slid from the bed and landed on the floor on her right side. Resident denies hitting head, witness to fall also states resident did not hit her head. Resident was assessed by the nurse and had no complaints of pain and no injuries were noted. This afternoon 10.04.24 [sic] at approximately 1300 resident had a syncopal episode and was complaining of shortness of breath. Residents pulse ox [oximetry] was noted to be 87% on room air. Resident was placed on 02 at 2 liters via [by] nasal cannula and pulse ox increased to 95% Resident was also noted with and elevated pulse. Resident was assessed by NP and order [sic] was given to send to the ER for further evaluation . . ."

Review of R40's hospital "CT Scan of Lower Extremity Bilateral" results, dated 10/04/24 and provided by the facility, revealed, ". . . Comminated fracture with impaction distal right femoral metaphysis...Comminated fracture with impaction distal left femoral metaphysis . . ."

During an interview on 01/21/25 at 9:30 AM, R40 stated she had fallen in October when a CNA rolled her over to the right side with the CNA standing behind her. R40 stated she was able to catch ahold of the bed railing to hold herself over to help staff. R40 stated she told the CNA that she was falling, and the CNA attempted to grab her leg, but she started falling and fell out of the bed that was in the high position. The resident stated the CNA was tall so she put the bed up high and then that was the height that she fell from. She reported that she had fractures of both legs, but the right leg fracture was worse than the

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left leg fracture.

A phone interview was attempted with CNA3 on 01/22/25 at 1:52 PM and again on 01/23/25 at 10:07 AM. Voice messages were left each time with a call back number for CNA3 to call. No return phone call was received.

During an interview on 01/23/25 at 11:46 AM, the Director of Nursing (DON) stated, "[name of CNA2] was [R40's] CNA when this incident occurred. The resident [R40] had been turned to her side with [CNA3] providing peri care while the resident was holding onto the side rail. [R40's] legs began to slide off the bed and the aide attempted to get the resident not to fall. [CNA3] should have rolled [R40] towards her [CNA3] instead of away from her [CNA3]." The DON was asked how many staff members were required for repositioning R40 in bed as care planned. The DON stated, "Two." The DON was asked how many staff members were assisting R40 in turning when this fall occurred and the DON stated, "Only one, [CNA3]." The DON continued, "We put [CNA3] on leave and before she took an assignment to return to work, [CNA3] was provided education on turning, repositioning and lifting of residents and of the door magnets. The door magnets will have, for example, TA2 XL which stands for total assistance of 2 staff members with XL standing for the size of the lift pad or sling to be used when using a lift for the resident. We even included this training for all staff."

During an interview on 01/23/25 at 2:00 PM, the Administrator confirmed this incident was taken to QAPI (Quality Assurance Performance and Improvement), and a QAPP (Quality Assurance

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Performance Plan) dated 10/04/24 had been developed. Review of this plan revealed monitoring and compliance of this plan would be achieved by "Performing random spot checks to observe staff compliance with care plans. Create a tracking log for high-risk residents to ensure plans are followed consistently. Assign the nurse manager or charge nurse to review adherence to the care plans weekly . . . Monitoring and follow up: Ongoing, with first evaluation at 30 days post implementation." Verification of this process was reviewed on 01/23/25 at 5:00 PM, and it was noted the facility had completed all training and implemented the door magnets on 10/06/24. The facility had completed the QAPI plan as outlined to this date.

This was determined be past non-compliace with a verified compliance date of 10/6/24.

2. Review of R96's annual "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) date of 12/22/24 and located in the "MDS" tab of the electronic medical record (EMR), revealed an admission date of 12/16/23 and a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, indicating R96's cognition was intact. It was recorded R96 had diagnoses of chronic pain, anxiety, and multiple sclerosis.

Review of R96's investigation report, dated 10/05/24 and provided by the facility, revealed, "[R96] is a resident at [facility name] who is alert and oriented x 2-3 with a BIMS of 15. At approximately 3:55pm, the resident asked a Certified Nurse Assistant [(CNA)4] [name] to heat up her hot water. The staff member stated he heated up the hot water for approximately three minutes and brought it to the resident. While

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helping the resident, he accidentally spilled hot water on her. Nursing immediately responded to this and provided first aid cooling treatment to her hand/wrist. Then nursing removed clothing and performed a whole-body skin assessment. Several reddened areas were identified: the dorsal side of left hand and wrist, left upper thigh, middle of abdomen, and side of left breast. First-aid cooling compresses were immediately applied to the affected areas. The nurse practitioner was contacted and an order for Silvadene was placed. Nursing is administering cooling compresses frequently on the areas as well as providing pain medication as needed, and the resident has stated that this has been effective for pain. Responsible party notified. Currently, the resident is calm and in good spirits. The facility is investigating this incident. We are providing re-education for staff on safe heating procedures."

Review of R96's 10/05/24 "Summary for Providers" note located in the EMR in the "Progress Note" tab revealed, ". . . Left hand opened blister observed measuring 6.4x4.9x< [less than]0.1. Left breast, left abdomen and left thigh with fading redness . . ."

Review of R96's "Wound Assessment Report, dated 10/08/24, located in the EMR under the "Miscellaneous" tab revealed the following burns:

"Location: left forearm/hand, Measurements Length: 24.00 cm, Width: 16.00 cm . . . Depth: 0.10 cm, Etiology: Second Degree Burn."

"Location: left breast, Measurements Length: 3.00 cm, Width: 7.50 cm . . . Etiology: First Degree Burn."

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"Location: abdomen, Measurements Length: 31.00 cm, Width: 30.00 cm . . . Depth: 0.10 cm, Etiology: Second Degree Burn."

"Location: left anterior thigh, Measurements Length: 17.00 cm, Width: 21.00 cm . . . Etiology: Second Degree Burn."

