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: Polaris Healthcare & Rehab Center LLC

DATE SURVEY COMPLETED: January 28, 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 13, 2024, through January 28, 2024. The facility census for the first day of the survey was ninety-one (91). The survey sample totaled twenty-eight (28).		
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 January 28, 2025: E037, E039, F561, F567, F578, F580, F585, F622, F625, F626, F641, F656, F657, F658, F677, F684, F688, F689, F690, F692, F695, F697, F710, F730, F755, F758, F760, F761, F773, F791, F805, F812, F941, F942, F944, F945, F946, F947, and F949.		

Provider's Signature [signature] Title Interim Administrator Date 3/18/2025

NAME OF FACILITY: Polaris Healthcare & Rehab Center LLC DATE SURVEY COMPLETED: January 28, 2025

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3201.3.3	Notice before transfer. Before a facility transfers or discharges a resident, the facility must—		
3201.3.3.1	Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.		
3201.3.3.2	Provide a copy of the notice to the Division; the State LTC ombudsman; the resident's Delaware Medicaid managed care organization (MCO), if any; any DHSS agency involved in the resident's placement in the facility, including APS; and the protection and advocacy agency as defined in Title 16 Del.C. §1102 if the resident is an individual with a developmental disability or mental illness.		
3201.3.3.3	Record the reasons in the resident's clinical record; and		
3201.3.3.4	Include in the notice the items described in paragraph 3.5 of this section.		
	Based on interview and record review and review of other facility documents it was determined that for one (R148) out of three residents reviewed for discharge the facility failed to ensure that discharge requirements were met when R148 was discharged from the facility on 10/9/24 without notice to the resident. Additionally, the facility failed to notify the State LTC Ombudsman that R148 would be discharged from the facility. Findings include. Review of R148's clinical record revealed: 8/23/24 - R148 was admitted to the facility with multiple diagnoses including a history of major depressive disorder with severe psychotic symptoms, anxiety, and suicidal ideation.		

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	8/26/24 - A five-day MDS assessment documented that R148 was cognitively intact with a goal of remaining in the facility. 10/9/24 7:53 AM - A note in R148's clinical record documented that the resident was sent to the hospital. 10/9/24 - The Transfer/Discharge notice indicated the reason for R148's transfer as "it is necessary for your welfare and needs cannot be met at the facility" the location of the transfer was to "hospital ER". The notice was signed by R148. Accompanying the transfer notice was a notification of bed hold policy that was signed by R148, and an "Acute Care Transfer" document checklist. 10/9/24 2:56 PM - A social service notes in R148's clinical record documented "Called [another nursing home] at 2:54 PM to see how to send over a referral for the resident." 10/9/24 - A discharge return not anticipated MDS assessment was completed for R148 with no discharge plan or referrals documented. 10/15/24 2:51 PM - A social service notes documented, "Returned the call from [inpatient psychiatric facility staff] on behalf of [R148] and they requested information on transferring the resident back to the facility. Social service director gave the information to the unit manager [E24(RN)]." October 2024 - The facility transfer list provided to the Ombudsman documented that R148 was transferred out for medical leave. The list did not indicate that R148 was discharged. 1/10/25 1:17 PM - During an interview E22 (SW) at inpatient psychiatric facility stated, "The facility would not allow [R148] to return,	• R148 no longer resides in the facility. The facility has no opportunity to resolve the alleged deficiency. • Residents who require transfer to an acute setting have the potential to be affected. The Nursing Home Administrator (NHA) or designee will audit residents who have been transferred to the hospital in the last 7 days to ensure discharge requirements are met. • The root causes analysis shows the facility failed to follow its discharge policy and practice. The Administrator or designee will educate the admissions director on the discharge policy and practice. • The NHA or designee will audit residents who have been transferred to the hospital and request return to ensure the facility policy has been followed until 100% compliance is achieved. The results of these audits will be reviewed at QAPI to determine if follow up action is needed	3/18/2025

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	and I got that from E6 (Admissions) but [R148] has been placed somewhere else." 1/21/25 1:47 PM - During an interview E23 (RN) confirmed that R148 was denied readmission to the facility. E23 stated, "I know she couldn't come back; I was told she owed money." 1/22/25 10:21 AM - During an interview E6 (Admissions) stated that R148 "Was having suicidal ideation with a plan that's why they sent her out to psych and the hospital sent her out to [inpatient psychiatric facility]." E6 confirmed that R148 was denied readmission to the facility following discharge from the inpatient psychiatric facility because "At the time she owed us a large bill like seventy thousand and corporate was not letting me readmit her. E21 (controller) my corporate direct denied the readmission because the bill was so large and would not allow R148 to return until Medicaid approval. Then Medicaid denied." 1/22/25 11:51 AM - During an interview E24 (RN) former unit manager stated, "E6 (Admissions) said we wouldn't be allowing R148 back because of a large bill". 1/22/25 11:58 AM -During an interview E21 (Controller) confirmed that R148 was not allowed readmission to the facility. E21 stated that R148 "Came in through the state program they stopped paying for her and we applied for Medicaid, and it was denied. She was here eight months without payment. There should be a regular discharge letter." The surveyor requested a copy of the Medicaid denial, any appeal documents, a bill, and discharge notice. The requested documents were not received, there was no evidence that the resident was provided the opportunity to contest the discharge per State regulations for a fair hearing.		

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	1/23/25 9:19 AM - During an interview E1 (NHA) confirmed the facility had no evidence of a discharge notice, or discharge summary for R148. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4(CCS). 1/30/25 – It was confirmed that the Division of Healthcare Quality (DHCQ) was not provided a copy of the discharge notice. Administrative Code, 3201, Skilled Care and Intermediate Care Facilities		
3201.9.8	**Reportable Incidents are as follows:**		
3201.9.8.4	**Significant Injuries**		
3201.9.8.4.2	**Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.** Based on record review and interview for two (R44 and R89) out of three residents reviewed for accidents the facility failed to report R44's fall with injury. 1.R44's clinical record revealed: 9/8/23 – R44 was admitted to the facility. 12/26/24 10:45 AM – A facility provided incident accident witness statement by E3 (ADON) documented "Walking around making rounds when residents primary nurse pulled me to assess patient after fall. Pt. (sic) noted with bruise and small laceration to forehead." 12/26/24 11:01 AM – A facility change in condition progress note by E7 (LPN) documented "Patient had a fall and hit head on wheelchair		

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	scale. Primary care provider responded with the following feedback send to ER (sic) for evaluation." 1/14/25 3:56 PM – The Surveyor sent an email to E1 (NHA) and E2 (DON) to review copies of the facility report investigation for R44's fall that occurred on 12/26/24. 1/22/25 11:00 AM – During an interview E2 (DON) confirmed and stated, "the report for [R44's] fall was not done, I was simply trained wrong under the old administration it was simply lack of education we were told a report would be prompted if treatment at the emergency room was given to the resident, so that is why a report was not submitted. The facility was unable to provide any evidence that the fall on 12/26/24 was ever reported. 1/23/25 3:18 PM – Findings were confirmed with E1 (NHA). 2. Review of R89's clinical record revealed: 5/22/24 - R89 was admitted to the facility with multiple sclerosis, a stroke, and was paraplegic. 8/7/2024 11:40 AM – A nursing progress note documented: "Floor nurse and aide called me to inform me resident had fallen on the floor during AM care. Aide informed me that patient was coughing and rolled off the bed and she was unable to catch her...Due to patient hitting head she was transferred out to (said hospital) for further evaluation and CT scan of the head." 8/7/24 12:03 PM – An emergency department note documented that R89 had a "minor head contusion from a mechanical fall".	• R44 & R89 accident with transfer to the hospital was submitted to the department of health. • Residents who are sent to the hospital related to fall have the potential to be affected. • The root cause analysis indicates the director of nursing received education on the The nursing home administrator or designee will educate the director of nursing services on the Delaware State Reporting Guidelines. • The Director of Nursing or designee will audit residents who experienced a fall with transfer to the hospital weekly for 3 weeks, then monthly for 3 months to ensure state was notified of the transfer until 100% compliance is achieved.	3/18/2025

Provider's Signature [signature] Title [illegible] Date 3/18/2025

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	8/7/2024 10:32 PM – A nursing progress note documented: "Resident returned from the ER after being seen from head contusion (sic.) pots fall." 1/16/25 1:25 PM - During an interview, E1 (NHA) stated that the facility did not report R89's fall related to R89 did not sustain any injury. The facility failed to report to the State agency that R3 had a fall with injury and a transfer to an acute care setting. 1/24/25 1:30 PM - Findings reviewed with E1, E2, E3, and E4.		

