DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

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

STATE SURVEY REPORT

NAME OF FACILITY: Regency Healthcare and Rehabilitation Center **DATE SURVEY COMPLETED:** February 4, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference also cites the findings specified in the Federal Report. An unannounced Annual and Complaint survey was conducted at this facility from January 28, 2025, through February 4, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was ninety-three (93). The investigative sample totaled twenty (20) residents.	Please refer to the CMS 2567 standard survey completed 2/4/25: F600, F641, F644, F656, F676, F684, F690 and F802	2/21/25
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 4, 2025: F600, F641, F644, F656, F676, F684, F690 and F802.		

Provider's Signature _____ Title NHA Date 2/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085012	A. BUILDING _____ B. WING _____	C 02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

(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 unannounced annual and complaint survey was conducted at this facility from January 28, 2025 through February 4, 2025. The facility census was 93 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from January 28, 2025 through February 4, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census on the first day of the survey was 93. The investigative sample totaled 20 residents. Abbreviations/definitions used in this report are as follows: ADLs - activities of daily living; ADON - Assistant Director of Nursing; Anticonvulsant - medication that help prevent or treat seizures by regulating nerve impulses in the brain; also used for nerve pain and bipolar disorder; Antipsychotic - class of medication used to manage psychosis, an abnormal condition of the mind involving a loss of contact with reality and	F 000		

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

Electronically Signed | 02/28/2025

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 000	Continued From page 1 other mental and emotional conditions; DCS - Director of Clinical Services; DON - Director of Nursing; IP - Infection Preventionist; MDS assessment - federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; NHA - Nursing Home Administrator: NP - Nurse Practitioner; PASRR - Preadmission Screening and Resident Review/screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; RM - Risk Manager; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; ROM - range of motion; SD - Staff Development; SSD - Social Services Director; VPO - Vice President of Operations.	F 000		
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	F 600		3/14/25

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F 600	Continued From page 2 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 interview, record review and review of other facility documents, it was determined that for two (R42 and R43) out of eight residents reviewed for abuse, the facility failed to ensure that R42 was free from resident - to - resident physical abuse by R43 and R43 was free from physical abuse by R42. Findings include: A review of the facility's abuse policy titled, "Abuse, Neglect, Exploitation and Misappropriation Prevention Program," revised April 2021, indicated," ... The resident abuse, neglect and exploitation prevention program...1. Protect residents from abuse ... by anyone including ,.. other residents; ...." Cross refer F600 Ex. 2., F684 and F690 1. A review of R43's clinical record revealed the following: 5/25/22 - R43 was initially admitted to the facility with diagnoses including dementia. 7/30/24 (revised 1/31/25) - R43's behavioral care plans included, physical aggression/abuse against others including, hitting resident on arm, throwing water on a resident and repeated episodes of aggression. R43's care plan approaches included, "Administer medications as ordered, allow resident time to calm down and	F 600	A. R43 remains at the facility. There is no opportunity to correct the alleged deficiency. R42 remains at the facility. There is no opportunity to correct the alleged deficiency. B. Residents with behaviors have the potential to be affected by this deficient practice. The DON or designee will provide in servicing to staff on how to deescalate residents with behaviors. The DON or designee will in-service Nursing staff regarding interventions that can be installed to prevent physical abuse and that the DON and/or the NHA are to be called if such events occur. C. The root cause analysis indicates that the nursing staff failed to recognize and prevent resident-to-resident physical abuse between R43 towards R42 and R42 towards R43. Staff failed to remove the toilet seat cover from R43 when they saw he had it at the nurses□ station and was seen putting it behind his back The IDT will review the 24 Hour Summary, grievances and incident reports to identify if any events occurred, that required immediate interventions. Continued education will be provided by DON or designee, if needed at that time. D. The DON or designee will audit the 24	

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F 600	Continued From page 3 reapproach, approach in calm, quiet manner, offer reassurance and support, psych consult, when necessary, remove resident from situation, and redirect when aggression is observed." 7/31/24 - R43's admission MDS (Minimum Data Set) assessment revealed that R43's cognition was severely impaired with a BIM's score of 5. R43 had no mood symptoms however R43 had verbal and physical behavioral symptoms occurring 1-3 days during the review period. 9/19/24 - R43 was re-admitted to the facility from a hospitalization with diagnoses including but not limited to dementia, bipolar disorder and insomnia due to mental disorder. 10/2/24 - R43's significant change MDS assessment revealed that R43's cognition was moderately impaired with a BIM's score of 9. R43 had no mood or behavioral symptoms exhibited during the review period. 10/15/24 - R43 was care planned for new disruptive behavior related to throwing objects at other residents and interventions included ensuring the safety of R43 and others and establishing boundaries and limits with R43. 11/4/24 - A psych note documented, "... returned from psych hospitalization ... on 9/19, [R43] was admitted for 13 days due to agitation and disorganization..." 11/4/24 9:41 PM - A nurse's progress note documented, "[R43] picked up a cup of water and threw it on another resident (unidentified). [R43] redirect with 1:1..."	F 600	Hour Summary, Incident Reports any grievances and any documented events to ensure issues are identified and interventions are immediately installed: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	