On 01/20/25 at 2:46 PM, R96 was observed in bed awake with a sleep cover over her eyes. R96 was asked if she had been burned by hot water. R96 stated, "Yes." R96 stated water for her coffee spilled on her lap after she asked the Certified Nurse Aide (CNA) to heat the water. R96 stated the CNA accidentally spilled it on her left hand, stomach, breast, and left leg a few weeks ago. R96 stated she received second-degree burns, but it was half healed now. R96 stated a treatment was ordered for Silvadene. R96 stated she thought the CNA used the microwave in the employee breakroom and heated her water for four minutes. R96's hands and body were covered with her blanket. R96 refused for her left hand and other areas previously burned to be observed.

On 01/22/25 at 9:04 AM, the nourishment room on station two was observed and at 9:06 AM the nourishment room on station one was observed. Both microwaves had safety signs posted and the microwave policy.

During an interview on 01/22/25 at 10:40 AM, the Director of Nursing (DON) was asked about the incident on 10/24 when R96 experienced a second-degree burn after a CNA spilled hot water on her. The DON stated CNA4 did not work at the facility anymore. The DON stated CNA4 used the

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F 689	Continued From page 33 microwave in the nourishment room on station two and this was the first time this type of incident had occurred. The DON stated CNA4 heated the water up for three minutes and poured it in R96's personal cup. The DON stated as CNA4 was putting on the lid to R96's travel mug, the hot water hit the bedside table and spilled on to R96 as she sat in her wheelchair in her room. The DON stated CNA4 immediately called the nurse who was in the hallway and CNA4 also reported to her soon after. The DON went on to say a treatment order for Silvadene was immediately obtained. The DON stated R96's skin has healed completely with no lasting issues and no scarring. During a telephone interview on 01/22/25 at 4:37 PM, CNA4 was asked about the incident when R96 was burned from hot water. CNA4 stated R96 had asked her to make her a cup of coffee. CNA4 stated she heated the water in the microwave in the nourishment room in another cup for about three minutes. CNA4 stated she returned to R96's room with the water, poured it in R96's cup, and while she was placing the lid on the cup, it spilled. CNA4 stated R96 felt the hot water sensation and screamed. CNA4 stated she immediately got the nurse who was in the hall. The nurse assessed R4's skin, undressed R96, and immediately applied cooling treatment on the skin. CNA4 stated she then reported the incident to the DON. CNA4 stated the facility conducted training on the use of the microwave and "the aides cannot use the microwave." CNA4 stated water could only be heated by the nurse thirty seconds at a time and a thermometer must be used to measure the temperature. CNA stated she was not aware of other residents getting burns from hot liquids.	F 689		

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F 689	Continued From page 34 During an interview on 01/23/25 at 8:10 AM, Registered Nurse (RN)1 was asked about the facility's policy for heating liquids in the microwave. RN1 stated only the nurses could heat something in the microwaves. RN1 then opened the nourishment room on station two that stored the microwave. The microwave was observed with signs posted with instructions that included "Microwave Safety Until further notice the microwaves in Dining room and nourishment rooms are not to be used by staff and they have been taken out of service. Please read attached policies on microwave safety and use and storage of food brought in by residents and visitors. Complete Quiz and sign attestation indicating that you have read and understand the policies and directions for using a microwave. This education is mandatory. It is to promote safe practice and reduce risk of injury. Any questions please see a member of management." During a follow up interview on 01/23/25 at 9:41 AM, the DON confirmed only a nurse could heat up food and beverages for residents, and the microwaves available for staff to heat resident food and beverages were in the nourishment rooms on stations one and two. The facility provided documentation staff training on microwave safety occurred on 10/05/24, a performance improvement plan was implemented, and the surveyor observed safety signs and the microwave policy in place on 01/22/25. The surveyor confirmed training and policy implementation with staff interviews. On 01/23/25 at 12:31 PM, R96 was asked if she had staff heat water for her since the accident. R96 stated, "No." R96 again declined her skin to	F 689		

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be observed.

This was determined to be past non-compliance with a verified compliance date of 10/5/24.

3. Review of R38's quarterly "MDS," with an ARD date of 10/22/24 and located in the "MDS" tab of the EMR, revealed an admission date of 11/18/16 and a "BIMS" score of three out of 15, indicating R38's cognition was severely impaired. It was recorded that R38 had one fall since admission with injury, and had diagnoses of Alzheimer's disease, anxiety, and unspecified dementia, severe, with mood disturbance.

Review of R38's "Nursing Quarterly Assessment," dated 06/12/24 and located in the EMR under the "Assessment" tab, revealed R38 was "High Risk" for falls, as indicated by a score of 16.0.

Review of R38's investigation, dated 07/09/24 and provided by the facility, revealed, "On 07/04/24 resident was found sitting on the fall mat with her back against her bed that was in the low position. Resident assessed at that time and no injury was noted and resident did not express any pain. On 07/05/24 bruising was noted to residents [sic] right thigh so an x-ray [high-energy electromagnetic radiation] of the right hip and femur was ordered. This x-ray showed no acute fracture. On 07/08/24 bruising was noted on resident's right knee. An x-ray was ordered of the right knee, femur, right hip, and right tibia and fibula. The mobile x-ray tech [technician] was only able to complete the x-ray of the right hip and pelvis. On 7/9/24 NP [nurse practitioner] assessed resident and noted swelling in her knee. The NP requested resident be sent to the ER [emergency room] for evaluation due to the