Provider's Signature [signature] Title ~~Director~~ Administrator Date 3/18/2025

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	085058	A. BUILDING _____ B. WING _____	C 01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POLARIS HEALTHCARE AND REHABILITATION CENTER	21 W CLARKE AVENUE MILFORD, DE 19963

(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 13, 2025 through January 28, 2025 . The facility census was 91 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, Emergency Preparedness deficiencies were identified.	E 000		
E 037 SS=E	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years.	E 037		3/18/25

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

Electronically Signed | 02/26/2025

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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E 037	Continued From page 1 (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		

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E 037	Continued From page 2 arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under	E 037		

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E 037	Continued From page 3 arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients,	E 037		

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E 037	Continued From page 4 personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review it was determined that for three (E28, E29, and E30) out of six (6) sampled staff members, the facility failed to to ensure that staff received annual Emergency Preparedness training in the previous twelve months. Findings include: Review of facility records for emergency preparedness training revealed three (3) staff members without evidence of training within the	E 037	Facility Director will conduct new employee orientation education and bi-annual education to all staff, including contracted service employees and volunteers on our emergency preparedness policies and procedures. Facility Director & Staff Development will maintain the new employee orientation and annual education training records.	

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E 037	Continued From page 5 past year: - E28 (Dietary Aide) had no record of any emergency preparedness training - E29 (RN) received the most recently documented Emergency Preparedness training on 4/10/23. - E30 (CNA) received the most recently documented Emergency Preparedness training on 10/23/23. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Corporate Support)	E 037	Staff knowledge and 100% competency of our emergency preparedness policies and procedures will be audited and documented. Safety Committee and QAPI committee will review training education and records for 90 days to ensure compliance and provide feedback if additional training is needed.	
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual	E 039		3/18/25

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E 039	Continued From page 6 natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of	E 039		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 7 the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 8 (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 9 community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is	E 039		

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E 039	Continued From page 10 community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 11 (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions	E 039		

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E 039	Continued From page 12 designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E 039		

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E 039	Continued From page 13 plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.	E 039		

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E 039	Continued From page 14 (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, it was determined that the facility failed to complete the required annual Emergency Preparedness testing in the previous twelve months. Findings include: 1/17/25 3:05 PM- An interview with E8 (Director of Maintenance) revealed the facility had not experienced a an actual qualifying emergency requiring the full activation of the emergency plan, which would have exempted the acuity from participation in other emergency plan testing. 1/24/25 10:45 AM- An email from E8 indicated that the facility was unable to provide documentation of the facility's participation in a full-scale community-based exercise, table exercise, or workshop in the past twelve months. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON) and E4 (Corporate Support)	E 039	Facility Director will coordinate and schedule (1) full scale exercise with local EMA, fire, police and EMS services on annual basis. (1) Table top exercise will be conduct annually, which will be led by our fire safety contractor to facilitate a group discussion reviewing our community□s Emergency preparedness policies and procedures. Safety Committee will audit monthly our completed exercises in accordance with our HVA to determine the specific exercises and table top discussion. Safety Committee and QAPI will review exercise schedule and table top exercise to be conducted annually in compliance with emergency preparedness guidelines. Safety Committee meeting minutes will reflect such schedule, testing requirements and exercise topics.	
F 000	INITIAL COMMENTS An unannounced Annual and Complaint Survey was conducted at this facility from January 13, 2025 through January 28, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 91. The investigative sample	F 000		

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F 000	Continued From page 15 totaled 37 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; BOM - Business Office Manager; CNA - Certified Nurse's Aide; CCS - Corporate Clinical Support; DON - Director of Nursing; LPN - Licensed Practical Nurse; NP - Nurse Reactionary; RN - Registered Nurse; SW - Social worker; Advance Directive - a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor; ALS - Amyotrophic lateral sclerosis, is a nervous system disease that affects nerve cells in the brain and spinal cord. ALS causes loss of muscle control and is a progressive and fatal disease. Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language; Anti-anxiety Medication - medication used to treat any of several disorders that cause nervousness, fear, apprehension and worrying; Antibiotic - medication used to treat bacterial infections; Arterial duplex scan - a painless exam that uses high-frequency sound waves (ultrasound) to capture internal images of the major arteries in the arms, legs and neck; BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15	F 000		

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F 000	Continued From page 16 with 15 being the best; Braden Scale - tool used to determine risk for development of pressure ulcers; Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently Cognitively Intact - able to make own decisions Debridement - removal of necrotic (dead) tissues so that healthy tissue can regenerate OR surgical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue OR the process of removing nonliving tissue from pressure ulcers Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue. Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning Diabetes mellitus: More commonly referred to as "diabetes" -- a chronic disease associated with abnormally high levels of the sugar glucose in the blood EMR - (Electronic Medical Record) - a systematized collection of patient and population electronically stored health information in a digital format. End-Stage Renal Disease - (ESRD) disease where the kidneys stop working Eschar - dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed OR dead tissue forming a hard	F 000		

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F 000	Continued From page 17 scab; usually black in color FlexPen - trademark for a device to administer insulin that is prefilled and color-coded. It allows for accurate measurement by dialing the number of units to be administered Foley catheter - a tubular, flexible instrument inserted and retained in the bladder by a balloon to empty urine from the bladder; Frequently Incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period Grievance - an official statement of a complaint over something believed to be wrong or unfair; Hallucinations - something that seems real but does not really exist; Hyperglycemia- high blood sugar; Incontinence - loss of control of bladder &/or bowel function Insulin - a hormone that lowers the level of glucose (a type of sugar) in the blood by helping glucose enter the body's cells. Doctors use this hormone to treat diabetes when the body can't make enough insulin on its own; Kardes - instructions for care provided to the residents by the CNA; MDS assessment- federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs; MG/DL - Milligrams per deciliter, a unit of measure that shows the concentration of a substance in a specific amount of fluid Moderate cognitive impairment - decisions poor; cues and supervision required Necrosis / Necrotic - tissue death, usually due to interruption of blood supply or injury OR dead; non-viable tissue Non-Alzheimer's Dementia- Dementia from	F 000		