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F 600	Continued From page 4 11/5/24 12:22 AM - A facility incident report submitted to the State Agency documented that on 11/5/24 at 11:50 PM, "...[R42] was at the nursing station when another resident [R43] threw a plastic cup of water at his head..." 11/5/24 - R43's behavior care plan intervention was updated to include offering R43 with activities that will entertain ... enjoys watching TV. 11/9/24 4:33 PM - A facility incident report submitted to the State Agency documented that on 11/9/24 at 3:34 PM, "...[R43] was sitting in (sic) a chair in front of the Nurse's Station while watching TV ... raised his arm and hand while holding a cup of water and threw the water on [R42]..." R42 was seated next to R43 (left side). 11/9/24 (revised 11/13/24) - R43's behavior care plan intervention was updated to include close observation. 11/17/24 5:05 PM - A facility incident report submitted to the State Agency documented that on 11/17/24 at 3:45 PM, "...[R42] was just sitting down at the nurses station watching TV, when the other resident approach (sic) him and threw a cup of water on him". 11/18/24 - R43's behavior care plan intervention was updated to include "monitor [R43] when giving beverages to attempt to avoid aggressive behavior with throwing beverage at other residents". 12/13/24 - An untimed facility incident witness statement by E21 (former DON) documented, "... [R43] was seen to have a toilet seat cover from a commode at the nursing station. [R43] was seen	F 600		

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F 600	Continued From page 5 putting the toilet seat cover behind his back in his wheelchair and began to wheel himself to his room (which is next to the nursing station). [R42] was walking around the nursing station and passed [R43]. [R43] was seen speaking to [R42] however unknown what was said. [R43] then took the toilet cover from behind him and hit [R42] in the left shoulder...". 12/13/24 - R43 was care planned for aggression from another resident related to being hit with a commode toilet seat and "resident hitting another resident with commode". R43's intreventions included "safety measures - including strategies to reduce the risk of infection, falls, injury initiated as appropriate." 1/31/25 - R43's behavior care plan intervention was updated to include "[R43] to go to (psych hospital) when needed as ordered". The facility failed to ensure that (R42) was free from physical abuse by R43 when on multiple occasions on 11/5/24, 11/9/24 and 11/17/24 R43 threw water on R42. In addition, on 12/13/24, R43 hit R42 with a toilet cover on R42's left shoulder. 1/31/25 5:00 PM - Finding was discussed with E1 (NHA). Cross refer F600 Ex. 1 2. A review of R42's clinical record revealed the following: 3/15/18 - R42 was admitted to the facility with diagnoses including but not limited to depression, anxiety disorder and dementia.	F 600		

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F 600	Continued From page 6 3/16/18 - R42 was care planned for impaired cognition and interventions including but not limited to, "... Needs supervision/assistance with all decision making." 9/18/24 - R42's quarterly MDS (Minimum Data Set) assessment revealed that R42's cognition was severely impaired with a BIM's score of 3 and no mood or behavioral symptoms during the review period. 11/13/24 (revised 12/23/24) - R42 was care planned for physical behaviors as evidenced by slapping a resident in the face...physical aggression ... "getting a cup of water thrown on him by another resident" and "being hit by another resident and then hitting back in the head". R42's interventions included: "analyze times, places, circumstances, triggers and what de-escalates behavior and document" and R42 "to be moved to another unit to ensure [R42's] safety. " 11/18/24 - R42 was care planned for alteration in comfort related to receiving aggressive behavior from another resident. Interventions included but not limited to ensuring that R42 feels safe and removing R42 from situation (12/30/24). 12/13/24 8:55 AM - A facility incident report submitted to the State Agency documented that on 12/13/24 at 12:30 AM, "... [R42] was observed suddenly hitting another resident [R43] over the head with a bedside commode toilet seat without provocation..." 12/13/24 - An untimed facility incident witness statement by E21 (former DON) documented, "... [R42] then took the toilet cover (from R43) and hit [R43] in the head ..."	F 600		