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knee swelling. At the ER an x-ray of the right knee revealed a fracture of the lateral femoral condyle . . . An investigation was initiated and completed- Staff statements were completed and collected. Resident was last seen sitting up in her bed with her legs straight out on the bed and the over the bed table over her while she was eating dinner. The bed was in the lowest possible position to accommodate the over the bed table. The over bed table was placed on the left side of the bed. Staff noted the over the bed table had been pushed slightly towards the end of the bed when they found resident sitting on the floor. Residents [sic] legs were noted to be crossed with the left leg over top of the right. Due to resident's dementia, she was not able to be interviewed. Resident's roommate did not see resident fall. Resident is known to be fidgety and impulsive with poor safety awareness. At the hospital resident underwent an x-ray of right knee revealing a fracture of the lateral femoral condyle. Right hip x-ray was noted to be unremarkable. Pelvis x-ray showed no acute fracture. A CT [computed tomography scan] of the right knee was completed and revealed a displaced comminuted oblique fracture of the distal metaphysis. A CT of the head showed no acute fracture. A CT of the spine showed a C1 [upper cervical spine] fracture that was also noted back in 6/5/2023 so it is not acute. Resident currently remains admitted to the hospital- Hospital states resident is not a candidate for surgery and they are treating resident for pain and have splinted the fracture to immobilize. Care plan was reviewed, new intervention added to increase safety checks."

Review of R38's "Care Plan," revised 07/12/24 and located in the EMR under the "Care Plan" tab

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of the EMR, revealed, "Resident is at high risk for falls: cognitive loss, lack of safety awareness, anxiety, ambulates with unsteady gait." The goal included, ". . . The resident will not sustain serious injury through the review date . . ." Interventions included to encourage the resident to participate in activities that minimize potential falls that provide diversion and distraction, keep the bed in low position, place a fall Mat on right side of bed, and increased safety checks.

Review of R38's July 2024 TAR located in the EMR under the "Order" tab revealed "Brace to Right lower extremity. skin check every shift. Maintain non weight bearing right lower extremity. every shift," order date 07/25/24 and discontinue date 09/23/24."

On 01/20/25 at 11:36 AM, R38 was observed awake lying in a low bed talking nonsensical and holding a crayon. R38 was very fidgety and was noted to have a laceration on her forehead. The overbed table and a wheelchair were on the fall mat, leaving no space on the mat should R38 fall.

On 01/21/25 at 8:49 AM, R38 was observed awake in a low bed dressed in pajamas with the lights off. R38's legs were pulled up to her chest, tugging up on her covers, and she was very fidgety. The fall mat next to R38's bed had an overbed table on top of the mat, leaving little space on the mat.

On 01/22/25 at 9:54 AM, R38 was observed asleep in a low bed with covers up to her chin. The fall mat was in place with an overbed table and a wheelchair on the mat, leaving little room on the mat.

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During an interview on 01/22/25 at 10:57 AM, CNA2 was asked if R38 was a fall risk. CNA2 stated R38 does fall and stayed in her bed most of the time. CNA2 stated, "[R38] can stand and that's when she falls." CNA2 stated when R38 was trying to get up from her low bed, they put her in the wheelchair and took her to the nurses' station so staff could keep an eye on her.

On 01/23/25 at 7:28 AM, R38 was observed asleep in bed with the head of the bed up and the overbed table on top of the fall mat.

During an interview on 01/23/25 at 8:52 AM, the DON and Regional Director of Nurses (RDON) were asked about R38's fall on 07/04/24. The DON stated it was unwitnessed, but later R38 complained of pain and a bruise was noted. The DON stated the first and second x-rays at the facility revealed no fracture, but R38 was still complaining of pain. She stated R38 was sent to the hospital where another x-ray revealed a fracture. The DON stated the origin of the injuries were unconclusive, stating staff were just in R38's room and the bed was in a low position with the fall mat in place. The DON stated it was possible the bedside table was nearby as R38 had just finished a meal and may have hit the base as she fell out of bed. The DON stated the plan of care was to have R38 in a low bed with fall mats. The DON stated staff knew R38 was at increased risk for falls and when "[R38] gets antsy" staff are to get R38 dressed and up in her wheelchair. The DON stated, "Staff document by [R38]'s door to keep an eye on her." The DON stated R38 liked to color so staff should give her coloring activities to occupy her. The DON was asked if the overbed table should be on the fall mat between meals, obstructing the purpose of the mat. The

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DON stated, No." The DON was informed that the overbed table and wheelchair had been noted on R38's fall mat while R38 was in bed during the days of the survey. The DON was asked why R38 was always in bed and at times very fidgety. The DON stated nursing should be getting R38 out of bed and providing activities to occupy her such as coloring. The DON stated R38 was constantly in movement due to anxiety and her medication had been changed on the 12/24/24 and 01/07/25. The DON stated since R38's medication changes she still had the urge to get up out of bed and had high anxiety. The DON stated they were to make the environment safe in her room to prevent injury should R38 fall. The DON stated the placement of the overbed table was important.

During an observation on 01/23/25 at 4:05 PM, R38 was observed in a low bed with a fall mat in place. The bedside table and wheelchair were on the mat, allowing little space on the mat should R38 fall.

During an observation in R38's room on 01/23/25 at 4:07 PM, the Assistant Director of Nurses (ADON)was asked about the fall mat being obstructed with the overbed table and wheelchair. The ADON confirmed the overbed table and wheelchair should not be on the mat in case R38 fell as R38 could fall on the equipment.