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F 000	Continued From page 18	F 000		

another cause other than Alzheimer's, such as vascular or brain damage caused by multiple strokes;
Offloading - removal of pressure from an area;
Oxycodone - an opioid pain medication sometimes called a narcotic; used to treat moderate to severe pain;
Pain Scale - 1-10. The most common scale for pain. The patient to identify their pain between one to ten, with ten being the worst pain imaginable and one being no pain at all;
Pixus - System for storage of emergency stock and back up medications.
Pressure Ulcers (PUs) - sore area of skin that develops when the blood supply to it is cut off due to pressure;
ROM - Range of motion - exercises to asssit with movement.
Scheduled (or timed) toileting program - fixed time interval toileting assistance for resident's with urinary incontinence;
Serosanguineous - drainage containing serum and blood;
Skin prep - a liquid film-forming dressing that, upon application to intact skin, forms a protective film;
Sliding scale with insulin coverage - A dosing schedule that is based on a particular blood sugar value or range of values. The insulin dose to be administered becomes greater when blood sugar readings are higher. Each sliding scale needs to be tailored to the individual, as each patient has unique circumstances and different insulin requirements;
TAR - Treatment Administration Record;
Unit - a type of measurement;
Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or

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F 000	Continued From page 19 brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed).	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for one (R85) out of thirty-seven	F 561	R85 was interviewed by the Director of Nursing or designee for her preferences	3/18/25

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F 561	Continued From page 20 residents reviewed in the investigative sample, the facility failed to ensure care preferences were being honored. Findings include: Review of R85's clinical record revealed: 12/12/24 - Resident was admitted to the facility. 12/13/24 - A resident preference evaluation documented that it was very important for R85 to choose between a tub bath, shower, bed bath or sponge bath. The evaluation indicated that R85 preferred a shower. 12/18/24 - A physician's order documented showers two times a week on Wednesday and Saturday 7:00 AM to 3:00 PM shift. 1/13/25 9:55 AM - An interview with R85 revealed that the facility did not ask R85 regarding her preference to time or day of showers. 1/17/25 8:40 AM - An interview with E48 (CNA) revealed that the residents shower schedule in the electronic medical record does not match the typed schedule posted at the nursing station. 1/17/25 8:50 AM - An interview with E17 (UM, RN) confirmed that the unit shower schedule is based on room number and will be adjusted if the resident or family tells the facility they don't like the schedule. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 561	related to showers and resident is happy with her current shower schedule. Residents who reside at this facility have the potential to be affected by this alleged deficient practice. The Director of Nursing or designee will review current residents to ensure their preference for showers are being honored. The Root Cause Analysis indicates R85 was interviewed about her preferences at the time of admission and indicated she preferred a shower rather than a bath. Resident BIMS is a 15 and is offered bathing options with each shower. She has never expressed a desire to shower on specific days or times. The DON or designee will educate staff on Resident Rights to include honoring resident preferences. NHA or designee will educate Activities Director to interview all new admissions for their preferences. The NHA or designee will interview 5 residents weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure their preferences for showers are being honored. Results of these audits will be reviewed at QAPI to determine if follow up action is needed.	
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii)	F 567		3/18/25

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F 567	Continued From page 21 §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account,	F 567		

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F 567	Continued From page 22 interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (R43 and R79) out of three residents reviewed for personal funds the facility failed to ensure residents had access to the their funds. Findings include: The facility policy entitled, "Deposit of Resident Funds" last updated March 2021 indicated, "Should the resident permit the facility to hold, safeguard, and manage his or her personal funds, the facility will: provide the resident access to funds of fifty dollars or less within twenty four hours, and access to funds in excess of fifty dollars within three banking days." 1. 11/2/24 - An MDS assessment documented that R79 was cognitively intact. 12/23/24 - A receipt in the facility records documented that R79 received 50.00 in personal funds from E17 (BOM). 1/13/25 10:48 AM - During an interview R79 stated, "They had a change in the person who was disbursing the money and she had to be oriented. I wanted it for Christmas and I got it two days before Christmas. Which was too late because I wanted to send Christmas cards. I made the request at least the beginning of the month and I didn't get it until the week of (sic). I was talking about it to [E1 (NHA) and E17 (BOM)]; I usually just have to call and then I sign a slip." 1/22/25 10:54 AM - During an interview R79 reported requesting personal funds from "[E17	F 567	R43 and R79 have access to their resident funds. Residents who are not private pay have the potential to be affected by this alleged deficient practice. NHA or designee will meet with the Resident Council to inform them of how they can access their funds during off hours. The Root Cause Analysis indicates the funds were not available per facility policy. The Business Office Manager (BOM) or designee reviewed and revised facility process to include funds being upon resident request. The BOM or designee will audit resident funds weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure funds are available in the facility. Results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 567	Continued From page 23 (former BOM)] and then I told reception. Then I had to wait." 2. 12/24/24 - A receipt in the facility records documented that R43 received 100.00 in personal funds from E17 (BOM). 12/27/24 - An annual MDS assessment documented that R43 was cognitively intact. 1/21/25 11:45 AM - During an interview E17 (BOM) "I came in mid December before that the (BOM)position was empty for quite some time." E17 confirmed that residents should be able to access personal funds within 24 hours if less than fifty dollars and "no more than three business days" for larger amounts. E17 provided the surveyor with two logs of personal funds received residents for December 2024 with no funds documented as disbursed from 12/13/24 - 12/23/24. 1/22/25 11:07 AM - During an interview R43 stated, "I told [E18] (former BOM) that I wanted to take out some money but then she left and I had to wait for the other one [E17 BOM] to get acclimated so I had to wait. I did eventually get the money. 1/22/25 11:27 AM - E1 (NHA) notified the surveyor that E18 (former BOM) last date of employment was 11/5/24 and that E17 (BOM) started on 12/16/24. E1 stated "I believe we had a regional person covering and reception was helping out as well." The facility lacked evidence of how this information was relayed to the residents. 1/24/25 1:30 PM - Findings were reviewed with	F 567		

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F 567	Continued From page 24 E1 (NHA), E2 (DON), and E4(CCS).	F 567		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to	F 578		3/18/25

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F 578	Continued From page 25 provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R81) out of five residents reviewed for Advance Directives, the facility failed to offer an opportunity to formulate an advance directive. Findings include: Review of R81's clinical record revealed: 3/25/24 - R81 was admitted to the facility. 3/30/24 - An admission packet for the facility was completed for R81 and revealed that "Exhibit G: advanced directed form" documented R81 was a full code. The remainder of the form was left blank relating to questions regarding formulating an advanced directive. 10/2/24 - A quarterly MDS assessment documented a BIMS score of 15 indicating R81 was cognitively intact. 1/13/25 11:34 AM - An interview with R81 revealed that he was not offered to formulate an advanced directive. 1/14/25 1:35 PM - An interview with E41 (SW) revealed that advanced directives get discussed during the initial care plan meeting. 1/14/25 2:33 PM - An interview with E6 (Admissions) revealed that nursing staff is expected to ask resident questions on admission	F 578	R81 was offered the opportunity to formulate an advanced directive and has filled out the document's requirements. Residents who are admitted to the facility have the potential to be affected by this alleged deficient practice Current residents will be audited to ensure their advanced directive is complete. The Root Cause Analysis indicates the Admissions Director lacked the knowledge in completing the form completely. The Administrator or designee will educate the admissions director on the process of completing advanced directives for new residents. The Administrator or designee will audit new admissions weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure the advanced directive is complete. Results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 578	Continued From page 26 sheet regarding advanced directive. E6 confirmed that she did not ask R81 if he would like to formulate an advanced directive. 1/14/25 2:45 PM - An interview with E27 (RN) confirmed that nursing staff is responsible to discuss advanced directive with newly admitted residents. E27 presented R81's "preferred intensity of medical care and treatment" form from the clinical record dated 3/25/24 and 8/9/24. E27 confirmed that these forms were completed with R81 post admission. The aforementioned form addresses a resident's preferred code status and lacks evidence of information regarding advanced directive. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		3/18/25

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F 580	Continued From page 27 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R64) out of two residents reviewed for change in condition, the facility failed to consult the provider and notify the responsible party when R64 experienced a significant change in condition and plan of care.	F 580	R64's daughter has been made aware of her change in condition that resulted in new orders from her physician. She has been made aware of the results of the ordered tests and is in agreement with the treatment plan.	