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F 600	Continued From page 7 12/13/24 - R42 was care planned to refrain from initiating aggressive behavior with interventions including: - remove and or distract [R42] if possible if his demeanor changes and is showing signs of aggression or anger; - [R42] encouraged to refrain from initiating aggressive behavior from others - Safety measures ... imitated as appropriate and; - Speak calmly to resident. The facility failed to ensure that R43 was free from physical abuse by R42 when on 12/13/24 R42 hit R43 with a toilet cover in the head. 1/31/25 5:00 PM - Finding was discussed with E1 (NHA). 2/4/25 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E15 (RM), E16 (VPO), E17 (DCS), E18 (Corp. IP/SD) and E19 (RN).	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R23, R53 and R89) out of three residents reviewed for communication the facility failed to ensure eash residents' MDS assessments accurately reflected their status. Findings include:	F 641	A. R23 and R89 no longer reside at the facility, whereas R53 continues to resident at the facility. There is no opportunity to correct the alleged deficiency. B. Residents who do not have English as their first language, residents who are ordered anticonvulsant medications and	3/14/25

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F 641	Continued From page 8 1. Cross refer to F656 and F676 R23's clinical record revealed: 11/8/24 - R23 was admitted to the facility. 11/9/24 7:41 AM - R23's admission evaluation documented: "... 8. Preferred Language: SPANISH 9. Do you need or want an interpreter to communicate with a doctor or health care staff? YES...". 11/14/24 - The admission MDS assessment, under Section A, documented that R23's preferred language was English. 2/4/25 at 1:30 PM - During an interview, E14 (RNAC) reviewed the 11/14/24 admission MDS and confirmed the MDS should have indicated Spanish as the preferred language. 2. R53's clinical record revealed: 11/16/24 - R53 had an active physician's order for depakote an anticonvulsant medication every 12 hours. 11/25/24 - An acute progress note by E24 (NP) documented to continue with depakote. 11/28/24 - The quarterly MDS assessment, under Section N, lacked evidence that R53 was taking depakote during the last 7 days. 2/4/25 at 1:30 PM - During an interview, E14 (RNAC) reviewed the 11/28/24 quarterly MDS and confirmed the inaccuracy.	F 641	residents admitted with lower extremity impairment have the potential to be affected by this alleged deficient practice. The Director of Clinical Reimbursement will in-service MDS coordinator accurately recording submissions of MDS assessments whether for newly admitted residents or Quarterly MDS submittals. C. The root cause analysis indicates that the MDS coordinator failed on multiple fronts: 1) accurately reflect that residents preferred language of Spanish, listed on R23's admission evaluation, was a properly reflected on her MDS; 2) MDS coordinator failed to accurately review R53 physician's order to reflect Depakote as an anticonvulsant medication; 3) documenting incorrectly R89's right and lower extremities range of motion impairment. These errors were due to oversights and failure to confirm documentation resulting in the 3 aforementioned inaccurate MDS submissions. The MDS coordinator will review Physical Therapy evaluations for functional limitation in range of motion for lower extremities, clinical records to verify if all anticonvulsant medications are recorded accurately and interview residents to ensure preferred language for communication is accurately captured. D. MDS Coordinator will audit admission assessments to ensure the correct preferred language and any functional limitations in range of motion for lower extremities for newly admitted residents are accurate as well as Quarterly MDS assessments reflect anticonvulsant	

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F 641	Continued From page 9 3. R89's clinical record revealed: 11/7/24 - R89 was admitted to the facility with diagnosis of a stroke. 11/9/24 - R89's Physical Therapy evaluation documented that right and left lower extremities range of motion were impaired. 11/13/24 - The admission MDS assessment documented R89's no functional limitation in range of motion for lower extremities. 2/4/25 at 1:30 PM - During an interview, E14 (RNAC) confirmed the MDS inaccuracy. 2/4/25 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E15 (RM), E16 (VPO), E17 (DCS), E18 (Corp. IP/SD) and E19 (RN).	F 641	medications daily to evaluate the accuracy until 100% success is achieved over 3 consecutive evaluations, then 3 times weekly until 100% success is achieved for 3 consecutive weeks, and finally monthly until 100% is achieved for 2 consecutive months. Results of the audits will be forwarded to the Quality Assurance and Performance Improvement Committee.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and	F 644		3/14/25