During a telephone interview on 01/23/25 at 5:52 PM, Licensed Practical Nurse (LPN)5 was asked about R38's fall on 07/04/24 and her fracture. LPN5 stated R38 was found on the floor on the fall mat but she did not see her fall. LPN4 stated R38's bed was in the low position and the fall mat was in place. LPN5 went on to say R38's plan to decrease falls included a low bed and a fall mat,

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F 689	Continued From page 40 and when R38 was restless staff would sit by her doorway and talk with her or get her up in the wheelchair. During a telephone interview on 01/23/25 at 5:59 PM, CNA7 was asked about R38's fall on 07/04/24. CNA7 stated she could not remember all the details but R38 was in a low bed and the fall mat was in place. CNA7 stated she thought the overbed table was in the way on the fall mat. CNA7 was asked what was in place to reduce R38's fall or injury. CNA7 stated all the staff took turns keeping an eye on R38 and keeping her in a low bed and fall mats next to her bed. CNA7 stated they were educated on R38's safety, saying, "It's important to keep the mat clear of objects." During a telephone interview on 01/23/25 at 6:13 PM, RN2 was asked about R38's fall in 07/04/24. RN2 stated she could not remember exactly as it had been a while and she did not see R38 fall. RN2 asked what interventions were in place to reduce falls. RN2 stated R38 was in a low bed, had a fall mat, and they anticipated her needs. RN2 stated when R38 was restless, a CNA would sit close to her or inside the room when she was in bed, and R38 did sit in her wheelchair at times.	F 689		
F 742 SS=D	Treatment/Srvcs Mental/Psychoscial Concerns CFR(s): 483.40(b)(1) §483.40(b) Based on the comprehensive assessment of a resident, the facility must ensure that- §483.40(b)(1) A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or	F 742		3/6/25

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F 742	Continued From page 41 post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to provide medically related social services to meet the resident's needs for one of 32 sampled residents (Resident (R) R90). This failure caused the resident to not receive the required care expected to be provided by the Social Services Director (SSD). Findings include: Review of "Social Services Director Job Description," undated and signed by the SSD, revealed ". . . The Social services Director is responsible for overseeing the development, implementation, supervision and ongoing evaluation of the Social Services Department designed to meet and assist residents in attaining or maintaining their highest practicable well-being . . ." Review of R90's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R82 was initially admitted on 03/30/23 with diagnoses that included dehydration, type 2 diabetes, peripheral vascular disease, and bipolar disorder. Review of R90's quarterly "Minimum Data Set (MDS)," located in the EMR under the "MDS" tab and with an Assessment Reference Date (ARD) of 01/06/25, revealed the resident had a "Brief Interview for Mental Status (BIMS)" score of 15	F 742	F742 Treatment/Srvcs Mental/Psychosocial Concerns (1) On 8/31/24, R90 received a trauma informed care assessment. He was seen by the psychologist on 9/3/24. R90 has been seen by the psychiatrist between one to three times per month since August of 2024. R90 has since been assessed by the social services director and psyche services, which are ongoing, to address his psychosocial and psychological well-being and needs. (2) Current residents in the facility have the potential to be affected. The administrator or designee will review the last 90 days of current residents requiring comprehensive assessments to ensure that social services has completed comprehensive assessments (admission, readmission, annual, and significant change assessments) as required. (3) The root cause of this deficient practice is that the social services director did not complete a comprehensive assessment resulting in not adequately assessing R90's psychosocial and psychological needs timely. The administrator or designee will educate social services staff on assessing residents' psychosocial and psychological	

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F 742	Continued From page 42 out of 15, indicating R90 was cognitively intact. R90 indicated he had little interest or pleasure in doing things and felt down, depressed, or hopeless nearly every day during the "MDS" lookback period. During an interview on 01/20/25 at 10:30 AM, R90 said he was depressed and was not sure why he had someone in his room all of the time. During an interview on 01/23/25 at 8:40 AM, the SSD stated, "[I] haven't done anything about [R90] his [psychosocial needs]" and stated since he had constant one to one supervision "I'm pretty sure that could be an issue, if someone is watching you constantly." She said she "would like to talk to him about his depression." During an interview on 01/23/25 at 12:21 PM, the DON stated the SSD should be involved in all residents' psychosocial needs and the SSD should be involved in R90's care related to his psychosocial needs, especially since R90 had a history of abuse and receiving one to one supervision. (Cross-Reference F600)	F 742	needs adequately and completing the social services assessments timely. (4) The administrator or designee will conduct a random audit of the social services comprehensive assessments (admission, readmission, annual, and significant change assessments) including a minimum of ten residents weekly x 1 for one month, biweekly x 2 for one month, and monthly x 1 for one month or until 100% compliance is achieved. Results of all audits will be presented by administrator or designee monthly for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced	F 804		3/6/25

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F 804	Continued From page 43 by: Based on observation, interview, and facility policy review, the facility failed to serve food that was palatable and at the appropriate temperature for three of five residents (Resident (R) 62, R46, and R11) reviewed for food palatability out of 32 sample residents. This deficient practice could potentially cause residents to lose weight and decrease quality of life. Findings include: Review of the facility's policy titled, "Food: Quality and Palatability," revised 2/2023, revealed ". . . Food will be prepared by methods that conserve nutritive value, flavor and appearance. Food will be palatable, attractive and served at a safe and appetizing temperature . . ." Review of the Centers for Disease Control website, located at https://www.cdc.gov/covid/hcp/infection-control/index.html, revealed, ". . . Recommended routine infection prevention and control (IPC) practices during the COVID-19 pandemic . . . Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures . . ." Review of the "Resident Council Minutes," dated 12/20/24 and provided by the facility, revealed two complaints of cold food. The resolution included "Will follow for trend." 1. Review of R62's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) date of 12/30/24 and located in the "MDS" tab of the electronic medical record (EMR), revealed an admission date of 06/23/23 and a	F 804	F804 Nutritive Value/Appear, Palatable/Prefer Temp (1) There have been no negative outcomes reported as a result of the deficient practice. Styrofoam containers had been temporarily used for the residents surveyed, which resulted in food not retaining heat well and not looking appetizing. This practice was discontinued. (2) All residents have the potential to be affected by the deficient practice. (3) The root cause of the deficient practice includes (1) Styrofoam was used temporarily due to a COVID-19 outbreak, a practice which has since been discontinued, (2) dietary staff need reeducation on food quality and palatability. The food service director will reeducate dietary staff on food quality and palatability, with an emphasis on plate appearance and ensuring food is thoroughly cooked and meets adequate food temperatures. (4) The food service director or designee will conduct random audits that include the following: (1) Monitor food temperatures to ensure that adequate food temperatures are achieved for random food trays after the food carts are delivered from the kitchen to the resident areas, (2) survey random residents with satisfaction surveys to obtain feedback on plate appearance and food palatability.	

