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

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

**STATE SURVEY REPORT**



NAME OF FACILITY: Cadia Rehabilitation Pike Creek

DATE SURVEY COMPLETED: February 17, 2025

| SECTION | STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES | COMPLETION DATE |
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| | **The State Report incorporates by reference and also cites the findings specified in the Federal Report.**<br><br>An unannounced complaint survey was conducted at this facility from February 11, 2025, through February 17, 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 148. The investigative sample totaled six residents. | | |
| 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.**<br><br>**This requirement is not met as evidenced by:**<br><br>Cross Refer to the CMS 2567-L survey completed February 17, 2025: F684, F695 and F773. | Cross Refer to the CMS 2567-L Survey completed February 17, 2025: F684, F695, and F773. | 4/7/2025 |

Provider's Signature Brandi Wilson Title NHA Date 3/24/25

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| | 085054 | A. BUILDING _____ B. WING _____ | C 02/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| CADIA REHABILITATION PIKE CREEK | 3540 THREE LITTLE BAKERS BLVD WILMINGTON, DE 19808 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced complaint survey was conducted at this facility from February 11, 2025 through February 17, 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 148. The investigative sample totaled six residents.<br><br>Abbreviations/definitions used in this report are as follows:<br><br>CNO - Chief Nursing Officer;<br>G-Tube - a tube inserted through the abdomen into the stomach;<br>Hypoxia - not enough oxygen reaching the body tissues;<br>LPN - Licensed Practical Nurse;<br>Neuro checks - exam consists of a physical examination to identify signs of disorders affecting your brain, spinal cord and nerves (nervous system);<br>MD - Medical Director;<br>MAR - Medication Administration Record;<br>NHA - Nursing Home Administrator;<br>RSV - respiratory syncytial virus/viral infection of the respiratory tract;<br>Seizure disorder - abnormal electrical activity in the brain causing repetitive muscle jerking;<br>Tracheostomy - an opening made in the throat to assist breathing. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that | F 684 | | 4/7/25 |

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

Electronically Signed | 03/14/2025

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 684 | Continued From page 1<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, it was determined that for two (R1 and R3) out of three residents sampled for falls, the facility failed to ensure that each resident received care and services in accordance with physician orders and professional standards of practice for post-fall assessments. For R1, the facility failed to obtain and document current vital signs (VS) every shift after alert charting was initiated for increased monitoring of the resident. For R3, the facility failed to ensure the resident was monitored after a fall which included seizure activity. Findings include:<br><br>The facility's policy and procedure entitled Alert Charting, last reviewed 1/3/25, stated, "... It is the policy... to utilize alert charting for residents experiencing changes in condition that warrant heightened observation as determined through nursing judgment... Procedure:.. Residents placed on alert charting are assessed by the nurse each shift and assessment data entered into nursing notes. Incidents that may warrant placing a resident on alert charting include; but are not limited to; resident falls... Document objective data related to the resident's condition i.e., vital signs...".<br><br>1. R1's clinical record revealed: | F 684 | F684 #1<br><br>1. R1 no longer resides in the facility. R1 was not negatively impacted by this deficient practice.<br>2. All residents who are placed on alert charting have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3.<br>3. A facility wide sweep of all residents who are currently on Alert Charting was completed and no other residents were affected by this deficient practice.<br>A root cause analysis was conducted, and it was determined that the licensed nurses failed to obtain current vital signs when charting on R1. The Staff Developer/designee will educate the licensed nursing staff on obtaining current vital signs each shift while the resident is on alert charting.<br>4. The Director of Nursing/designee will audit five random residents who are on alert charting to ensure that current vital signs are obtained each shift of the alert charting process.<br>The audit process will be conducted three times weekly until compliance is | |

