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: Cadia Rehabilitation Broadmeadow
DATE SURVEY COMPLETED: March 28, 2025

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report.		
	An unannounced Follow-up Survey to the Annual, Complaint Survey ending on January 22, 2025, was conducted by the State of Delaware Division of Heath Care Quality, Office of Long-Term Care Residents Protection on March 25, 2025, through March 28, 2025. The facility census on the first day of the survey was one hundred sixteen (116). The sample size was thirty-one (31) residents.		
3201			
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.		
	The facility was found to not be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care as of March 28, 2025.		

Provider's Signature Ashaf Hylton Title Administrator Date 4/7/25

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	This requirement is not met as evidenced by: Cross Refer to the CMS 2567-L survey completed March 28, 2025: F684, F692, and F773.		

Provider's Signature Angel Hylton Title Administrator Date 4/7/25

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Provider's Signature Alfred Hylton Title Administrator Date 4/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. BUILDING _____ B. WING _____	R-C 03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION BROADMEADOW	500 SOUTH BROAD STREET MIDDLETOWN, DE 19709

(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	{E 000}		
{F 000}	INITIAL COMMENTS An unannounced Follow-up Survey to the Annual, Complaint Survey ending on January 22, 2025 was conducted by the State of Delaware Division of Heath Care Quality, Office of Long Term Care Residents Protection on March 25, 2025 through March 28, 2025. The facility census on the first day of the survey was one hundred sixteen (116). The sample size was thirty one (31) residents. The facility was found to not be in substantial compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care as of March 28, 2025. Abbreviations/definitions used in this report are as follows: CNA - Certified Nurse's Aide; DON - Director of Nursing; MD - Medical Doctor; NHA - Nursing Home Administrator; NP - Nurse Practitioner; RN - Registered Nurse; Antibiotic - Medication used to treat bacterial infections; Acute kidney injury (AKI) - refers to a sudden decline in kidney function that causes waste products to accumulate in the body. It may manifest as symptoms of weakness, confusion, and less frequent urination; Bacteria - microscopic-size organisms, some of which cause disease and some of which live	{F 000}		

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

Electronically Signed | 04/07/2025

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

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{F 000}	Continued From page 1 peacefully within us; BMP - Basic Metabolic Panel; set of tests that measure blood sugar, calcium levels, kidney function, and chemical and fluid balance; CMP (comprehensive metabolic panel) - blood test that measures sugar (glucose) level, electrolyte and fluid balance, kidney function, and liver function; Congestive Heart Failure - (CHF) heart unable to pump enough blood to meet the body's needs; Contact precautions - series of procedures used to minimize the transmission of infectious organisms by direct or indirect contact, such as wearing gloves and a gown; Culture & Sensitivity (C&S) - laboratory test to identify what bacteria is causing an infection and which antibiotic will effectively kill the bacteria; Dehydration - a condition in which the body has less than normal fluid; Diuretics - medicines that help reduce the amount of water/excess fluid in the body; EMR - (Electronic Medical Record) - a systematized collection of patient and population electronically stored health information in a digital format; Escherichia coli (E. coli), a type of bacteria commonly found in the gastrointestinal (GI) tract; Euvolemic - a balanced state of fluid volume in the body. It means that the body's fluid levels are within a normal range, neither excessive (hypervolemic) nor insufficient (hypovolemic). Maintaining euvolemia is crucial for proper bodily functions and health; Fluid overload - too much fluid in the blood; Hydration - the taking in of water; used commonly in the sense of reduced hydration or dehydration; Hypernatremia- high salt or sodium blood level due to a decrease in total body water; MDS assessment- federally mandated	{F 000}		