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F 804	Continued From page 44 "Brief Interview for Mental Status (BIMS)" of 14 out of 15, indicating R62's cognition was intact. It was recorded that R62 had diagnoses of diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. Review of R62's "Care Plan," dated 06/28/23 and located in the EMR under the "Care Plan" tab, revealed, "The resident has nutritional problem r/t [related to] therapeutic diet restrictions, morbid obesity." An intervention included, ". . . Provide, serve diet as ordered. Monitor intake and record q [every] meal . . ." Review of R62's "Orders," dated 01/16/25 and located in the EMR under the "Order" tab, revealed "Infection Precautions - droplet, contact for covid positive." During an interview on 01/20/25 at 3:09 PM, R62 voiced complaints about being served cold food. R62 stated the noodles, carrots, and rice were not cooked well. During an observation and interview on 01/22/25 at 12:37 PM, R62 was served lunch in her room in a disposable foam tray. R62's meal included chicken, mixed vegetables, fruit, noodles, and a roll. R62 stated her food was not warm but she was going to eat it anyway. During an observation and interview on 01/23/25 at 8:07 AM, R62 was served breakfast in her room in a disposable foam tray. R62's meal included fried eggs, toast, and cream of wheat. R62 stated her food was served cold. During an observation and interview on 01/23/25 at 12:40 PM, R62 was served lunch in her room	F 804	The food service director or designee will conduct audits weekly x 1 for one month, biweekly x 2 for one month, and monthly x 1 for one month or until 100% compliance is achieved. Results of all audits will be presented monthly by the administrator or designee for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F 804	Continued From page 45	F 804		

in a disposable foam tray. R62's meal included chicken, stuffing, Brussel sprouts, fruit, and a roll. R62 stated, "It's not warm, just not warm enough."

During an interview on 01/23/25 at 8:04 AM, the Dietary Manager (DM) was asked why disposable foam trays were used. The DM stated they were used for COVID positive residents only. The DM was asked if he was aware of cold food complaints. The DM stated they just changed the delivery service last night to help with keeping the food warm. The DM stated all the COVID trays were now placed on one cart to help with faster hall tray service and retain heat because the foam trays were not insulated. The DM stated he was not aware of the newest CDC guidance for COVID residents that stated routine management of food service utensils should be used.

During an interview on 01/23/25 at 1:48 PM, the Registered Dietitian (RD) was asked about the cold food complaints residents had during the survey. These residents received their meals in the disposable foam trays. The RD stated the foam trays were used to serve residents their meals in their rooms for the COVID outbreak. The RD was asked about her expectations for keeping the food warm. RD stated, "Get back to the system of regular utensils as soon as possible."

2. Review of R46's "Admission Record," located under the "Profile" tab of the EMR, revealed R46 was admitted on 06/28/24 with diagnoses of type two diabetes and acquired absence of right leg below the knee.

Review of R46's quarterly "MDS," located in the

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F 804	Continued From page 46 EMR under the "MDS" tab and with an ARD of 01/05/25, revealed the resident had a "BIMS" score of 15 out of 15, indicating R46 was cognitively intact. During an interview on 01/20/25 at 2:55 PM, R46 said she had concerns with the food. She said she used to work in the kitchen and the food was disgusting. She said the kitchen just "don't know how to fix food." During an interview on 01/22/25 at 1:25 PM, R46 said the food was cold today and "didn't look appetizing." She said the cabbage was not cooked either. She said because of the way it looked; she ordered out. R46 said the food was always cold. 3. Review of R11's "Orders" tab of the EMR revealed R11 was admitted to the facility on 08/23/2017 with diagnoses that included dementia and multiple sclerosis (a chronic disease that affects the central nervous system.) Review of R11's quarterly "MDS," with an ARD of 11/24/24 and located in the EMR under "MDS" tab, revealed R11 had a "BIMS" score of 12 out of 15, which indicated R11 had moderate cognitive impairment. During an interview on 01/21/25 at 10:27 AM, R11 stated the food was not good and it was cold. R11 stated, "If I do not like it, I do not eat it." R11 stated he usually ordered food for delivery. During an observation on 01/23/25 at 7:58 AM, R11's meal arrived in Styrofoam dishes (which could contribute to foods cooling rapidly), and it was the last tray to be served from the cart that	F 804		

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F 804	Continued From page 47 arrived on the unit at 7:33 AM. 4. On 01/23/25 at 7:44 AM, a test tray containing coffee, juice, sausage, pancakes, and oatmeal was obtained. The food temperatures were tested by the Dietary Manage (DM) using a new thermometer which could not be calibrated. The oatmeal temperature registered at 135 degrees Fahrenheit (F); however, the surveyor noted the oatmeal to taste lukewarm.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and facility policy review, the facility failed to ensure cold storage units contained interior temperature gauges, kitchen floors and walls were kept clean	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary (1) Immediately upon identification of the	3/6/25