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F 580	Continued From page 28 Findings include: Cross refer F773 Review of R64's clinical record revealed: 11/27/24 - R64 was admitted to the facility. 12/4/25 - An admission MDS documented R64 was a BIMS of 7 indicating severe cognitive impairment. 1/10/25 - A progress note documented that FM3 reported that R64 was lethargic and not at her baseline. E27 (RN) documented R64's assessment and called the on-call provider. 1/10/25 1:34 PM - A progress note documented that R64 had a non-productive cough, mild confusion, speech unclear at times, elevated heart rate, was drowsy nd not her usual self. Additionally, R64 was given cough medicine, Tylenol, and Tums per provider order. 1/10/25 7:56 PM - A progress note documented that R64 refused dinner and continued with an elevated heart rate. Additionally, the progress note documented the on call provider was notified with new orders. 1/10/25 11:00 PM - A physician's order for R64 documented complete blood count (CBC), comprehensive metabolic panel (CMP), and infuse normal saline at 100 mL/hr total 1 liter. 1/11/25 1:37 PM (Saturday) - A lab result report for R46 documented the white blood cell count was high.	F 580	Residents residing at the facility, who have a change in condition, have the potential to be affected by this alleged deficient practice. The Director of Nursing (DON) or designee will review the last 7 days for residents with changes in conditions resulting in a change to their treatment plan. If changes in condition or change to treatment plan were identified the DON or designee will ensure resident and/or resident representative notification. The nurse identifying the change in the resident condition failed to contact the resident's sister after identifying the change condition and subsequently receiving new physician's orders to treat the identified change due to this being an on-going condition and lacked the knowledge to notify with each new intervention. The DON or designee will in-service licensed nursing staff on notifying and documenting notification of the resident and/or resident representative with changes in resident condition and changes to the resident treatment plan. The DON or designee will review the 24-hour report weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure residents identified with a change in condition have resident and/or resident representative notification of the change. The results of these audits will be	

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F 580	Continued From page 29 1/11/25 3:48 PM - A progress note documented that R46 pulled out peripheral line from left arm. 1/13/25 4:30 PM - A physician's order for R64 documented a chest x-ray with two views and Rocephin (antibiotic) inject one gram intramuscularly immediately (STAT) for white blood cell elevation. 1/14/25 3:25 PM - A physician's order for R64 documented Bactrim (antibiotic) 800-160 mg give one tablet two times a day for left base infiltrate (pneumonia) for five days. 1/15/25 1:15 PM - In an interview FM3 revealed she was unaware that R46 had a chest X-ray done, received labwork, was diagnosed with pneumonia, started on antibiotics as well as being changed to thickened liquids. FM3 stated she had not received an update on R46's condition since 10:00 PM on 1/10/25 when staff nurse called to notify her that R46 was ordered an IV related to dehydration. 1/15/25 1:45 PM - Interview with E27 (RN) confirmed that the progress notes lacked evidence of notification to FM3 about changes to plan of care for R46. 1/15/25 2:13 PM - Interview with E17 (RN, UM) confirmed that the progress notes lacked evidence of notification to the provider of R46's lab results. The facility lacked evidence of notification to the provider of R46's lab results and lacked evidence of updating R46's responsible party of change in condition that changed the plan of care.	F 580	reviewed at QAPI to determine if follow up action is needed.	

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F 580	Continued From page 30 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file	F 585		3/18/25

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F 585	Continued From page 31 grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance,	F 585		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 585	Continued From page 32 the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation, it was determined that for one (R64) out of one reviewed for grievances, the facility failed to ensure that resident concerns received by the facility included prompt efforts to resolve the resident's problems. Findings include: Review of R64's clinical record revealed: 11/27/24 - R64 was admitted to the facility. 12/30/24 - A grievance form was filed by FM3 regarding missing clothing for R64 and a complaint related to staff care. The form documented that the grievance was resolved on 1/6/25 by E2 (DON).	F 585	R64's grievance has been resolved and the resident and her representative are satisfied with the resolution. Residents who reside in the facility and have a grievance have the potential to be affected by this same alleged deficient practice. The Nursing Home Administrator (NHA) or designee will audit grievances received for the prior 30 days to ensure the grievance has been resolved and the resident or person placing the grievance is satisfied with the resolution. The root cause analysis indicates the Nursing Home Administrator assigned the grievance to be investigated and resolved	

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	085058	A. BUILDING _____ B. WING _____	C 01/28/2025

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F 585	Continued From page 33 1/13/25 12:33 PM - An interview with FM3 revealed that R64 was missing a pair of pajama bottoms and that a staff member threw them away. FM3 stated that on 12/30/24 she was in to visit R64 and she told FM3 about her pants being missing. FM3 stated that R64 was very upset and told her that the person who threw the pants away was not nice to her on the date in question. FM3 also stated that the facility did not rectify the missing pants with her or offer to replace them. 1/15/25 11:23 AM - An interview with E1 (NHA) and E2 (DON) confirmed that the facility had addressed the grievance. E2 stated that the staff member mentioned in the grievance was given education about customer service. E2 stated he did not offer to replace the pants or provide reimbursement. E1 called FM3 and requested a receipt for the pajama pants to reimburse. The facility failed to ensure that resident concerns received by the facility included prompt efforts to resolve the resident's problems. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 585	by to two separate individuals for their perspective parts. The grievance was mistakenly resolved after the first part of the grievance was investigated and resolved but not the second part of the grievance. The NHA or designee will in-service the interdisciplinary team on the grievance process and the follow up to ensure resolution. The NHA or designee will review grievances submitted weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure residents grievance has been resolved to the resident's satisfaction. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;	F 622		3/18/25

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F 622	Continued From page 34 (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer	F 622		

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F 622	Continued From page 35 or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of	F 622	R148 no longer resides in the facility.	

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F 622	Continued From page 36 other facility documents it was determined that for one (R148) out of three residents reviewed for discharge the facility failed to ensure that discharge requirements were met when the facility initiated discharge regarding R148 occurred on 10/9/24 without notice to the resident. Findings include. Cross refer to F626. Review of R148's clinical record revealed: 8/23/24 - R148 was admitted to the facility with multiple diagnoses including a history of major depressive disorder with severe psychotic symptoms, anxiety, and suicidal ideation. 8/26/24 - A five day MDS assessment documented that R148 was cognitively intact with a goal of remaining in the facility. 10/9/24 7:53 AM - A note in R148's clinical record documented that the resident was sent to the hospital for suicidal ideation. 10/9/24 - The Transfer/Discharge notice indicated the reason for R148's transfer as "it is necessary for your welfare and needs cannot be met at the facility". The location of the transfer was to "hospital ER". The notice was signed by R148. Accompanying the transfer notice was a notification of bed hold policy that was signed by R148, and an "Acute Care Transfer" document checklist. 10/9/24 2:56 PM - A social service note in R148's clinical record documented, "Called [another nursing home] at 2:54 PM to see how to send over a referral for the resident."	F 622	The facility has no opportunity to resolve the alleged deficiency. Residents who require transfer to an acute setting have the potential to be affected by this alleged deficient practice. The Nursing Home Administrator (NHA) or designee will audit residents who have been transferred to the hospital in the last 7 days to ensure discharge requirements are met. The root causes analysis shows the facility failed to follow its discharge policy and practice. The Administrator or designee will educate the admissions director on the discharge policy and practice. The NHA or designee will audit residents who have been transferred to the hospital and request return to ensure the facility policy has been followed until 100% compliance is achieved. The results of these audits will be reviewed at QAPI to determine if follow up action is needed	