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| F 684 | Continued From page 2<br>1/28/25 4:47 PM - A nurse's note documented, "Resident was found by staff lying on the floor in front of his bed... Neuro checks and alert charting initiated."<br><br>1/28/25 - The following physician's order was entered in R1's record: "Alert Charting s/p [status post] fall x [times] 3 days, every shift for 3 days."<br><br>According to the facility's daily staff posting on 1/28/25, the facility has three shifts for nurses: day shift (7 AM to 3:30 PM); evening shift (3 PM to 11:30 PM); and night shift (11 PM to 7:30 AM).<br><br>The Alert Charting notes in R1's record were the following:<br>- E7 (LPN) documented, "Effective Date: 01/29/2025 04:51 [4:51 AM]... Resident is on Alert Charting for Fall. Vitals:...BP [Blood Pressure] 156/74 - 1/28/2025 22:36 [10:36 PM]... T [Temperature] 98.2 - 1/28/2025 22:36... P [Pulse] 77 - 1/28/2025 22:36... R [Respirations] 18.0 - 1/28/2025 22:36... O2 [Oxygen Saturation] 94.0 % - 1/28/2025 22:36...". E7 failed to obtain and document R1's current vital signs.<br><br>- E7 (LPN) documented, "Effective Date: 01/30/2025 03:22 [3:22 AM]... Resident is on Alert Charting for S/p [status post] fall. Vitals:... BP 145/66 - 1/29/2025 21:20 [9:20 PM]... T 97.9 - 1/29/2025 21:20... P 81 - 1/29/2025 21:20... R 18.0 - 1/29/2025 21:20... O2 93.0 % - 1/29/2025 21:20...". E7 failed to obtain and document R1's current vital signs.<br><br>- E8 (LPN) documented, "Effective Date: 01/30/2025 11:49 [11:49 AM]... Resident is on Alert Charting for s/p fall. Vitals:... BP 145/66 - 1/29/2025 21:20 [9:20 PM]... T 97.9 - 1/29/2025 | F 684 | consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.<br><br>F684 #2<br><br>1. R3 still resides in the facility and was not negatively impacted by this deficient practice.<br>2. All residents who are readmitted to the facility following an evaluation at the emergency room after experiencing a fall in the facility have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3.<br>3. A facility wide sweep of all residents who have been readmitted to the facility following an emergency room visit following a fall in the facility was completed and no other residents were affected by this deficient practice.<br>A root cause analysis was conducted, and it was determined that the licensed nurses failed to obtain current vital signs or conduct an assessment on R3. The Staff Developer/designee will educate the | |

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| F 684 | Continued From page 3<br>21:20... P 81 - 1/29/2025 21:20... R 18.0 - 1/29/2025 21:20... O2 93.0 % - 1/29/2025 21:20...". E8 failed to obtain and document R1's current vital signs.<br><br>- E9 (LPN) documented, "Effective Date: 01/30/2025 22:46 [10:46 PM]... Resident is on Alert Charting for s/p fall. Vitals:... BP 145/66 - 1/29/2025 21:20 [9:20 PM]... T 97.9 - 1/29/2025 21:20... P 81 - 1/29/2025 21:20... R 18.0 - 1/29/2025 21:20... O2 93.0 % - 1/29/2025 21:20...". E9 failed to obtain and document R1's current vital signs.<br><br>- E7 (LPN) documented, "Effective Date: 01/31/2025 03:03 [3:03 AM]... Resident is on Alert Charting for Fall. Vitals:... BP 145/66 - 1/29/2025 21:20 [9:20 PM]... T 97.9 - 1/29/2025 21:20... P 81 - 1/29/2025 21:20... R 18.0 - 1/29/2025 21:20... O2 93.0 % - 1/29/2025 21:20...". E7 failed to obtain and document R1's current vital signs.<br><br>- E8 (LPN) documented, "Effective Date: 01/31/2025 10:16 [10:16 AM]... Resident is on Alert Charting for Fall. Vitals:... BP 145/66 - 1/29/2025 21:20 [9:20 PM]... T 97.9 - 1/29/2025 21:20... P 81 - 1/29/2025 21:20... R 18.0 - 1/29/2025 21:20... O2 93.0 % - 1/29/2025 21:20...". E8 failed to obtain and document R1's current vital signs.<br><br>2/1/25 - R1 was placed on Alert Charting for signs/symptoms (s/s) of FLU/COVID/RSV, which included the following:<br>- E7 (LPN) documented, "Effective Date: 02/1/2025 06:00 [6:00 AM]... Resident is on Alert Charting for S/S OF FLU/COVID/RSV. Vitals:... BP 117/60 - 1/31/2025 21:46 [9:46 PM]... T 98.3 - 1/31/2025 21:46... P 91 - 1/31/2025 21:46... R | F 684 | licensed nursing staff on obtaining current vital signs and complete an assessment on residents who are readmitted to the facility following an emergency room visit after experiencing a fall the facility.<br>4. The Director of Nursing/designee will audit all residents who are readmitted from an emergency room visit following a fall, to ensure that current vital signs and assessments are obtained each shift of the alert charting process.<br>The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. | |