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{F 000}	Continued From page 2 comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; Medication Administration Record (MAR) - list of daily medications to be administered; Mental status change - It can affect your speech, thought, mobility, memory, attention span, or alertness. It can range from slight confusion to complete unresponsiveness (coma). Altered mental status can be a sign of a serious underlying medical condition; NSS - normal saline solution, a sterile mixture of salt and water with a salt concentration similar to tears, blood, and other body fluids; SBAR (Situation Background Assessment Recommendation) - tool used to communicate between members of the health care team; Sepsis - potentially deadly medical condition characterized by a whole-body inflammatory state; symptoms include fever, difficulty breathing low blood pressure, fast heart rate, and mental confusion; Shingles - a viral infection that causes a painful rash; Sodium- a mineral and electrolyte found in salt; blood tests show how much is in blood; Tachycardia - an abnormally fast heart rate; Urinalysis (UA) - is an array of tests performed on urine, and one of the most common methods of medical diagnosis; ug/mL - microgram per milliliter - In the metric system, a microgram is a unit of mass equal to one millionth of a gram. A milliliter is one thousandth of a liter (liter is slightly more than a quart); Urine culture and sensitivity (C&S) - a microscopic study of the urine culture performed to determine the presence of pathogenic bacteria	{F 000}		

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{F 000}	Continued From page 3 in patients with suspected urinary tract infection; Urosepsis - severe illness that occurs when an infection starts in the urinary tract and spreads into the bloodstream;	{F 000}		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R31) out of three residents reviewed for quality of care, the facility failed to treat a urinary tract infection for twenty hours, after receiving a positive result of infection. Findings include: Cross refer F692 and F773 Review of R31's clinical record revealed: 11/3/23 - R31 was admittied to the facility. 3/6/25 12:45 AM - A physician's order documented to obtain a urinalysis, if the urinalysis was positve send for culture and sensitivity for increased confusion and lethargy. 3/9/25 8:03 PM - A lab result report received in the facility EMR system documented that R31's	F 684	F684 Quality of Care 1. R31 was transferred to the hospital, treated, and returned to the facility on 4/4/2025 2.All residents have the potential to be affected by this deficient practice. Future residents will be protected by measures taken below in number 3. 3. A facility-wide audit was conducted of all residents with a positive urine culture and all labs have been reviewed by the provider. The root cause analysis determined that the lab did not call the facility with a positive urine culture result. The lab result was uploaded directly into the electronic health record. As a result, the RN supervisor was not aware of the	4/14/25

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F 684	Continued From page 4 urinalysis noted culture growth of escherichia coli (e coli) with a colony count greater than 100,000 cfu/mL indicating a postive result for urinary tract infection. 3/10/25 9:01 AM - A time stamp noted in the EMR that E6 (NP) reviewed the urine results on the lab result report. The was 11 hours after the facility received the results of a positive UTI. 3/10/25 4:00 PM - A physician's order documented ceftriaxone (antibiotic) one gram inject one gram intramuscularly every twenty four hours for UTI (urinary tract infection) for five days. Give with lidocaine 2.1 mL. This was seven hours after the provider reviewed the positive lab results for a UTI. 3/10/25 4:27 PM - A review of R31's MAR documented that ceftriaxone was administered. 3/10/25 7:00 PM - A change in condition assessment documented R31 was having mental status changes, unable to respond properly to questions asked, lethargy, and neurological changes, and not able to focus. The assessment documented a recommendation of the primary clinician that R31 to be sent to the emergency room for further evaluation. 3/27/25 3:00 PM - An interview with E6 confirmed that R31 had a positive urine culture and that E6 ordered antibiotics. E6 confirmed that she instructed the 3:00 PM to 11:00 PM shift to send R31 to the emergency room due to change in condition. E6 further revealed that staff did not call the urine results to her on 3/9/25. 3/28/25 9:15 AM - An interview with E6 confirmed	F 684	abnormal result to call the provider. CNO will educate the lab director that all positive urine cultures are to be called to the facility. All positive urine results are to be called to the provider. Nursing management will be educated by Staff D to review the lab portal in the electronic health record at the beginning and ending of their shifts daily to ensure all positive urine cultures are addressed and provider notified. 4. The DON and/or designee will conduct audits of all urine lab results to ensure the results are reviewed timely and positive results are called to the provider. The audit will be conducted daily for one month to ensure 100% compliance. Audits will continue 3 times weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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F 684	Continued From page 5 that she reviewed R31's urine results at 9:00 AM on 3/10/25 and confirmed that R31 needed antibiotics to treat the UTI. E6 stated that she did not need to wait on R31's lab results collected on 3/10/25 to initiate the antibiotics for the UTI. The facility failed to treat a UTI for 20 hours after the facility received a positive lab result. 3/28/25 3:21 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 684		
{F 692} SS=G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:	{F 692}		4/14/25