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F 622	Continued From page 37 10/9/24 - A discharge return not anticipated MDS assessment was completed for R148 with no discharge plan or referrals documented. 10/15/24 2:51 PM - A social service note documented, "Returned the call from [inpatient psychiatric facility staff] on behalf of [R148] and they requested information on transferring the resident back to the facility. Social service director gave the information to the unit manager [E24(RN)]." October 2024 - The facility transfer list provided to the Ombudsman documented that R148 was transferred out for medical leave. 1/10/25 1:17 PM - During an interview E22 (SW) at inpatient psychiatric facility stated "The facility would not allow [R148] to return and I got that from E6 (Admissions) but [R148] has been placed somewhere else." 1/22/25 10:21 AM - During an interview E6 (Admissions) stated that R148 "Was having suicidal ideation with a plan that's why they sent her out to psych and the hospital sent her out to [inpatient psychiatric facility]." E6 confirmed that R148 was denied readmission to the facility following discharge from the inpatient psychiatric facility because "At the time she owed us a large bill like seventy thousand and corporate was not letting me readmit her. E21 (Controller) my Corporate Director denied the readmission because the bill was so large and would not allow R148 to return until Medicaid approval. Then Medicaid denied." 1/22/25 11:51 AM - During an interview E24 (RN)	F 622		

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F 622	Continued From page 38 former unit manager stated, "[E6] (Admissions) said we wouldn't be allowing R148 back because of a large bill". 1/22/25 11:58 AM - During an interview E21 (Controller) confirmed that R148 was not allowed readmission to the facility. E21 stated that R148 "Came in through the state program they stopped paying for her and we applied for Medicaid and it was denied. She was here eight months without payment. There should be a regular discharge letter." The surveyor requested a copy of the Medicaid denial, any appeal documents, a bill, and discharge notice. The requested documents were not received from the facility. 1/23/25 9:19 AM - During an interview E1 (NHA) confirmed the facility had no evidence of a discharge notice or discharge summary for R148. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4(CCS).	F 622		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state	F 625		3/18/25

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F 625	Continued From page 39 plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for three (R35, R46 and R61) out of three sampled residents for hospitalization, the facility failed to provide written bed hold notice to the resident and/or the resident's representative when transferred to the hospital. Findings include: A facility policy and procedure titled "Bed-Holds and Returns" revised 10/2022 documented... 1. "All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Resident's regardless of payor source, are provided written notice about these policies at least twice." 1. Review of R35's clinical record revealed: 12/23/24 - R35's MDS 5 day admission assessment revealed the resident was cognitively	F 625	R46 current resident and have been made aware of their bed hold rights. R35 and R61 no longer resides in the facility and the facility cannot correct the alleged deficiency. Residents who require transfer to an acute setting have the potential to be affected by this alleged deficient practice. The Nursing Home Administrator (NHA) or designee will audit residents who have been transferred to the hospital in the last 7 days to ensure they received a copy of the facility bed hold policy. The root causes analysis shows the nursing staff transferring the resident to the hospital failed to provide the bed hold policy to the resident during an emergency transfer to the hospital. The root cause analysis also indicates the admissions director did not issue the bed	

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F 625	Continued From page 40 intact with a BIMS score of 15. 1/10/25 - R35 was transferred to the hospital. 1/16/25 10:44 AM - During an interview E6 (AD) confirmed E35 had been transferred from the facility to the emergency room on 1/10/25 and admitted to the hospital. Additionally, E35's clinical record lacked evidence that notification of R35 being sent to the ER or a bed hold notice to either R35 and or R35's responsible representative. 1/16/25 2:51 PM - E6 confirmed and stated, "No a bed hold notice had not been provided to R35 after transfer to the hospital or the responsible representative. Further review of R35's clinical record lacked evidence of any attempts to contact R35 or the responsible representative of a bed hold notice. 1/23/25 3:18 PM - Findings were confirmed with E1 (NHA). 2. Review of R46's clinical record revealed: 11/10/24 8:29 AM - A progress note in R46's clinical record documented, "Resident sent to Emergency room via 911." 11/15/24 9:50 PM - A progress note in R46's clinical record documented, "Resident returned from acute care hospital." November 2024 - Review of the facility transfer log documented that R46 was transferred to the hospital on 11/10/24. Review of R46's electronic clinical record lacked evidence of a corresponding bed hold notification provided to	F 625	hold policy within 24 hours of an emergency transfer to the hospital. The NHA or designee will in-service licensed nursing staff and admissions staff on the bed hold policy. The NHA or designee will review resident transfers weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure resident bed hold's have been issued. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 625	Continued From page 41 R46 or a representative upon R46's transfer. 1/16/25 10:34 AM - The surveyor requested evidence of notice of the bed hold policy for R46's 11/10/24 hospitalization from E6 (Admissions). 1/16/25 11:41 AM - During an interview E6 (Admissions) confirmed that neither R46 nor her representative recived notification of the bed hold notice policy upon the residents transfer to the hospital. 3. Review of R61's clinical record revealed: 12/28/24 3:30 PM - A progress note in R61's clinical record documented, "Resident was taken to Hospital". 12/31/24 - R61 was readmitted to the facility from the hospital. December 2024 - Review of the facility transfer log documented that R61 was transferred to the hospital on 12/28/24 for acute care. Review of R61's electronic clinical record lacked evidence of a corresponding bed hold notification provided to R61 or a representative upon R61's transfer. 1/17/25 2:56 PM - During an interview E1 (NHA) confirmed the findings. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4(CCS).	F 625		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility.	F 626		3/18/25

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F 626	Continued From page 42 A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R148) out of three residents reviewed discharge the facility failed to ensure R148 was readmitted to the facility or that	F 626	R148 has not returned to the facility. The facility has no opportunity to resolve the alleged deficiency.	