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| F 684 | Continued From page 4<br>18.0 - 1/31/2025 21:46... O2 93.0 % - 1/31/2025 21:46...". E7 failed to obtain and document R1's current vital signs.<br><br>2/17/25 at 12:46 PM - During an interview, Surveyor reviewed with E12 (NP) and E12 acknowledged that current vital signs were not obtained and documented by nursing staff.<br><br>2/17/25 2:00 PM - During an interview, findings were reviewed with E3 (CNO). No further information was provided to the Surveyor.<br><br>2. Review of R3's clinical record revealed:<br><br>12/17/22 - R3 was admitted to the facility with diagnoses including acute and chronic respiratory failure, seizure disorder, ventilator dependence, and persistent vegetative state.<br><br>12/20/22 - R3's seizure care plan (revised 2/15/23 and 9/9/23) documented, " ...At risk for falls r/t [related to] seizure d/o [disorder] & involuntary movement ...the resident is on hypnotic for seizures ..."<br><br>12/9/24 - R3's annual MDS documented, "Completely dependent on staff for all activities of daily."<br><br>1/26/25 11:19 AM - R3's clinical records documented, " ...Received order to send resident to ER for further evaluation ..."<br><br>1/26/25 11:42 AM - R3's clinical records documented, " .... On the floor ...no visible injuries noted, but resident was seizing to the point where automatic blood pressure could not be taken on the arms but [sic] taken on the legs. Seizures | F 684 | | |

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| F 684 | Continued From page 5<br>lasted about 5 minutes ...CNA reported that resident was first found on her face then was turned on her back ..."<br><br>1/27/25 1:44 AM - R3 returned to facility from the hospital.<br><br>The facility lacked evidence that R3's vital signs, clinical assessments and seizure monitoring were done on for 1/27/25 on the 7-3 and 3-11 shifts.<br><br>2/3/25 6:26 PM - The facility's 5-day follow up report submitted to the Division documented, " ... Resident noted with possible seizure activity."<br><br>2/14/25 12:00 PM - During a telephone interview E5 (RN supervisor) stated, "I was called to the room and saw the resident [R3] laying on her back on the floor. Her arms and legs were shaking. Her arms were shaking so badly that her blood pressure had to be taken on her leg." The surveyor asked E5 whether R3 was coughing, E5 stated, "No, but her arms and legs were shaking."<br><br>12/14/25 12:30 PM - Findings were confirmed with E3 (CNO.)<br><br>2/17/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (CNO), E10 (Corp. Nurse) and E11 (Corp. Nurse). | F 684 | | |
| F 695 SS=E | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.<br>The facility must ensure that a resident who needs respiratory care, including tracheostomy | F 695 | | 4/7/25 |

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| F 695 | Continued From page 6<br>care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that for five (R2, R3, R4, R5, and R6) out of five residents reviewed for respiratory care, the facility failed to ensure that respiratory care, including tracheostomy care and respiratory mouth care, was provided consistent with professional standards of practice and the comprehensive person-centered care plan.<br>Findings include:<br><br>1. Review of R2's clinical record revealed:<br><br>8/3/23 - R2 was admitted to the facility with diagnoses including acute respiratory failure with hypoxia, and tracheostomy. R2 was dependent on the staff for all activities of daily living.<br><br>8/4/23 - R2's respiratory care plan documented, "The resident [R2] has a tracheostomy." The interventions included, "Trach care per order ... Provide good oral care ..."<br><br>8/4/23 - R2's respiratory treatment administration record documented, "Respiratory to perform mouth care every shift .... Trach care every shift."<br><br>A review of R2's respiratory TAR revealed the following:<br><br>6/6/24 7:00 PM - R2's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care. | F 695 | F695 #1<br><br>1. R2 no longer resides in the facility. R2 was not negatively impacted by this deficient practice.<br>2. All residents who have a tracheostomy have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3.<br>3. A facility wide sweep of all residents who have a tracheostomy was completed to ensure that tracheostomy and oral care was provided per the physician□s order and documented. No other residents were affected by this deficient practice.<br>A root cause analysis was conducted, and it was determined that the licensed respiratory staff failed to document that tracheostomy and oral care were completed. The Staff Developer/designee will educate the licensed respiratory staff on ensuring that residents with a tracheostomy receive tracheostomy and oral care every shift as ordered and ensure that the provided care is documented.<br>4. The Director of Respiratory Therapy/designee will audit five random residents who have a tracheostomy to ensure that tracheostomy and oral care have been provided as ordered and | |