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{F 692}	Continued From page 6 Based on record review and interview, it was determined that for one (R31) out of two residents reviewed for hydration, the facility failed to ensure that R31 was offered sufficient fluids to maintain proper hydration when R31's oral intake significantly dropped. This failure resulted in harm with R31 being transferred to the hospital on 3/10/25 with a diagnosis of dehydration and AKI (acute kidney injury). Findings include: The BUN (blood urea nitrogen) lab measures the amount of urea nitrogen in the blood. The BUN is directly related to the metabolic function of the liver and the excretory function of the kidney ... BUN levels also may vary according to the state of hydration, with increased levels seen in dehydration and decreased levels seen in overhydration. Mosby's Diagnostic and Laboratory Test Reference 2023. Cross refer F684 and F773 Review of R31's clinical record revealed: 11/3/23 - R31 was admitted to the facility with the diagnosis of but not limited to congestive heart failure (CHF). 11/3/23 - An admission nutritional assessment documented that R31's recommended fluid intake was 1600 - 1900 mL/day. 1/3/24 - An annual nutritional assessment documented that R31's recommended fluid intake was a 1500 mL fluid restriction. 11/15/24 - A physician's order documented that R31's 1500 mL fluid restriction would consist of 840 mL from dietary, 660 mL from Nursing: 270	{F 692}	F692 Nutrition/Hydration Status Maintenance 1. R31 was transferred to the hospital, treated, and returned to the facility on 4/4/2025 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected by the measures taken below in section 3. 3. A facility-wide audit was completed of all residents evaluated to be at risk of poor po intake and no further issues were identified. The root cause analysis was conducted, and it was determined that the facility did not have a system in place to capture all the fluids that are offered between meals. All residents are provided with a minimum of 16oz of water at the bedside every shift, which is not captured in the electronic health record (EHR). All residents on contact/droplet isolation will receive an order to encourage fluids Q shift. Staff D will educate all licensed nurses to document any additional fluids the resident was offered and consumed between meals on the treatment administration record (TAR). The dietician will review the total amount of po fluids consumed daily and the dietician will educate the weekend RN supervisor to calculate the po fluid intake of all residents on contact/droplet isolation to ensure fluid goals are met. Residents that failed to meet their fluid goals for the previous 24-hour period, the provider will be notified.	

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{F 692}	Continued From page 7 mL on day shift, 270 mL on evening shift, and 120 mL on night shift. 12/4/24 - A progress note documented that per E5 (Cardiologist) "new order received to discontinue fluid retriction for [R31]. [R31] and responsible party made aware." It was unclear what R31's fluid goal was after the fluid restriction was discontinued. 1/28/25 - A quaterly MDS documented that R31 required set up assistance of one staff for feeding and hydration. R31 was also documented as a BIMS score of 12 indicating she was cognitively intact. 2/5/25 - A review of R31's labs (BMP) revealed a sodium level (NA) of 143 mmol/L and normal value is 137 - 145 mmol/L. The blood urea nitrogen level (BUN) was 18.0 mg/dL and normal value is 9.0 - 20.0 mg/dL. Labs were reviewed by E6 (NP) and documented in electronic medical records (EMR). The daily totals obtained from CNA flow sheets for R31's fluid intake were: -2/24/25 - 1210 mLs. -2/25/25 - 1020 mLs. -2/26/25 - 1000 mLs. -2/27/25 - 1120 mLs. -2/28/25 - 880 mLs -3/1/25 - 960 mLs. -3/2/25 - 960 mLs. 3/3/25 3:00 PM - A physician's order documented that R31 was placed on isolation precautions related to a new diagnosis of shingles for seven days. R31 was moved from the Warner Unit to	{F 692}	4. The dietician and/or designee will audit residents on contact/droplet isolation daily, for the duration of their isolation period, to ensure residents are meeting their fluid goals. Once 100% compliance is met for 3 consecutive months, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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{F 692}	Continued From page 8 the Everest Unit to be placed on isolation. 3/3/25 10:00 PM - A physician's order documented R31 was to take valacyclovir 1 gm tablet, one by mouth every eight hours for shingles. The daily totals obtained from CNA flow sheets for R31's fluid intake were: -3/3/25 - 480 mLs. -3/4/25 - 720 mLs. -3/5/25 - 720 mLs. 3/6/25 12:01 AM - A physician's progress note documented R31 was seen related to "nursing reporting [R31] having increased confusion, vitals remain stable, resident [R31] noted to be lethargic during visit." The progress note further documented neurological exam revealed R31 was disoriented to person, place, and time and noted minimal response to verbal and tactile stimulation. "The plan documents related to lethargy/confusion/ altered mental status (AMS) ordered labs CBC with differential, CMP, Magnesium, urine analysis and urine culture if urinalysis is positive. R31 is to continue on furosemide (diuretic) R31 continues to be euvolemic." 3/6/25 - The daily total obtained from CNA flow sheet for R31's fluid intake was 580 mLs. 3/7/25 12:01 AM - A physician's progress note documented R31 was seen for a follow up "[R31] currently being treated for shingles, on valacyclovir, medications and labs reviewed, noted confusion and lethargy. [R31] had poor intake noted and euvolemic." The progress note further documented neurological exam revealing	{F 692}		