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F 644	Continued From page 10 all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R69) out one resident reviewed for mood/behavior, the facility failed to coordinate with the PASRR program under Medicaid and refer the resident for an assessment. Findings include: 1. R69's clinical record revealed: 12/17/24 - A PASRR Level 1 Screen was completed by the hospital and documented that R69 had no mental health diagnosis known or suspected and no current mental health medications prescribed. 12/27/24 - R69 was admitted to the facility. 1/13/25 - A psychiatric evaluation documented, "... past psychiatric history of depression and anxiety... review of psychotropic med (medication) regimen and management of mood/behaviors... Does endorse feelings of anxiousness intermittently... Available records prior to facility admit reviewed and appreciated. Reportedly w/ (with) lengthy psych history and diagnosis of anxiety as well as depression... noted h/o (history of) paranoia. Resident was previously treated in the past with Olanzapine [antipsychotic]...". 1/13/25 - A physician's order prescribed mirtazapine medication daily for R69's depression.	F 644	A. R69 continues to reside at the facility. The Social Worker responsible for corrective action has already entered the necessary PASRR as of February 26, 2025. B. Residents requiring a PASRR as well as residents with a change in mental status diagnosis from the prior Level 1 review or when the PASRR is no longer an accurate representation of what is going on clinically with the resident, have the potential to be affected by this same deficient practice. NHA or designee will in-service Social Services on how and when to resubmit a status change review. Social Services will be given Delaware PASARR Help Desk information at Maximus for questions about the referral process. Social Services and/or designee will in-service the IDT to ensure that residents with new mental status diagnosis are discussed in morning clinical meeting ahead of status change submittals being entered into the AssessmentPro Maximus portal. C. Root cause analysis is that the Admissions Director or Social Worker did not review the PASRR upon admission failed to capture the history of a mental health diagnosis given by a physician prior to his admittance to the facility and therefore an updated PASARR request was not submitted into the	

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REGENCY HEALTHCARE & REHAB CENTER	801 N. BROOM STREET WILMINGTON, DE 19806

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F 644	Continued From page 11 1/14/25 - A physician's order prescribed xanax medication two times a day and as needed for R69's anxiety. 1/15/25 - R69 was care planned for anxiety and depression with approaches that included, but were not limited to, administering medications as ordered. 1/29/25 - A psychiatric note documented, "... seen today at request of facility staff due to worsening anxiety... Recommendations: 1. Continue mirtazapine... for depression... benefits greater than risks at this time. 2. Continue xanax... for anxiety... 5. Plan to contact out patient psych provider... for additional history/verification, may need to consider resume olanzapine/alternative AP [antipsychotic] as there is evidence of potential underlying psychotic process...". 1/31/25 at 1:45 PM - During an interview, E9 (SSD) was asked if he submitted a referral to the PASARR office to have a Level 1 screen completed for R69. E9 replied "no". 2/4/25 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E15 (RM), E16 (VPO), E17 (DCS), E18 (Corp. IP/SD) and E19 (RN).	F 644	AssessmentPro Maximus porta . New Admissions PASRR will be reviewed for accuracy by the Admissions Director and or Social Service Director prior to admission. The IDT will audit residents seen by the Behavioral specialist biweekly to ensure that any new mental health diagnosis or any new mental health medication prescribed results in a new PASRR being entered into the Assessment Pro Maximus portal. D. Social Service and /or Designee will review and conduct daily audits of visits by Behavioral Practitioners to determine if any new mental health diagnoses were entered so that an updated PASARR is submitted. Audits will be conducted: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		3/14/25

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F 656	Continued From page 12 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656		

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F 656	Continued From page 13 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R23, R89 and R43) residents reviewed for care plans the facility failed to develop and implement person-centered care plans, that included measurable objectives and timeframes, to meet each residents' needs. Findings include: Cross refer to F641 and F676 1. R23's clinical record revealed: 11/8/24 - R23 was admitted to the facility. 11/9/24 7:41 AM - R23's admission evaluation documented: "... 8. Preferred Language: SPANISH 9. Do you need or want an interpreter to communicate with a doctor or health care staff? YES...". 11/14/24 - The admission MDS assessment, under Section A, incorrectly documented that R23's preferred language was English. From 11/8/24 through 1/7/25, R23 lacked a person-centered communication care plan as a Spanish-speaking resident. 1/8/25 - Two months after R23 was admitted to the facility, a care plan was initiated for communication problem related to language barrier with an approach that included, but was not limited to, obtaining translation services. 1/13/25 - R23 was discharged to home.	F 656	A. R23 and R89 no longer reside at the facility. R23 Comprehensive care plans were updated to reflect use of translation services for preferred language of Spanish. R89 Care Plan was unable to be revised to account for measurable objectives and timeframes to meet medical, mental and psychosocial needs as R89 has since discharged. R43 care plan has been updated with an updated personalized toileting program to assist in preventing falls. B. Residents with preferred languages other than English have the potential to be affected by this deficient practice. Additionally residents requiring person-centered activity plans to meet medical, mental and psychosocial needs have the potential to be affected by this deficient practice. Lastly residents requiring interventions and installation of a toileting program to prevent falls have the potential to be affected by this deficient practice. Facility educator or designee will in-service licensed nursing staff on developing and updating a comprehensive care plan to account for a language other than English and utilizing translation services of an outside contracted service. Facility educator or designee will in-service Activity Director on how to create a person-centered Activity Care Plan to meet the medical, mental and psychosocial needs of each resident. Facility educator or designee will in-service licensed Nursing staff regarding	