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| F 695 | Continued From page 7<br><br>6/9/24 7:00 PM - R2's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care.<br><br>The facility failed to provide tracheostomy and respiratory mouth care for two out of 24 opportunities.<br><br>2. Review of R3's clinical record revealed:<br><br>12/17/22 - R3 was admitted to the facility with diagnoses including acute and chronic respiratory failure, seizure disorder, ventilator dependence, and persistent vegetative state. R3 was completely dependent on staff for all activities of daily.<br><br>2/16/23 - R3's respiratory care plan documented, "The resident is ventilator dependent r/t [related to] Respiratory Failure." The interventions included, "Trach care per order."<br><br>9/26/23 - R3's respiratory treatment record documented, "Respiratory to perform mouth care, Trach care every shift."<br><br>12/14/25 12:15 PM - A review of R3's respiratory TAR revealed the following:<br><br>6/9/24 7:00 PM - R3's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care<br><br>The facility failed to provide tracheostomy and respiratory mouth care for one out of a total of 60 opportunities.<br><br>3. Review of R4's clinical record revealed: | F 695 | documented.<br>The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.<br><br>F 695 #2<br><br>1. R3 still resides in the facility and was not negatively impacted by this deficient practice.<br>2. All residents who have a tracheostomy have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3.<br>3. A facility wide sweep of all residents who have a tracheostomy was completed to ensure that tracheostomy and oral care was provided per the physician□s order and documented. No other residents were affected by this deficient practice.<br>A root cause analysis was conducted, and it was determined that the licensed respiratory staff failed to document that tracheostomy and oral care were completed. The Staff Developer/designee | |

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| F 695 | Continued From page 8<br><br>8/22/23 - R4 was admitted to the facility with diagnoses including left sided paralysis status post stroke, chronic respiratory failure and tracheostomy. R4 was dependent on staff for all activities of daily living.<br><br>8/23/23 - R4's respiratory care plan documented, " .... Has a tracheostomy ..." The interventions included, "Monitor/document respiratory rate, depth and quality. Check and document q [every] shift as ordered."<br><br>5/17/24 - R4's physician's orders documented, "Trach care every shift, Respiratory to perform mouth care every shift."<br><br>A review of R4's respiratory TAR revealed the following:<br><br>6/6/24 7:00 PM - R4's respiratory TAR lacked evidence of tracheostomy care.<br><br>6/9/24 5:00 PM - R4's respiratory TAR lacked evidence of respiratory mouth care, and tracheostomy care at 7:00 PM.<br><br>6/17/24 5:00 PM - R4's respiratory TAR lacked evidence of respiratory mouth care, and tracheostomy care at 7:00 PM.<br><br>6/18/24 5:00 PM - R4's respiratory TAR lacked evidence of respiratory mouth care, and tracheostomy care at 7:00 PM.<br><br>6/23/24 1:00 PM - R4's respiratory TAR lacked evidence of respiratory mouth care.<br><br>The facility failed to provide tracheostomy and | F 695 | will educate the licensed respiratory staff on ensuring that residents with a tracheostomy receive tracheostomy and oral care every shift as ordered and ensure that the provided care is documented.<br>4. The Director of Respiratory Therapy/designee will audit five random residents who have a tracheostomy to ensure that tracheostomy and oral care have been provided as ordered and documented.<br>The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.<br><br>F695 #3<br><br>1. R4 still resides in the facility and was not negatively impacted by this deficient practice.<br>2. All residents who have a tracheostomy have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. | |