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{F 692}	Continued From page 9 R31 was disoriented to person, place, and time and noted minimal response to verbal and tactile stimulation. "The note (sic) documented the plan related to lethargy/confusion/AMS: urinalysis positive for trace leukocytes (increased white blood cells) pending urine culture. The plan for AKI (Acute kidney injury) documented normal saline 1 liter at 50 mL/hr and rechecking basic metabolic panel (BMP) on Monday (3/10/25)." 3/7/25 12:50 PM - A review of the lab results report documented that R31 had a BUN of 34.0 mg/dL (high), Creatinine 1.30 mg/dL (high), Glucose level of 55 mg/dL (low), magnesium 1.4 mg/dL (low) and the labs were signed off by E6 at 4:48 PM on 3/7/25. 3/7/25 3:00 PM - A physician's order documented sodium chloride 0.9% administer 50 mL/hr intravenously for 24 hours due to lethargy and poor intake. 3/7/25 4:50 PM - A physician's order documented labs for BMP and magnesium for AKI and hypomagnesmia to be obtained on 3/10/25. The daily totals obtained from CNA flow sheets for R31's fluid intake were: -3/7/25 - 600 mLs. IV fluid total - 450 mLs. -3/8/25 - 480 mLs. IV fluid total - 750 mLs. -3/9/25 - 420 mLs. The facility lacked evidence of offering sufficient fluid intake and evidence of nursing interventions to encourage fluid intake for R31. 3/10/25 2:25 PM - The lab results report in the EMR documented that R31 had a BUN of 42.0 mg/dL (high), Creatinine 1.50 mg/dL (high),	{F 692}		

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{F 692}	Continued From page 10 Sodium level of 148 mmol/L (high), Magnesium 1.9 mg/dL (normal) and the labs were signed off by E6 at 5:20 PM on 3/10/25. 3/10/25 - The CNA flow sheet documented R31's fluid intake was 650 mLs. 3/10/25 8:28 PM - A progress note from the hospital documented that R31 "had an elevated BUN level of 44 mg/dL (high) and Creatinine level of 1.71 mg/dL (high) and presenting with a pretty substantial AKI. [R31] was given IV fluids and two doses of metoprolol (heart control medication) and tachycardia (elevated heart rate) did not change. Administration of levophed (vasopressor - raise blood pressure) and maxed out on level 5. Differential (labs) most suspicious of septic shock related to to UTI (urinary tract infection)." 3/11/25 1:00 AM - A physician's progress note from an assessment at 1:00 PM on 3/10/25 (prior to hospitalization) documented R31 was seen for a follow up visit regarding "[R31] developed lethargy and confusion... [R31] continues to have poor appetite, magnesium level now within normal limits, sodium level elevated likely from fluids... Tachycardia noted... Considered antibiotic therapy in the facility but due to worsening condition and labs, it was recommended patient be sent for further evaluation. Sepsis is of concern." 3/11/25 2:40 AM - A hospital physician's progress note documented that R31 had a creatinine level of 1.71 mg/dL and was elevated indicating acute kidney injury "elevated from decreased oral intake over previous days and possible acute tubular necrosis (ATN) from sepsis as well. [R31] also was noted to have hypernatremia, acute likely	{F 692}		