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F 656	Continued From page 14 2/4/25 2:00 PM - During an interview, finding was reviewed with E1 (NHA). 2. R89's clinical record revealed: 11/7/24 - R89 was admitted to the facility. 11/8/24 - A care plan entitled, "Resident to attends (sic) activities of choice until next progress note. The goal was "Resident will attend group activities of choice until next review." Approaches were: escort to activity as needed; provide independent activity material as needed; provide monthly calendar; and remind resident of upcoming activities and/or event. 2/4/25 at 2:00 PM - During an interview, finding was reviewed with E1 (NHA). The facility failed to develop and implement a person-centered activity care plan for R89 that included measurable objectives and timeframes to meet R89's medical, mental and psychosocial needs. Cross refer F690 3. Review of R43's clinical records revealed: 9/19/24 - R43 was re-admitted to the facility with diagnoses including but not limited to dementia, bipolar disorder and insomnia due to mental disorder. 1/31/25 - A review of R43's fall incident reports from August 2024 through December 2024 revealed that R43 fell six (6) times related to his need for assistance with toileting on the following dates:	F 656	installing interventions and a toileting program for resident falls correlated to needing to use the bathroom. C. The root cause analysis indicates that the facility failed to identify resident□s preference for preferred language of communication to meet nursing needs in addition to creating a person-centered activity plan to meet the needs of resident□s for not participating in group or individual activities and lastly, implementing interventions and a toileting program to reduce for falls. The DON or designee will audit current residents with preferred languages other than English, person-centered Activity care plans to meet needs of residents and resident falls correlating to a lack of a toileting program to ensure their respective care plan are updated. Care plans will be updated and new orders will be reviewed in clinical meeting. D. The ADON or designee will audit 1) resident Care Plans for non-English speaking resident to ensure translation services are secured to communicate effectively; 2) residents person-centered activity plans meet medical, mental and psychosocial needs; 3) residents requiring interventions and installation of a toileting program to prevent falls when needing to use the bathroom : 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the	

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F 656	Continued From page 15 - 8/13/24 11:40 PM; - 8/14/24 12:04 AM; - 10/17/24 12:45 PM; - 10/17/24 1:00 PM; - 10/18/24 5:10 AM and; - 10/21/24 10:10 AM. 1/31/25 - A review of R43's care plan lacked evidence that person centered care plan was developed to maintain or restore bladder and bowel continence after R43's multiple falls related to his need for toileting assistance. 1/31/25 5:00 PM - During interview, E1 (NHA) confirmed that an incontinence care plan was not developed for R43 and that the clinical team will be looking into it. 2/3/25 3:52 PM - In an email correspondence, E1 sent an attached file pertaining R43's incontinence care plan initiated on 2/2/25. The facility failed to ensure R43's person centered care plan interventions and a personalized toileting program was reviewed to address R43's falls related to R43's need to use the bathroom. 2/4/25 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E15 (RM), E16 (VPO), E17 (DCS), E18 (Corp. IP/SD) and E19 (RN).	F 656	audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must	F 676		3/14/25

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F 676	Continued From page 16 provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R23) out of three residents reviewed for communication, the facility failed to provide Spanish-speaking	F 676	A. R23 no longer reside at the facility. Care Plan was revised prior to discharge to utilize language services to meet R23□s nursing care needs.	

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F 676	Continued From page 17 translation/interpretation services during nursing care for R23. Findings include: The facility's policy and procedure entitled Translation and/or Interpretation of Facility Services, revised November 2020, stated, "This facility's language access program will ensure that individuals with limited English proficiency (LEP) shall have meaningful access to information and services provided by the facility... 6. Competent oral translation of vital information that is not available in written translation... shall be provided in a timely manner... 10. It is understood that in order to provide meaningful access to services provided by this facility, translation and/or interpretation must be provided in a way that is culturally relevant and appropriate to the LEP individual...". Cross refer to F641 and F656 11/8/24 - R23 was admitted to the facility. 11/9/24 at 7:41 AM - R23's admission evaluation documented: "... 8. Preferred Language: SPANISH 9. Do you need or want an interpreter to communicate with a doctor or health care staff? YES...". 12/22/24 at 2:38 PM - A nurses note documented, "Reported to me that resident is on the floor. Resident lying on the floor on her left side, able to move all extremities... Resident unable to state what happened due to language issues...". 12/23/24 at 9:43 AM - A nurses note documented, "At 0300 (3 AM) resident CNA came to the nurses station stating resident was lying on the floor in	F 676	B. Residents with preferred languages other than English have the potential to be affected by this alleged deficient practice. Facility educator or designee will in-service licensed nursing staff on developing and updating a comprehensive care plan to account for a language other than English and utilizing translation services of an outside contracted service. C. The root cause analysis indicates that the facility failed to identify resident□s preferred language of communication, therefore facility did not provide R23 with translation and or interpretation at all times during her stay at the facility The DON or designee will audit current residents with preferred languages other than English to ensure their respective care plan are updated as needed during clinical meeting. D. The ADON or designee will audit resident Care Plans for non-English speaking resident to ensure translation services are secured to communicate effectively: daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	