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F 812	Continued From page 48 and in good repair, and leftovers were cooled down correctly, in one of one kitchen. This deficient practice had the potential to affect 107 of 107 residents who received meals prepared in the facility. This failure had the potential to affect the spread of food borne illness. Findings include: Review of the facility's policy titled, "Sanitation Inspection," revised 03/29/23, revealed "It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations." "1. All food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. 2. The department shall establish a sanitation program for food services based on applicable state and federal requirements." "4. Sanitation inspections will be conducted in the following manner: a. Daily: Food service staff shall inspect refrigerators/coolers, freezers, storage area temperatures, and dishwasher temperatures daily." Review of the United States Food & Drug Administration Food Code 2022, dated 01/18/23 and located at https://www.fda.gov/media/164194/download?attachment, revealed "3-501.14 Cooling. (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 57ºC (135ºF [Fahrenheit]) to 21ºC (70°F); and (2) Within a total of 6 hours from 57ºC (135ºF) to 5ºC (41°F) or less." During the kitchen tour on 01/20/25 at 10:45 AM	F 812	deficient practices, (1) The walls throughout the kitchen were cleaned, (2) the food service director ensured that all cold storage units contained a temperature gauge, (3) the food service director discarded the eggs in the refrigerator noted on 1/20/25 that did not meet the appropriate cooling temperature, (4) Food service director reviewed the policy and procedure for food preparation, including time and temperature control for safety and acknowledged understanding on 1/27/25. Dietary staff were educated by the food service director from 1/28/25 through 1/31/25 on the food cooling procedures and they acknowledged understanding. The maintenance director has repaired the door frames and wall damage. The food service director and assistant dietary manager have attested they will report any damage in the kitchen to the maintenance department timely. (2) All residents have the potential to be affected by the deficient practice. (3) The root cause of the observed deficient practices includes the need for reeducation of dietary staff on (1) cleaning schedules with an emphasis on kitchen walls, (2) ensuring each cold storage unit contains internal temperature gauges, (3) food preparation policy and procedures for cooling food properly. The root cause of the observed damage to the kitchen doors/walls is due to the food service director not reporting the damage to the maintenance director timely.	

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F 812	Continued From page 49 with the Dietary Manager (DM), the following observations were made: 1. The walls throughout the kitchen contained a collection of dried splatters, notably in and around the coffee and tea station, the range, the hand sink, along the lower walls at the reach-in refrigerator, and under the dish machine. An accumulation of food and dust debris was noted along the wall strips and on and around electrical switches. The strips along the lower walls were broken and an accumulation of a dark substance was noted at the wall tile and floor junctures. The door frames were gouged, exposing raw wood. 2. Four cold storage units did not contain a temperature gauge inside. These units included the first reach-in refrigerator located in the food storage room storing produce, the reach-in freezer storing ice cream, the reach-in freezer with vegetables, and the milk box in the food storage room. 3. The second reach-in refrigerator located in the food storage room was observed to have containers of pureed scrambled eggs, regular scrambled eggs, and link sausage. The DM stated these containers were leftovers from 01/20/25 at breakfast and they were taken off the steamtable at 8:00 AM. The DM was asked to take the temperature of the leftovers. The containers of pureed scrambled eggs measured 96 degrees F, regular scrambled eggs measured 86 degrees F, and link sausage measured 75 degrees F. The DM was asked if he was aware the temperature of the leftovers should be at 70 degrees F within two hours. However, two hours and 45 minutes had lapsed, and the temperatures were greater than 70 degrees F.	F 812	(4) Food service director or designee will conduct random audits on the cooling of hot food to ensure that the appropriate cooling procedure is followed, and that food is cooled to the appropriate temperatures within the required timeframe prior to storage. The food service director or designee will complete random audits on (1) monitoring all cooling units to ensure internal temperature gauges are present, (2) monitoring the cleaning schedule sheet to ensure staff responsible for cleaning initial that they cleaned the required areas and also checking those areas to ensure they are adequately cleaned. The food service director or designee will conduct audits weekly x 1 for one month, biweekly x 2 for one month, and monthly x 1 for one month or until 100% compliance is achieved. Results of all audits will be presented by the administrator or designee monthly for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F 812	Continued From page 50	F 812		

The DM stated, "Yes, they use ice baths to cool foods, but not today due to short staff." The DM then placed the containers back into the refrigerator.

4. On 01/22/25 at 8:32 AM, the walls were again observed throughout the kitchen containing a collection of dried splatters, notably in and around the coffee and tea station, the range, the hand sink, along the lower walls at the reach-in refrigerator, and under the dish machine. An accumulation of food and dust debris was noted along the wall strips and on and around electrical switches. The strips along the lower walls were broken and an accumulation of a dark substance was noted at the wall tile and floor junctures. The door frames were gouged, exposing raw wood. The DM was asked about the walls and tile build-up. The DM stated the kitchen was responsible for the walls but housekeeping and maintenance were responsible for the tile and floors as they have the proper tools to scrape off the build-up, but the kitchen staff only had a mop. The DM was asked for a working copy of the kitchen's cleaning schedule. The DM stated, "it's not posted this week." The DM was asked to provide a copy of what the kitchen was to use. The DM then searched on his computer for a copy and was unable to locate it.

5. On 01/22/25 at 8:42 AM, a pan of ice was observed with three containers of food on top of the ice. The Dietary Assistant Account Manager (DAAM) stated the food was from 01/22/25 at breakfast. These included a pan of sausage, regular scrambled eggs, and pureed scrambled eggs which were 10 inches full and warm to touch. The DAAM was asked about the full container of eggs and would the temperature get