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	085050	A. BUILDING _____ B. WING _____	R-C 03/28/2025

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due to decreased oral intake." The progress notes also documented "BMP notable for hypernatremia to 149 hypochloremia (low chrloride) to 116 likely from dehydration, she is showing signs of vomiting status on her physical exam with a dry mouth, she received a liter of fluid to help with this. She had an elevated BUN and creatinine to 44 and 1.71 respectively, her last creatinine was 0.9 representing a pretty substantial AKI."

3/27/25 11:26 AM - An interview with E7 (CNA) revealed that R31 was able to feed herself and was on thin liquids. E7 stated that she completed care for R31 and provided a sixteen ounce styrofoam cup with water each shift. E7 stated that during the time period of 3/8/25 to 3/10/25, R31 was not drinking a lot and total intake was reported to the nurse on duty. Staff was reminded by nursing to encourage fluids to R31.

3/27/25 11:32 AM - An interview with E8 (CNA) revealed that "I know [R31] but I was never assigned to do her care. I saw her every morning because I was assigned to tell residents of the day's lunch and dinner menu and collect their order for dietary. [R31] was able to feed herself and pick up a cup to drink her water. [R31] was on isolation precaution for shingles. Staff gives out water cups to all residents. I was not aware if [R31] had preferences for drinks and beverages."

3/27/25 11:41 AM - An interview with E9 (RN) revealed that " I [E9] was the regular nurse for the [R31] and she was transferred to Everett from Warner due to shingles when placed on isolation precautions. [R31] had tendency to refuse her fluids." E9 stated she always gave R31 fluids with her meds and gave water in the 16 oz water cup

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each time E9 saw her in her room. This is in addition to the water cups the aides give. R31 was not on fluid restriction and received thin liquids. "I [E9] assumed the Unit Manager (UM) and Dietitian reviews the fluid consumption information. I worked Friday that day shift, confirmed that [R31] had blood work was collected in the morning and the results didn't come back until later that day after my shift was over. When labs come back late in the day, staff will usually start the IV in the afternoon 3:00 PM -11:00 PM shift."

3/27/25 11:55 AM - An interview with E10 (RN UM) revealed that R31 had IV fluids but E10 did not remember R31's lab values during this time. E10 stated that E4 (dietician) would follow R31 for needs for adaptive device and check ability to feed self, also including monitoring fluid intake. E10 stated all staff get alerts in the EMR tracking. "[R31] was discussed in morning meetings with [E4] and [E2]. [E2] and [E4] both had access to the EMR triggers."

3/27/25 3:00 PM - An interview with E6 (NP) revealed that "I (E6) saw R31 on 3/6/25 with lethargy so I ordered labs and urinalysis. R31 was seen again on 3/7/25 by myself (E6) and E11 (MD). E11 ordered IV fluids to run at 50 mL/hr for 24 hrs due to R 31's history of CHF (congestive heart failure; prevent overload of fluids). R31 also had a follow up blood work (BMP) to include Mg ordered for 3/10/25." R31 was not seen by a provider again over the weekend. I (E6) "did not receive any phone calls from staff over the weekend (3/8 - 3/9/25) regarding R31's clinical presentation or lab results." E6 saw the R31 midday on Monday (3/10/25) where R31 was lethargic, and had the same clinical presentation