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F 676	Continued From page 18 her room. Supervisor and nurse immediately rushed to room... Resident was observed lying on the floor on her stomach next to the bed. Resident could not explain where and what she was doing. Resident only speaks Spanish...". The facility lacked evidence that nursing staff were utilizing translation services, including during the 12/22/24 and 12/23/24 post-fall assessments. 2/4/25 at 2:00 PM - During an interview, E1 (NHA) was asked for evidence of nursing staff utilizing translation services for R23. E1 provided a list of eight transactions for translation service payments with dates and times from the corporation. Neither date of 12/22/24 or 12/23/24 were listed on this document nor was there documentation in R23's clinical record that translation services were provided. 2/4/25 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E15 (RM), E16 (VPO), E17 (DCS), E18 (Corp. IP/SD) and E19 (RN).	F 676		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		3/14/25

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F 684	Continued From page 19 by: Based on clinical record review and interview, it was determined that for one (R43) out of one sampled resident, the facility failed to ensure the physician's order to administer quetiapine fumarate (Seroquel) . Findings include: Cross refer F600 Review of R43's clinical record revealed: 7/24/24 - R43 was admitted to the facility with diagnoses including dementia. 7/25/24 - R43 was care planned for receiving antipsychotic medication (to help manage his aggressive behaviors) and is at risk for behaviors and side effects. 7/30/24 - R43 was care planned for behavior as evidenced by physical aggression and interventions included to administer meds as ordered. 11/7/24 - R43 had a physician's order for quetiapine fumarate (Seroquel) 50 mg give 1 tablet by mouth two times a day for bipolar disorder. 12/3/24 1:11 PM - A nurse progress noted documented, "... quetiapine fumarate... med presently N/A (not available), reordered from pharmacy..." 12/4/24 10:15 AM - A nurse progress note documented, "... quetiapine fumarate... med not delivered from pharmacy despite being reordered. Spoke to pharmacy and they stated that 'the claim was paid and it will be sent on our evening delivery'. will pass in rpeort..."	F 684	A. R43 continues to reside at the facility. There is no opportunity to correct the deficiency. B. Resident requiring Seroquel have the potential to be affected by this alleged deficient practice. The Facility Educator and/or designee will in-service licensed nurses regarding the importance of having medication orders for Seroquel administered as ordered, and what the reconciliation process is if medication is unavailable for administration. C. Root cause analysis indicates the facility failed to comply with Physicians order by securing and administering Seroquel as ordered. Facility failed to notify the physician that Seroquel was not available to administer as ordered. DON or designee will audit residents with Seroquel orders and will be reviewed at morning Clinical meeting to ensure that no medications were missed, and if they were, that the proper process was followed D. Nursing Administration will conduct review of medication orders for Seroquel at morning meeting and at end of day wrap-up to confirm all administrations have verifiably been completed: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will	

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F 684	Continued From page 20 12/4/24 1:37 PM - A nurse progress note documented, "... quetiapine fumarate...awaiting delivery of med..." 12/5/24 9:36 AM - A NP encounter note documented, "...Of note, patient (sic) quetiapine (sic) 50 mg tablets not delivered by pharmacy and missed PM dose yesterday as well as AM and PM doses today, per nursing staff pharmacy reported to be delivered this evening. Will plan to administer additional 50 mg doses at bedtime with routine 200 mg order..." 1/31/25 12:34 PM - Review of R43's December 2024 MAR revealed that R43 missed three (3) doses of quetiapine fumarate 50 mg 1 tab on 12/3/24 at 2 pm. The following day, 12/4/24, R43 missed two more doses at 8:00 AM and 2:00 PM, for a total of three missed doses. 1/31/25 2:40 PM - In an interview, E4 (LPN/UM) confirmed that R43's quetiapine fumarate 50 mg doses were not administered on 12/3/24 at 2:00 PM and on 12/4/24 at 8:00 AM and at 2:00 PM. 1/31/25 3:10 PM - During interview, E1 (NHA) confirmed that the physician was not notified right away on 12/3/24 when the quetiapine fumarate medication was not available. 1/31/25 5:00 PM - Findings were discussed with E11 (NHA). 2/4/25 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E15 (RM), E16 (VPO), E17 (DCS), E18 (Corp. IP/SD) and E19 (RN).	F 684	determine the need for further audits and/or action plans.	