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F 812	Continued From page 51 to 70 degrees F in two hours. The DAAM stated, "Yes." On 01/22/25 at 11:35 AM, a follow-up was conducted on the leftovers. The DM was asked to take the temperature of the pureed eggs in the 10-inch container. The pureed eggs measured 93.5 degrees F. The DAAM stated the eggs were taken from the steam table at 7:50 AM on 01/22/25. However, three hours and 45 minutes had lapsed, and the temperatures were greater than 70 degrees F. 6. During an interview on 01/23/25 at 1:48 PM, the Registered Dietitian (RD) was asked about the incorrect cooling down of leftovers observed on 1/20/25 and 1/22/25. The RD stated she wasn't told that the leftovers were incorrectly cooled down and weren't in a shallow pan. The RD asked what her expectation was for the kitchen to cool down leftovers. The RD stated, "the kitchen shouldn't have any leftovers but if they do, they should be in a shallow pan as that's the way to cool it down the fastest." The RD was asked about the kitchen walls and floors in need of cleaning. The RD stated she identified dirty and stained walls in her last monthly sanitation report and confirmed they needed thorough cleaning.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		3/6/25

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F 880	Continued From page 52 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: §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	F 880		

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F 880	Continued From page 53 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §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, record review, and interview, the facility failed to 1.) complete wound care in a manner to prevent cross contamination for one of one resident (Resident (R) 78) reviewed for wound care out of a total sample of 32, and 2.) wear the proper Personal Protective Equipment (PPE) when entering into a contact isolation room for one of 27 residents (Room 120) noted to be COVID positive. These failures put the vulnerable population of residents at greater risk of developing infections and the increased risk of staff spreading infections throughout the facility by not adhering to the isolation precautions. Findings include: 1.Review of R78's undated "Face Sheet," located	F 880	F 880 - 483.80 Infection Prevention and Control (1) Saline was immediately discarded, and the treatment cart was cleaned. RN 2 was re-educated by the director of nursing on 1/23/25, on the principles of clean dressing changes to avoid cross contamination and proper donning of PPE. HSKG 1 was immediately educated by NPE on proper PPE use when entering rooms identified as isolation rooms (2) Current residents requiring wound care have the potential to be affected by the deficient practice. Current residents and HSKG staff have the potential to be affected by the deficient practice.	

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F 880	Continued From page 54 under the "Profile" tab in the electronic medical record (EMR), revealed R78 was admitted to the facility on 02/20/24 with diagnoses of dementia, chronic obstructive pulmonary disease, and chronic kidney disease. Review of R78's quarterly "Minimum Data Set (MDS)," located under the "MDS" tab in the EMR and with an "Assessment Reference Date (ARD)" of 11/14/24, revealed R78 was at risk for developing a pressure ulcer. It was recorded R78 had a "Brief Interview for Mental Status (BIMS)," score of three out of 15, which indicated the resident was severely cognitively impaired. Review of R78's "Care Plan," located under the "Care Plan" tab in the EMR and dated 12/31/24, indicated, ". . . The resident [R78] has open [sic] area on his sacrum r/t [related to] incontinence/ immobility . . ." Interventions were, ". . . Assess characteristics of wound, including color, size (length, width, depth), drainage, and color. Low air mattress at 200 [sic]. Monitor site of impaired tissue integrity for color changes, redness, swelling, warmth, pain, or other signs of infection. Provide skin tissue care as needed . . ." Review of R78's "Physician Orders," located under the "Orders" tab in the EMR and dated 01/16/25, revealed, ". . . Sacrum Stage 3 [sic]. Cleanse with NS [Normal Saline], apply medical grade honey, cover with bordered gauze daily and PRN [as needed] [sic] . . ." During the wound care observation on 01/22/25 at 3:20 PM, Registered Nurse (RN) 2, the following failures were noted with wound care: 1) RN2 sprayed Saline Wound Cleanser to a clean 4x4 gauze pad and then patted all areas of the	F 880	(3) Root Cause: The facility determined the current licensed nursing staff needs re-education on the procedures for performing clean dressing changes to avoid cross contamination and how to properly don PPE. Current HSKG staff need re-education on donning the appropriate PPE prior to entering rooms identified as isolation rooms. NPE/designee will provide re-education to current licensed nursing staff on the policy and procedures for performing clean dressing changes with a focus on avoiding cross contamination and on how to properly don PPE prior to those dressing changes. NPE/designee will provide re-education to current housekeeping staff on donning the appropriate PPE prior to entering rooms identified as isolation rooms. (4) Random Audits will be conducted by DON or designee to verify staff are wearing PPE appropriately and to verify clean dressing change is being completed correctly weekly x 1 for one month, biweekly x 2 for one month, and monthly x 1 for one month. Results of all audits will be presented NPE or designee monthly for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F 880	Continued From page 55	F 880		

wound bed with the same 4x4. 2) RN2 applied the medical grade honey to the wound bed with a clean Q tip. As she was applying the honey, a small amount of honey dropped to the intact skin below the wound. RN2 took the Q tip and pushed the honey into the wound bed. 3) During the wound care observation, the front of RN2's gown came down to the breast area, exposing RN2's uniform. The theRN2 right arm sleeve of the gown came off her shoulder and was down to the elbow area of RN2. This also exposed RN2's uniform. 4) RN2 brought the spray bottle of saline wound cleanser out of R78's room and placed it back into the bottom drawer of the wound cart without first cleaning the bottle.

During an interview on 01/22/24 at 3:50 PM, RN2 stated, "I should have fastened the top of my gown before I started the wound care so it wouldn't slide down. I should have also cleaned the bottle of saline wound cleanser with a disinfectant wipe before putting it in the bottom of the wound cart." When asked if RN2 all areas of the wound bed should have been wiped with one 4x4, RN2 stated, "No, I should have gotten a new one before I wiped it the second time." RN2 was asked if she should have pushed the honey from the skin below the wound to the middle of the wound bed, and she replied, "I didn't think it was dirty."

During an interview on 01/23/25 at 12:08 PM, the Director of Nursing (DON) stated, "I expect the nurse to clean the wound bed using a circular motion with one 4x4 then discard it and then get a clean 4x4 to clean the wound bed again. [R78] was positive for COVID so nothing should have been brought out of his room that the nurse took into the room for wound care. The nurses' gown

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	085027	A. BUILDING _____ B. WING _____	C 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT SILVER LAKE LLC	1080 SILVER LAKE BLVD DOVER, DE 19904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 56	F 880		

should have been fastened at the top to prevent her scrubs from getting contaminated due to the resident having COVID."