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F 626	Continued From page 43 the facility complied with discharge requirements. R148 was sent to the hospital on 10/9/24 and was not permitted to return to the facility. Findings include: Review of R148's clinical record revealed: 8/23/24 - R148 was admitted to the facility with multiple diagnoses including a history of major depressive disorder with severe psychotic symptoms, anxiety, and suicidal ideation. 8/26/24 - A five day MDS assessment documented that R148 was cognitively intact with a goal of remaining in the facility. 10/9/24 7:53 AM - A note in R148's clinical record documented that the resident was sent to the hospital for suicidal ideation. 10/9/24 - The Transfer/Discharge notice indicated the reason for R148's transfer as "it is necessary for your welfare and needs cannot be met at the facility" the location of the transfer was to "hospital ER". The notice was signed by R148. Accompanying the transfer notice was a notification of bed hold policy that was signed by R148, and an "Acute Care Transfer" document checklist. 10/9/24 2:56 PM - A social service note in R148's clinical record documented "Called [another nursing home] at 2:54 PM to see how to send over a referral for the resident." 10/9/24 - A discharge return not anticipated MDS assessment was completed for R148 with no discharge plan or referrals documented.	F 626	Residents who are transferred to the hospital have the potential to be affected by this same alleged deficient practice. The Nursing Home Administrator (NHA) or designee will audit residents who have been transferred to the hospital in the last 7 days to determine the resident□s status on returning to the facility. The root causes analysis shows the facility failed to follow its discharge policy and practice. The NHA or designee will in-service the admissions staff on the process for hospitalized residents who want to return to the facility. The NHA or designee will review current hospitalized residents weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure return as appropriate. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 626	Continued From page 44 10/15/24 2:51 PM - A social service note documented, "Returned the call from [inpatient psychiatric facility staff] on behalf of [R148] and they requested information on transferring the resident back to the facility. Social service director gave the information to the unit manager [E24(RN)]." October 2024 - The facility transfer list provided to the Ombudsman documented that R148 was transferred out for medical leave. 1/10/25 1:17 PM - During an interview E22 (SW) from the in-patient psychiatric facility stated "The facility would not allow [R148] to return and I got that from E6 (Admissions) but [R148] has been placed somewhere else." 1/21/25 1:47 PM - During an interview E23 (RN) confirmed that R148 was denied readmission to the facility. E23 stated, "I know she couldn't come back, I was told she owed money." 1/22/25 10:21 AM - During an interview E6 (Admissions) stated that R148 "Was having suicidal ideation with a plan that's why they sent her out to psych and the hospital sent her out to [inpatient psychiatric facility]." E6 confirmed that R148 was denied readmission to the facility following discharge from the inpatient psychiatric facility because "At the time she owed us a large bill like seventy thousand and corporate was not letting me readmit her. E21 (Controller) my Corporate Director denied the readmission because the bill was so large and would not allow R148 to return until Medicaid approval. Then Medicaid denied." 1/22/25 11:51 AM - During an interview E24 (RN)	F 626		

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F 626	Continued From page 45 former unit manager stated, "[E6] (Admissions) said we wouldn't be allowing R148 back because of a large bill". 1/22/25 11:58 AM - During an interview E21 (Controller) confirmed that R148 was not allowed readmission to the facility. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4(CCS).	F 626		
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 §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	F 656		3/18/25

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F 656	Continued From page 46 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- (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 eight (R3, R4, R27, R46, R57, R63, R89 and R91) out of thirty-seven residents investigated the facility failed to develop person centered care plans. Findings include: 1. Review of R46's clinical record revealed: 11/22/24 - An annual MDS assessment documented that R46 received insulin. 11/15/24 - A physicians order was written for R46 to receive Insulin Glargine 20 units at bedtime. 11/16/24 - A physicians order was written for R46 to receive Insulin Aspart (with Niacinamide) 12 units one time a day for diabetes.	F 656	R46's care plan has been reviewed by the interdisciplinary team and revisions made to her diabetic Care Plan as appropriate. R57's care plan has been reviewed by the interdisciplinary team and revisions made to care plan to include the use of antianxiety and antidepressant medications. R63's care plan has been reviewed by the interdisciplinary team and revisions made to her care plan to include her refusal to shave her facial hair. R91's care plan has been reviewed by the interdisciplinary team and revisions made to individual her fall risk interventions. R91's care plan has been reviewed by the interdisciplinary team and revisions made	

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F 656	Continued From page 47 1/16/25 - Review of R46's care plans lacked evidence of a care plan that addressed the residents use of insulin and diagnosis of diabetes. 1/16/25 2:20 PM - E1 (DON) provided a care plan that addressed R46's diabetes and use of insulin. The creation date of the care plan was 1/16/25. E1 confirmed the finding. 2. Review of R57's clinical record revealed: 8/27/24 - Physicians orders were written for R57 to receive an anti-anxiety and an anti-depressant medication. 9/6/24 - An annual MDS assessment documented that R57 received anti-anxiety and anti-depressant medications. 12/7/24 - A quarterly MDS documented that R57 received anti-anxiety and anti-depressant medications. 1/15/24 - Review of R57's care plans lacked evidence that they addressed R57's anxiety and depression, use of anti-anxiety medications and anti-depressant medications. 1/15/25 1:53 PM - E1 (DON) confirmed the findings and created corresponding care plans to address R57's use of antidepressant and anti-anxiety medications. 3. Review of R63's clinical record revealed: 4/18/22 - R63 was admitted to the facility with dementia. 4/24/24 - An annual MDS assessment	F 656	to her respiratory care plan. Resident no longer resides in the facility. R3's care plan has been reviewed by the interdisciplinary team and revisions made to her Dementia care plan. R4's care plan has been reviewed by the interdisciplinary team and revisions made to his bowel care plan. R27's care plan has been reviewed by the interdisciplinary team and revisions made to her Dementia care plan as appropriate. Residents who reside in the facility with the diagnosis of respiratory issues, incontinence, receiving psychoactive medications, who receive insulin or sustained a fall have the potential to be affected by this alleged deficient practice. The Director of nursing or designee has reviewed current resident with falls, residents with respiratory issues, incontinent residents, residents receiving psychoactive medications and insulin to ensure their care plans are in place. The root cause analysis indicates the interdisciplinary care team failed to initiate or revise residents plan of care on admission and with newly identified changes in condition. The Social Services Director or designee has reviewed the residents with dementia to ensure their care plan is in place and individualized to their care needs. The Director of Nursing or designee has reviewed current residents with orders for insulin, incontinence, falls, respiratory and psychoactive medications to ensure their	

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F 656	Continued From page 48 documented that R63 was severely cognitively impaired. 1/13/25 8:53, 1/14/25 1:46 PM, 1/15/25 11:41 AM, and 1/17/25 8:33 AM, R63 was observed with approximately one half of an inch of gray and black facial hair on her chin. 1/17/25 8:33 AM - During an interview E10 (CNA) confirmed R63's extensive facial hair. E10 stated that R63 is combative with care and especially showers. E10 added that R63 will not let anyone shave her because she does not like "anything near her face". 1/17/25 8:37 AM - During an interview, E12 (LPN) confirmed that R63 did not have a care plan for refusals of shaving and bathing. 4. Review of R89's clinical record revealed: 5/22/24 - R89 was admitted to the facility with multiple sclerosis, a stroke and was paraplegic. 5/22/24 - R63's fall care plan included for her call bell to be in reach and to apply non-skid footwear except during hygiene. 5/29/24 - A quarterly MDS assessment documented that R89 was totally dependent on staff for all care and could not walk. Although R89 had a fall care plan in place, it was not comprehensive and patient centered related to R89's paraplegic status, and resultant inability to utilize the call bell and or walk. 1/22/25 approximately 1:45 PM - E2 (DON) confirmed that R89's care plan was not	F 656	care plan is in place and individualized to their care needs. The DON or designee will in-service the interdisciplinary team on the process for initiating a comprehensive individualized plan of care for newly admitted residents and revising the plan of care with changes to resident condition. The DON or designee will review new admissions care plan, residents with changes to their treatment plan; including new medications and changes in condition weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure the RNAC is aware of the fall with injury. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 656	Continued From page 49 appropriate for R89's status. 5. Review of R91's clinical record revealed: 11/5/24 - R91 was admitted to the facility with a tracheostomy and dependent on a ventilator. 11/12/24 - An admission MDS assessment documented that R91 had a tracheostomy and was ventilator dependent. Review of R91's care plan revealed that the facility failed to create a comprehensive care plan to include her respiratory status. 1/22/25 approximately 1:45 PM - E2 (DON) confirmed that R91 did not have a care plan for her respiratory status. 6. Review of R3's clinical record revealed: 9/26/23 - R3 was admitted to the facility with a diagnosis of dementia. 1/2/25 - A quarterly MDS documented that R3 was severely cognitively impaired and had a diagnosis of non-Alzheimers dementia. Review of R3's careplan revealed that the facility failed to create a comprehensive care plan to include dementia care. 1/23/25 3:34 PM - An interview with E17 (UM RN) confirmed that R3 did not have a care plan for dementia care. 7. Review of R4's clinical record revealed: 12/5/24 - R4 was admitted to the facility.	F 656		