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F 690	Continued From page 21	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by:	F 690		3/14/25

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F 690	Continued From page 22 Based on record review, observation and interview, it was determined that for one (R43) out of three residents reviewed for bowel and bladder, the facility failed to evaluate R43's decline in urinary continence and failed to maintain or restore continence after R43's multiple falls related to his need for toileting assistance. Findings include: Cross refer F600 and F684 A review of R43's clinical records revealed the following: 7/24/24 - R43 was admitted to the facility with diagnoses including but not limited to dementia. 7/25/24 - R43 was care planned for ADL (Activities of Daily Living) deficit related cognition with interventions including assisting R43 to attend activities of choice. In addition, R43 was set up for care and "supervise/verbal dues (sic) to assure he follow thru." 7/25/24 - R43 was care planned for falls related to...poor safety awareness...with interventions including offering toileting before going to bed (8/14/24) and reminding R43 "not to go to the bathroom without help" (10/25/24). 7/31/24 - R43's admission MDS assessment revealed that R43's cognition was severely impaired and was always continent of urine and bowel during the review period. 9/6/24 (revised 1/22/25) - R43 was care planned for behaviors as evidenced by urinating on the floor and also defecating on the AC (air condition) unit. R43's interventions included encouraging R43 to call for assistance when he is ready to use	F 690	A. R43 continues to reside at the facility. Care Plan was updated and revised for R43 by installing interventions and a personalized toileting program to prevent falls. B. Residents who had a fall while attempting to use the bathroom have the potential to be affected by this deficient practice. Facility educator or designee will in-service licensed Nursing staff regarding installing interventions and a toileting program for resident falls correlated to needing to use the bathroom. The DON or designee will audit current residents falls correlating to a lack of a toileting program to ensure their respective care plan are updated. C. The root cause analysis indicates that the facility failed to revise interventions to R43 toileting program to assist in potentially reducing falls while resident is attempting to use toilet. The DON or designee will audit current residents falls, correlating to a lack of a toileting program, to ensure their respective care plan are updated if needed. Care plans will be updated and will be reviewed in clinical meeting. D. The ADON or designee will audit residents requiring interventions and installation of a toileting program to prevent falls when needing to use the bathroom: 1) daily until 100% success is achieved over 3 consecutive evaluations; 2) weekly until 100% success is achieved over 3 consecutive evaluations; 3) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The	

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F 690	Continued From page 23 the bathroom and providing R43 with a urinal. 9/19/24 - R43 was re-admitted from the psych hospital from 9/6/24 through 9/19/24.. 9/19/24 - A facility Bladder and Bowel Continence Evaluation - Readmission Assessment documented: "Is resident completely continent? - No Functional Mobility, Manual Dexterity, Toileting Ability - Extensive Assist Bowel Continence - Occasional Bladder Continence - Occasional Resident toileting preference - Brief List any further important details - none" 9/25/24 - a facility Bladder and Bowel Program Evaluation - Quarterly Assessment documented: "How long has the resident been incontinent - don't know Has a trial of a toileting program attempted? No Current toileting program or trial - No Bowel - continent of stool - no Is a toileting program currently being used...? - No Program initiation: urinary TP - No...bowel TP - No Do not initiate program, why? - (no answer) " 10/2/24 - R43's significant change MDS assessment revealed that R43's cognition was moderately impaired and was frequently incontinent of urine and bowel. R43 was not on a toileting program during the review period. 10/3/24 - A facility Bladder and Bowel Program Evaluation - Quarterly Assessment documented: "How long has the resident been incontinent - don't know	F 690	Committee will determine the need for further audits and/or action plans.	

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F 690	Continued From page 24 Has a trial of a toileting program attempted? Unable to determine Current toileting program or trial - No Bowel - continent of stool - no Is a toileting program currently being used...? - No Program initiation: urinary TP - No...bowel TP - No Do not initiate program, why? - (no answer) " 11/14/24 - R43 was care planned for risk for skin break down as evidenced by incontinence and limited mobility with interventions including incontinent care after each incontinent episode. 1/2/25 - R43's quarterly MDS assessment revealed that R43's cognition was moderately impaired and was always continent of urine and occasionally incontinent of bowel during the review period. 1/3/24 - A facility Bladder and Bowel Program Evaluation - Quarterly Assessment documented: "How long has the resident been incontinent - N/A - continent Has a trial of a toileting program attempted? No Current toileting program or trial - No Bowel - continent of stool - yes Is a toileting program currently being used...? - No Program initiation: urinary TP (Toileting Program) - No...bowel TP - No Do not initiate program, why? - continent of bladder and bowel" 1/31/25 - A review of R43's fall incident reports from August 2024 through December 2024 revealed the following: - 8/13/24 11:40 PM - Resident was found sitting	F 690		