During an interview on 01/23/25 at 5:11 PM, the Infection Preventionist (IP) stated, "The nurse's gown should have been tied at the top or the strap placed over her head so the gown would not slide down. The nurse should clean the wound in a circle, getting a clean 4x4 each time this is done. The saline wound cleanser should not have been brought out of the resident's room because he [R78] is in contact isolation."

2. During an interview on 01/20/25 at 9:45 AM, the Director of Nursing (DON) reported the facility currently had 27 residents who were in droplet precautions after testing positive for the COVID virus, or who had close contact with a resident who tested positive.

On 01/20/25 at 11:28 AM, Housekeeper (HSK) 1 went into room 120 to clean the room. Posted on the room's door frame was a sign indicating droplet precautions were in place. The sign directed staff to sanitize their hands and don a gown, gloves, N95 mask, and an eye shield prior to entering the room and to discard them prior to leaving the room. HSK1 entered room 120, wearing an N95 mask and gloves. No gown or face shield were used. While cleaning the room, HSK1 exited the room twice while wearing gloves and the N95 mask, took several steps to the cart, and replaced or obtained cleaning supplies without discarding the N95 mask and gloves or completing hand hygiene.

During an interview on 01/20/25 at 11:40 AM, HSK 1 acknowledged the error and stated the

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F 880	Continued From page 57 guidelines posted outside the room should have been followed.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the Antibiotic Stewardship Program was consistently implemented. The facility failed to document criteria for the use of antibiotics, antibiotics used, and results of culture and sensitivity testing. The facility failed to analyze antibiotic stewardship data to plan process improvements. This failure placed all 111 of 111 residents at risk for adverse events related to administration of antibiotics. Findings include: Review of the facility's policy titled, "Antibiotic Stewardship Program," dated 08/02/24, indicated, ". . . Antibiotic Use Protocols. i. Nursing staff shall complete an SBAR [Situation, Background, Assessment, Recommendation] noted to notify the physician. ii. Laboratory testing shall be in accordance with current standards of practice. iii. The facility uses updated McGeer criteria to define infections. iv. The Loeb Minimum Criteria	F 881	F881 - 483.80 Antibiotic Stewardship Program (1) Current residents receiving antibiotic therapy were reviewed by the Nurse Practitioner for appropriate use on 2/10/25, and the monthly inspection surveillance log was updated to include all the required elements. (2) Current residents have the potential to be affected by the deficient practice. (3) Root Cause: The facility determined current licensed nurses and medical staff have the need for re-education on the principles of antibiotic stewardship. IP/designee will re-educate current licensed nursing staff and medical staff on the guidelines of Antibiotic Stewardship. The Director of Nursing will re-educate the NPE on completing the monthly inspection	3/6/25

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F 881	Continued From page 58 is used to determine whether to treat an infection with antibiotics. V. All prescriptions shall specify the dose, duration and indication for use." b. Monitoring Antibiotic use. "i. Monitor response to antibiotics, and lab results when available, to determine if the antibiotic is still indicated or adjustments should be made (e.g.an antibiotic time-out). ii. Antibiotic orders obtained on admission, whether new or readmission, to the facility should be reviewed for appropriateness. iii. Antibiotic orders obtained on admission from consultants, specialty, or emergency providers shall be reviewed for appropriateness. iv. Monitor during each monthly medication review when the resident is prescribed antibiotics .... v. Random audits of antibiotic prescriptions for shall be performed to verify completeness and appropriateness. vi. At least one outcome measure associated will be tracked monthly as prioritized by the infection control risk assessment or other surveillance data . . ." The protocols indicated the Infection Preventionist, Administrator and Physicians were responsible for implementing the Antibiotic Stewardship program. During an interview on 01/23/25 at 10:45 AM, the Infection Preventionist (IP) stated the facility maintained a monthly line listing of the resident infections. When asked how IP received information about antibiotic use, she stated they got notified if an order for antibiotics was initiated. When asked about monthly summary reports, the IP explained she was new to the facility and the role of IP and would ask the former IP who was now the Director of Nursing (DON). The DON stated she had completed monthly summaries of the line listings. When asked if they kept any floor	F 881	surveillance log and how to use it to track and trend. (4) Audits will be completed by DON or designee to verify compliance with antibiotic stewardship and to verify the surveillance log is completed fully weekly x 1 for one month, biweekly x 2 for one month, and monthly x 1 for one month. Results of all audits will be presented by the NPE or designee monthly for three months to the quality assurance performance improvement committee for further evaluation, recommendations, and sustainability of plan.	

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F 881	Continued From page 59 plans that identified the location of the infections treated (to observe for clusters or trends) the DON and IP reported they did not. The DON then provided six months of logs and monthly summaries. Review of the January 2025 "Monthly Infection Surveillance Log (MISL)," revealed 12 of 22 entries on the log identifying the residents were treated with antibiotics; however, the data was incomplete. Missing information included if the criteria for the definition of an infection was met (McGeers), the name of the antibiotic that was administered, and/or the results of culture and sensitivity testing (to ensure the antibiotic would be effective). Review of logs dated September 2024 through December 2024, revealed a pattern of missing data. Review of the December 2024 "Monthly Infection Surveillance Summary Report (MISSR)" Page 1 showed the percentage of patients with an infection was 18.8%. There was no documented evidence that the facility used data from the MISL or MISSR to analyze trends or patterns or to identify potential areas for improvement. During an interview on 01/23/25 at 3:30 PM, the IP confirmed the missing data on the MISL.	F 881		