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F 656	Continued From page 50 12/18/24 - An admission MDS documented that R4 was always continent of urine and occasionally incontinent of bowel. Review of R4's careplan revealed that the facility failed to create a comprehensive care plan to include bowel incontinence. 1/23/25 3:34 PM - An interview with E17 (UM RN) confirmed that R4 did not have a care plan for bowel incontinence. 8. Review of R27's clinical record revealed: 10/14/24 - R27 was admitted to the facility with vascular dementia. 10/21/24 - An admission MDS documented R27 was cognitively intact and diagnosis of non-Alzheimers dementia. Review of R27's careplan revealed that the facility failed to create a comprehensive care plan to include dementia care. 1/23/25 3:34 PM - An interview with E17 (UM RN) confirmed that R27 did not have a care plan for dementia. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		3/18/25

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F 657	Continued From page 51 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview it has been determined that the facility failed to review and revise for one (R85) out of thirty-seven sampled residents' care plans. Findings include: A facility policy and procedure titled "Using the Care Plan" last revised 8/2006 documented ... 1. "Other facility staff noting a change in the resident's condition must also report those changes to the Nurse Supervisor and or the MDS Assessment Coordinator ... 2. Changes in the resident's condition must be reported to the MDS	F 657	R85's was interviewed to determine acceptable levels of pain. The interdisciplinary team reviewed and revised her plan of care to include acceptable pain levels and non-pharmacological pain intervention. Residents who reside in the facility who have pain have the potential to be affected by this alleged deficient practice. The Director of nursing or designee has reviewed current residents who	

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F 657	Continued From page 52 Assessment Coordinator so that a review of the resident's assessment and care plan can be made." Cross refer F697 1. Review of R85's clinical record revealed: 12/12/24 - R85 was admitted to the facility with the diagnoses including but not limited to low back pain, fibromyalgia, muscle weakness, and unspecified abnormalities of gait. 12/12/24 11:09 PM - An admission assessment documented R85 had no complaints of pain, lacked an acceptable level of pain, and lacked treatment for pain. 12/15/24 - A care plan was initiated for R85 that documented potential for alteration in comfort related to pain. The care plan documented the goal as pain medication will be effective in controlling discomfort by next review. The following interventions were included: assess for verbal and non-verbal signs and symptoms of pain, assist with turning and repositioning, medication as ordered and notify the physician if not effective or side effects, and provide diversional activities. 12/19/24 - An admission MDS assessment documented that R85 was on a scheduled pain regimen in the last five days, received PRN (as needed) pain medication, and received no non-medication interventions. The MDS also documented that R85 was having pain frequently, pain occasionally affecting sleep, pain occasionally affecting therapy activities, pain that was occasionally affecting day to day activities,	F 657	experience pain to ensure their care plans reflect acceptable pain levels and individualized plan of care to include non-pharmacological pain interventions. The root cause analysis indicates that nursing failed to develop and implement a care plan to provide and monitor acceptable pain levels and non-pharmacological pain interventions. The DON or designee will in-service the interdisciplinary team on the care plan revision process. The DON or designee will audit newly admitted residents and residents with new medication orders for acceptable pain levels and non-pharmacological pain interventions weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure the current care plan reflects the identified changes. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 657	Continued From page 53 and a pain score of 10/10 with no verbal description indicator. The MDS also documented that R85's BIMS score was 15 indicating R85 was cognitively intact. 1/23/25 3:34 PM - An interview with E17 (RN UM) revealed that R85's care plan lacked revision related to acceptable pain level and appropriate interventions related to pain. The care plan lacked evidence of an acceptable pain level and pain level goal for R85. The care plan also lacked non-pharmacological interventions for addressing R85's pain.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R6 and R27) out of thirty seven residents sampled, the facility failed to provide services that meet professional standards of quality by having Licensed Practical Nurses (LPN) complete admission assessments and admission progress notes. Findings include: Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024 ... Admission Assessments * - RN ...* = Once a care plan is established, the LPN may do assessments ...". 1. Review of R6's clinical record revealed:	F 658	R27 & R6's no longer resides in the facility. The facility has no opportunity to resolve the alleged deficient practice. Newly admitted residents have the potential to be affected by this alleged deficient practice. The Director of nursing or designee will review residents admitted in the prior 7 days to ensure a registered nurse completed the initial assessment of the resident. The root cause analysis indicates that the facility failed to have a RN complete the	3/18/25

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F 658	Continued From page 54 12/12/24 - R6 was admitted to the facility. 12/12/24 - E45 (LPN) completed the following assessments: admission evaluation, bowel and bladder continence evaluation, elopement risk evaluation, fall risk evaluation, pain evaluation, side rail evaluation, transfer evaluation, and Braden scale assessment. An LPN, not an RN, as required by the Delaware State regulation for Board of Nursing Scope of practice, completed the admission process for R6. 1/21/25 10:47 AM - An interview with E17 (UM RN) confirmed that R6's admission assessments were completed by an LPN. 2. Review of R27's clinical record revealed: 10/14/24 - R27 was admitted to the facility. 10/14/24 - E46 (LPN) completed the following assessments: admission evaluation, bowel and bladder continence evaluation, elopement risk evaluation, fall risk evaluation, side rail evaluation, and Braden scale assessment. 1/21/25 10:47 AM - An interview with E17 (UM RN) confirmed that R27's admission assessments were completed by an LPN. An LPN, not an RN, as required by the Delaware State regulation for Board of Nursing Scope of practice, completed the admission process for R27. 1/24/25 1:30 PM - Findings were reviewed with	F 658	nursing admission assessment. The DON or designee will in-service the licensed nursing staff on the requirements for RN staff to conduct the initial resident assessment. The DON or designee will review new admission assessments weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure a registered nurse completed the initial assessment. The results of these audits will be reviewed at QAPI to determine if follow up action is needed	

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F 658	Continued From page 55 E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R6) out of nine residents reviewed for ADLs, the facility failed to ensure ADLs were provided to dependent residents. Findings include: Review of R6's clinical record revealed: 12/12/24 - R6 was admitted to the facility. 12/13/24 - A care plan was initiated and documented that R6 was unable to do own activities of daily living (ADLs) without assistance related to general weakness and goal that R6 will be well groomed and odor free with the assist of staff while participating to their best ability for ninety days. The care plan documented interventions to assist R6 to pick out clothes, assist to attend activities, and toileting schedule as R6 allows. 12/19/24 - An admission MDS documented that R6 had an impairment to lower extremity on one side and also documented R6 was dependent for showering. 1/13/25 2:34 PM - An interview with R6 revealed	F 677	R6 no longer resides in the facility. The facility has no opportunity to resolve the alleged deficiency. Residents who reside in the facility and have a preference for nail care have the potential to be affected by this alleged deficient practice. Director of nursing or designee will audit current resident's fingernails to identify residents requiring nail care and/or their preference for nail care to ensure nail care is completed per their preference. The root cause analysis indicates that the CNA failed to provide nail care as the resident has increased her independency with ADLs and did not request nail care. The DON or designee will in-service the nurse aide staff on the process for fingernail care and ensuring fingernail care is provided to dependent residents on their shower days and when nail care is requested by a dependent resident. The DON or designee will audit fingernail	3/18/25