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F 690	Continued From page 25 on the floor at the bathroom door with his feet facing his bed... - 8/14/24 12:04 AM - Resident fell out of wheelchair onto his left side...Stated he was trying to take himself to the bathroom...had recent fall related to toileting himself... - 10/17/24 12:45 PM - Resident was transferring self from bed to go to the bathroom without asking for assistance, he fell before reaching to the bathroom, he reported hitting his head...was going to the bathroom fell and hit his head. - 10/17/24 1:00 PM - Resident was found on the floor next to the bathroom in his room. Resident stated he was trying to use the bathroom and he fell ... stated that he hit his head and he was nauseous ...sent resident to hospital for further evaluation... Resident is being offered a commode and a medical review is underway due to resident frequent falls...Where Changes made to the care plan? Yes offer commode. Resident to be toileted via commode. - 10/18/24 5:10 AM - Resident sitting on buttocks at the foot of the bed. "I was trying to use the bathroom ..." - 10/21/24 10:10 AM - Resident lying on the floor by the bathroom door "trying to go to the bathroom." 1/30/25 9:31 AM - During an obsevation, R43 was observed sitting on the bench in front of the nurse station while watching TV. E3 (ADON) and E4 (LPN/UM) were observed talking in the nurses station. 1/31/25 9:33 AM - In a follow up observation, R43 stood up with unsteady gait, transferred self on the wheelchair and propelled his way to his room. R43 parked his wheelchair outside the bathroom, stood up, entered the bathroom unassisted and	F 690		

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F 690	Continued From page 26 unsupervised. The sound of the toilet flushed was heard. R43 came out the bathroom and with unsteady gait turned to sit on the wheelchair. R43 was seen self propelling back to the nurses station. 1/31/24 9:35 AM - During interview, E6 (LPN) stated that R43 is continent of bowel and bladder and is able to go to the toilet but will still require staff supervision. E6 added that R43 was a high fall risk and has impulsive and aggressive behaviors that could be harmful to himself, to the other residents or to the staff. "We have to be careful when we are around him cause he gets agitated so easily and he is not compliant with asking for assistance when using the bathroom." The facility failed to evaluate R43's toileting decline and initiate a personalized toileting program to address his falls while attempting to use the toilet. 1/31/25 5:00 PM - Findings were discussed with E1 (NHA). 2/4/25 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E15 (RM), E16 (VPO), E17 (DCS), E18 (Corp. IP/SD) and E19 (RN).	F 690		
F 802 SS=E	Sufficient Dietary Support Personnel CFR(s): 483.60(a)(3)(b) §483.60(a) Staffing The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity	F 802		3/14/25

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F 802	Continued From page 27 and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.60(a)(3) Support staff. The facility must provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. §483.60(b) A member of the Food and Nutrition Services staff must participate on the interdisciplinary team as required in § 483.21(b)(2)(ii). This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that a qualified person in charge was present during all hours of operation. The presence of a certified food protection manager reduces the risk for a foodborne outbreak especially for vulnerable populations. "CMS recognizes the U.S. Food and Drug Administration's (FDA) Food Code and the Centers for Disease Control and Prevention's (CDC) food safety guidance as national standards to procure, store, prepare, distribute, and serve food in long term care facilities in a safe and sanitary manner." 1/29/25 11:00 AM - Review of the kitchen staff work schedule provided by E23 (District Food Service Manager) revealed that only one staff person E22 (Food Service Manager) out of three (E22, E23 and E25) who possessed valid Food Protection Manager certificates from an Accredited Food Safety Program was scheduled to work from 12/1/24 through 12/28/24. E22 was	F 802	A. In the absence of Food Services and/or Dietician, the qualified person in charge of the kitchen possesses valid certification from an Accredited Food Safety Program. B. The District Manager or designee will audit current supervisors of the kitchen to ensure each has valid certification from an Accredited Food Safety Program. C. The root cause analysis indicates that the kitchen did not have a qualified person in charge of the kitchen possessing valid certification from an Accredited Food Safety Program during all hours of operation. District Manager and/or designee will in-service Food Services Director regarding securing valid certifications from an Accredited Food Safety Program for all Supervisors of kitchen during all hours of operation. D. Food Service Director or designee will audit Dietary supervisors have valid certifications from an Accredited Food	

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F 802	Continued From page 28 scheduled to work seventeen days out of twenty-eight on the December 2024 kitchen staff schedule and eight days out of fourteen on the partial January 2025 schedule. E23 and E25 (Dietary) were not listed to work any days on the December 2024 or January 2025 kitchen staff schedule. 2/4/25 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E15 (RM), E16 (VPO), E17 (DCS), E18 (Corp. IP/SD) and E19 (RN).	F 802	Safety Program for all Supervisors of kitchen during all hours of operation: 1) weekly until 100% success is achieved over 3 consecutive evaluations; 2) monthly for 3 months until 100% success is achieved. Results of the audits will be forwarded to the QAPI Committee. The Committee will determine the need for further audits and/or action plans.	