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{F 692}	Continued From page 13 despite IV fluid interventions plus heart rate increased and went up (tachycardic). [R31] had an elevated BUN and [E6] instructed the 3:00 PM to 11:00 PM shift to send [R31] to the hospital for treatment and evaluation. E6 was "unaware of the time the R31 left in the evening." E6 stated I "did not think it would matter to recheck labs prior to Monday as it would not have changed the outcome of the general change of condition [R31] was undergoing if it was collected that Sunday." 3/28/25 4:10 PM - An interview with E13 (RN) revealed that R31 had poor oral intake and that the CNA's had notified her that R31 was not drinking much on 3/7/25. E13 confirmed that she would offer R31 240 mL per med pass and that R31 would only take sips of water at a time. E13 stated that R31 had an IV infusion on 3/7/25 and that E13 did not have R31 on her assignment again until 3/10/25. E13 stated when she came to work on 3/10/25 she was informed that R31 was getting ready to be sent to the hospital. E13 stated R31's condition was not her normal and she remembered her oxygen levels were low and E13 had to put oxygen on R31 prior to her going to the hospital. 3/27/25 4:35 PM - An interview with E14 (CNA) confirmed that R31 was on his assignment on 3/8/25 and that R31 did not eat dinner or any snacks that shift. E14 revealed that R31 was not drinking enough fluids during that shift and reported to the nurse (E13). E14 confirmed that he offered R31 fluids and she would only take small sips and did not finish any cups of fluids offered. Despite the CNA's reporting R31's declined fluid intake to nursing, the facility failed to increase	{F 692}		

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{F 692}	Continued From page 14 monitoring or notify the provider of this change. 3/28/25 10:05 AM - Review of R31's EMR progress notes lacked evidence of efforts to address R31's decreased oral fluid intake including approaches to increase hydration and consultation with the doctor. 3/28/25 3:21 PM - Findings were reviewed with E1 and E2 during the exit conference.	{F 692}		
{F 773} SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that, for one (R31) out of four residents sampled for laboratory services, the facility failed to promptly notify the ordering provider of laboratory results. Findings include: Cross refer F684 and F692 Review of R31's clinical record revealed:	{F 773}	F773 Lab Services 1. R31 was transferred to the hospital, treated, and returned to the facility on 4/4/2025 2. All residents have the potential to be affected by this deficient practice. Future residents will be protected by measures taken below in number 3.	4/14/25

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{F 773}	Continued From page 15 11/3/23 - R31 was admitted to the facility. 3/6/25 12:45 PM - A physician's order documented an order to obtain a urinalysis, if the urinalysis was positve send for culture and sensitivity for increased confusion and lethargy. 3/9/25 8:03 PM - A lab result report documented that R31's urinalysis noted culture growth of escherichia coli (e coli) with a colony count greater than 100,000 cfu/mL indicating a postive result for urinary tract infection. 3/10/25 9:01 AM - A time stamp noted in the EMR that E6 (NP) reviewed the urine results on the lab result report. 3/27/25 3:00 PM - An interview with E6 confirmed that she did not receive a phone call on 3/8/25 regarding R31's abnormal lab results. 3/28/25 9:26 AM - An interview with E15 (RN) confirmed that if abnormal lab results come in on the weekend the nurse on duty would be expected to call the provider. 3/28/25 9:51 AM - An interview with E9 confirmed that if abnormal results come in on a weekend E9 confirmed she would notify the supervisor of the results and either the nurse or supervisor on duty would be expected to notify the provider at that time. 3/28/25 10:05 AM - Review of R31's EMR progress notes lacked evidence of notifying the provider of abnormal lab results. 3/28/25 3:21 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit	{F 773}	3. A facility-wide audit was conducted of all residents with a positive urine culture and all labs have been reviewed by the provider. The root cause analysis determined that the lab did not call the facility with a positive urine culture result. The lab result was uploaded directly into the electronic health record. As a result, the RN supervisor was not aware of the abnormal result to call the provider. CNO will educate the lab director that all positive urine cultures are to be called to the facility. All positive urine results are to be called to the provider. Nursing management will be educated by Staff D to review the lab portal in the electronic health record at the beginning and ending of their shifts daily to ensure all positive urine cultures are addressed and provider notified. 4. The DON and/or designee will conduct audits of all urine lab results to ensure the results are reviewed timely and positive results are called to the provider. The audit will be conducted daily for one month to ensure 100% compliance. Audits will continue 3 times weekly or until 100% compliance is achieved for 3 consecutive weeks. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is met, the deficient practice will be considered resolved. All audits will be reviewed by the Quality Assurance Committee.	

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{F 773}	Continued From page 16 conference.	{F 773}		