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| F 695 | Continued From page 9<br>respiratory mouth care for four out of 60 out of opportunities.<br><br>4. Review of R5's clinical record revealed:<br><br>8/25/23 - R5 was admitted to the facility with diagnoses including chronic obstructive pulmonary failure, acute respiratory failure, and tracheostomy.<br><br>2/23/24 - R5's care respiratory care plan documented, " ...Has a tracheostomy ..." The interventions included, " ... Trach care per orders ..."<br><br>6/1/24 - R5's respiratory treatment record documented, "Trach care every shift." "Respiratory to perform mouth care two times a day."<br><br>A review of R5's respiratory TAR revealed the following:<br><br>6/6/24 7:00 PM - R5's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care.<br><br>6/9/24 7:00 PM - R5's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care.<br><br>6/17/24 7:00 PM - R5's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care.<br><br>The facility failed to perform tracheostomy and respiratory mouth care for three out of total 60 opportunities. | F 695 | 3. A facility wide sweep of all residents who have a tracheostomy was completed to ensure that tracheostomy and oral care was provided per the physician□s order and documented. No other residents were affected by this deficient practice.<br>A root cause analysis was conducted, and it was determined that the licensed respiratory staff failed to document that tracheostomy and oral care were completed. The Staff Developer/designee will educate the licensed respiratory staff to ensure that residents with a tracheostomy receive tracheostomy and oral care every shift as ordered and ensure that the provided care is documented.<br>4. The Director of Respiratory Therapy/designee will audit residents who have a tracheostomy to ensure that tracheostomy and oral care have been provided as ordered and documented. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. | |

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| F 695 | Continued From page 10<br>5. Review of R6's clinical record revealed:<br><br>12/6/22 - R6 was admitted to the facility with diagnoses including anoxic brain damage, persistent vegetative state, acute and chronic respiratory failure, and tracheostomy. R6 was completely dependent on staff for all activities of daily living.<br><br>12/6/22 - R6's respiratory care plan documented, " ...Resident has a tracheostomy r/t [related to] impaired breathing mechanic ..." The interventions included, "Suction as necessary. Trach care per order."<br><br>4/24/24 - R6's respiratory TAR documented, "Trach care every shift, and respiratory to perform mouth care 2 times a shift."<br><br>A review of R6's respiratory TAR revealed the following:<br><br>6/6/24 7:00 PM - R6's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care.<br><br>6/9/24 7:00 PM - R6's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care.<br><br>6/17/24 7:00 PM - R6's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care.<br><br>6/18/24 7:00 PM - R6's respiratory TAR lacked evidence of tracheostomy and respiratory mouth care.<br><br>The facility failed provide tracheostomy and | F 695 | F695 #4<br><br>1. R5 still resides in the facility and was not negatively impacted by this deficient practice.<br>2. All residents who have a tracheostomy have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3.<br>3. A facility wide sweep of all residents who have a tracheostomy was completed to ensure that tracheostomy and oral care was provided per the physician□s order and documented. No other residents were affected by this deficient practice and documented.<br>A root cause analysis was conducted, and it was determined that the licensed respiratory staff failed to document that tracheostomy and oral care were completed. The Staff Developer/designee will educate the licensed respiratory staff on ensuring that residents with a tracheostomy receive tracheostomy and oral care every shift as ordered and ensure that the provided care is documented.<br>4. The Director of Respiratory Therapy/designee will audit residents who have a tracheostomy to ensure that tracheostomy and oral care have been provided as ordered and documented. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently | |

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| F 695 | Continued From page 11<br>respiratory mouth care for a total of four out of 60 opportunities.<br><br>2/14/25 2:30 PM - During an interview the Surveyor asked E6 (RT) which department provided tracheostomy and respiratory mouth care for the residents. E6 stated, "Respiratory therapy."<br><br>2/16/25 2:00 PM - Findings were confirmed with E3 (CNO.)<br><br>2/17/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (CNO), E10 (Corp. Nurse) and E11. | F 695 | achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.<br><br>F695 #5<br><br>1. R6 still resides in the facility and was not negatively impacted by this deficient practice.<br>2. All residents who have a tracheostomy have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3.<br>3. A facility wide sweep of all residents who have a tracheostomy was completed to ensure that tracheostomy and oral care was provided per the physician□s order and documented. No other residents were affected by this deficient practice.<br>A root cause analysis was conducted, and it was determined that the licensed respiratory staff failed to document that tracheostomy and oral care was completed. The Staff Developer/designee will educate the licensed respiratory staff on ensuring that residents with a tracheostomy receive tracheostomy and oral care every shift as ordered and ensure that the provided care is documented.<br>4. The Director of Respiratory | |

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| F 695 | Continued From page 12 | F 695 | Therapy/designee will audit residents who have a tracheostomy to ensure that tracheostomy and oral care have been provided as ordered and documented. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. | |
| F 773 SS=D | Lab Srvcs Physician Order/Notify of Results<br>CFR(s): 483.50(a)(2)(i)(ii)<br><br>§483.50(a)(2) The facility must-<br>(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.<br>(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.<br>This REQUIREMENT is not met as evidenced by: | F 773 | | 4/7/25 |

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| F 773 | Continued From page 13<br>Based on record review and interview, it was determined that for two (R1 and R3) out of three residents reviewed for falls, the facility failed to obtain laboratory services when ordered by a provider. Findings include:<br><br>1. R1's clinical record revealed:<br><br>11/4/16 - R1 was admitted to the facility with a diagnosis of seizure disorder.<br><br>9/23/24 - R1 had the following physician orders for an active diagnosis of seizure disorder:<br>- Administer two medications twice daily: Phenobarbital and Keppra; and<br>- Obtain Phenobarbital and Keppra lab levels every six months starting on 10/25/24.<br><br>Review of R1's clinical record revealed the absence of 10/25/24 Phenobarbital and Keppra lab results.<br><br>2/12/25 at 10:30 AM - During an interview, finding was confirmed with E3 (CNO). The two labs were not completed.<br><br>2. Review of R3's clinical record revealed:<br><br>12/17/22 - R3 was admitted to the facility with diagnoses including acute and chronic respiratory failure, seizure disorder, ventilator dependence, and persistent vegetative state. R3 was completely dependent on staff for all activities of daily.<br><br>10/24/24 - R3's physician's orders included, "Phenobarbital, Keppra Levels every night shift every 6 month(s) starting on the 25th ..." | F 773 | F773 #1<br><br>1. R1 no longer resides in the facility. R1 was not negatively impacted by this deficient practice.<br>2. All residents who have a physician's order to obtain laboratory services have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3.<br>3. A facility wide sweep of all residents who have a physician's order to obtain laboratory services was completed to ensure that the laboratory services were obtained per physician's orders and results were received. No other residents were affected by this deficient practice.<br>A root cause analysis was conducted, and it was determined that the nursing management team failed to ensure that the physician ordered laboratory services were obtained, and results were received.<br>The Staff Developer/designee will educate the nursing management team on ensuring that laboratory services are obtained per the physician's order, and the results are received.<br>4. The Director of Nursing/designee will audit ten random residents who have an order to obtain laboratory services to ensure that the laboratory services are obtained per the physician's order and the results are received.<br>The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a | |

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| F 773 | Continued From page 14<br>Lab draw was scheduled for 10/25/24 on the 11-7 shift. R3's clinical records (lab records) documented that the labs were drawn on 10/28/24.<br><br>2/12/25 11:00 AM - A review of R3's clinical records failed to show evidence of the antiseizure medications laboratory results from 10/28/24. During an interview, E3 (Unit Manager) stated, "I will check for the results." E3 confirmed with the Surveyor that the lab results were not available in R3's clinical record.<br><br>2/12/25 3:08 PM - Phenobarbital results of 33.2 from 10/28/24 was uploaded into R3's clinical record.<br><br>The clinical record lacked evidence that the labs for Keppra was obtained.<br><br>12/14/25 12:14 AM - R3's clinical record revealed that the lab results were reviewed by the NP (more that 3 1/2 months after the labs were drawn.)<br><br>The facility failed to obtain antiseizure medications lab results per physician's orders for a resident with a diagnosis of seizure disorder.<br><br>12/14/25 12:30 PM - Findings were confirmed with E3 (CNO.)<br><br>2/17/25 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (CNO), E10 (Corp. Nurse) and E11 (Corp. Nurse). | F 773 | week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.<br><br>F773 #2<br><br>1. R3 still resides in the facility and the lab was drawn on February 13, 2025, and was within normal limits.<br>2. All residents who have a physician's order to obtain laboratory services have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3.<br>3. A facility wide sweep of all residents who have a physician's order to obtain laboratory services was completed to ensure that the laboratory services were obtained per physician's orders and results were received. No other residents were affected by this deficient practice.<br>A root cause analysis was conducted, and it was determined that the nursing management team failed to ensure that the physician ordered laboratory services were obtained per physician's orders and results were received. The Staff Developer/designee will educate the licensed nursing staff on ensuring that laboratory services are obtained per the | |

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| F 773 | Continued From page 15 | F 773 | physician's order and the results are received.<br>4. The Director of Nursing/designee will audit ten random residents who have an order to obtain laboratory services to ensure that the laboratory services are obtained per the physician's order and the results are received.<br>The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. | |