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F 677	Continued From page 56 that she had a shower on the previous day and no one had assisted her to clip her nails. R6 stated that no one had offered to clip her nails. 1/14/25 10:19 AM - An observation of R6 with long overgrown nails. 1/15/25 12:24 PM - An observation of R6 with long overgrown nails. 1/16/25 3:33 PM - An observation of R6 with long overgrown nails. An interview with E35 (RN) confirmed that R6 was supposed to have a shower on 1/15/24 and that R6 had long overgrown nails. E35 stated she would make sure R6's nails were clipped. 1/17/25 8:37 AM - An interview with E48 (CNA) confirmed that she gave R6 a shower and clipped her nails this morning. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 677	care for at least 5 residents weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure fingernail is completed per their preference. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	
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:	F 684		3/18/25

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F 684	Continued From page 57 Based on interview and record review, it was determined that for one (R64) out of two residents reviewed for change in condition, it was determined that the facility failed to follow physician orders. Findings include: Review of R64's clinical record revealed: 11/27/24 - R64 was admitted to the facility. 12/4/24 - An admission assessment for documented that R64 was independent for eating. 1/14/25 7:23 PM - A physician's order documented that R64 was on thickened liquids. 1/15/25 1:15 PM - An observation of R64's lunch tray revealed that R64 was served water, coffee, and juice all thin liquids. R64 was actively eating and drinking when observation occurred, during this time an observation of R64 drinking the thin liquids resulting in coughing. 1/15/25 1:30 PM - An interview with E48 (CNA) revealed that E48 was not informed that R46 was on thickened liquids during report and E48 went to replace the thin liquids with thickened. 1/15/25 1:35 PM - An interview with E51 (LPN) and E35 (RN) revealed that when a new diet is ordered the order gets entered in the electronic medical record (EMR) and a dietary communication slip is completed. If the order is completed after dietary is closed the nurse will deliver the dietary communication to the front desk to give to dietary in the morning. 1/15/25 1:45 PM - An interview with E52	F 684	R64 physician has been notified of resident drinking thin liquids during lunch. No new orders were given. Residents who reside in the facility who have a change to their liquid consistency have the potential to be affected by this alleged deficient practice. The Director of Nursing or designee has reviewed current residents identified with a thickened fluid consistency to ensure thick fluid consistency is being provided to the resident per the physician's order. The root cause analysis indicates that the licensed nurse entering the change in liquid order entered it under the "other" category in the medical record causing the order not to be seen by dietary. The DON or designee will in-service licensed nursing staff on the process for entering physician's orders for diet or fluids consistency into the electronic medical record. The DON or designee will review the new physician's orders for diet and liquid consistency weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure the orders were placed as a diet category in the electronic health record and the order was received by dietary. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 684	Continued From page 58 (Secretary) confirmed that no dietary communication slip was left at the front desk for the dietary department. 1/15/25 2:00 PM - An interview with E53 (Dietician) revealed that she was unaware of the new order for R64. E53 reviewed the new order in the EMR and confirmed that the diet order was not input as a dietary order so therefore the electronic system did not communicate the new order to dietary. E53 also confirmed that no dietary communication slip was completed and given to the dietary department. The facility failed to follow a physician's order when R64 was served thin liquids. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		3/18/25

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F 688	Continued From page 59 assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R37) out of two residents reviewed for ROM the facility failed to ensure that R37 received appropriate treatment and services to prevent further decrease in range of motion when the annual contractures measurement comparison evaluation was not completed on time. Findings include: The facility policy on Prevention and screening for contractures management last updated January 2025, indicated "Secondary prevention targets early identification of a contractures to limit it's course and complications through scheduled screenings such as annual screenings or during clinical reviews." 1. Review of R37's clinical record revealed: 12/15/23 - An entry MDS assessment was created for R37. 12/18/23 - A contractures measurement comparison evaluation was completed for R37 that documented the resident had "All joints within functional limits." 12/19/23 - A discharge return not anticipated MDS assessment was completed for R37. 1/2/24 - R37 was readmitted to the facility with several diagnoses including history of stroke, generalized muscle weakness, abnormalities of gait and mobility, and limitation of activities due to	F 688	R37's contracture measurement assessment was completed by the physical therapist and did not indicate a change to the current treatment plan. Current residents who reside at the facility have the potential to be affected by this same deficient practice. The Director of Rehab or designee reviewed current residents to ensure current contracture management assessment and plan as indicated. The root cause analysis indicated that R37 was hospitalized and readmitted and screened by therapy. The physical therapist failed to track the contracture management assessment from completion date to ensure the resident was reassessed annually. The Director of Rehab services will re-educate therapy staff on the cadence and requirement of the contracture management assessments. The Director of Rehab or designee will audit contracture measurement assessments weekly times three weeks until 100% compliance is achieved and monthly times three months with a goal of 100% compliance to be achieved and sustained to assure contracture measurements assessments are	

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F 688	Continued From page 60 disability. 1/8/24 - An admission MDS assessment documented that R37 had an impairment on one side of an upper extremity. 1/26/24 - A care plan was created related to R37's potential for contractures. Interventions in the care plan included Therapy department to assess ROM and record findings yearly. 7/29/24 - An OT clarification order was written for R37's recertification of services to continue with OT 3-4x/wk for 30 days to address limitations. Treatment: ortho fit and train. 8/27/24 - An order was written for an OT evaluation for Trigger finger/use of carrot and Ortho consult for trigger finger. 8/28/24 - An order was written for R37 to wear a left extension splint placed at PM care, removed at AM care as tolerable. Resident able to self manage and remove as needed. 11/5/24 - R37's care plan related to potential for contractures was reviewed by the facility with no changes. 1/8/25 - An annual MDS assessment documented that R37 had an impairment on one side of an upper extremity. 1/13/25 10:34 AM - During an interview R37 stated, "I want to see a doctor because my [left] hand worsened". 1/15/25 9:30 AM - The surveyor sent an email to E2 (DON) that requested the most recent	F 688	completed in time. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 688	Continued From page 61 contractures measurement comparison evaluation completed for R37. 1/15/25 10:11 AM - A contracture measurement comparison evaluation was completed by E34 (PT) for R37 that documented, "Left joint contractures status severe; all joints functional limits except left hand Resident continues with left hand contractures. The evaluation was past the annual date of 12/18/24. 1/16/25 1:29 PM - During an interview R37 confirmed that prior to 1/15/25 therapy had not been to assess the residents hand in "a long time". 1/16/25 1:56 PM During an interview E34 (PT) confirmed that the contracture measurement comparison evaluation was completed late. E34 stated, "they should be done annually. The problem is our software doesn't alert on their anniversary date." When asked what prompted E34 to complete R37's recent assessment E34 stated, "[E4 (CCS) asked me for it, I saw it wasn't done and went and did it." E4 present during the interview confirmed the request for R37's contractures measurement comparison evaluation was relayed to her by E2 (DON). When asked if the facility identified a change from the prior contractures evaluation, E34 stated, "[R37] had no significant changes between the two. [R37] already has a palm-guard for that issue so that was established from OT in the summer." Review of R37's clinical record revealed an OT evaluation and corresponding interventions on 8/27/24 and 8/28/24 related to R37's left hand. However the clinical record lacked evidence of measurements and evaluation to determine degree of changes until the surveyor	F 688		

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F 688	Continued From page 62 requested an evaluation on 1/15/25. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (CCS).	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R47) out of two residents reviewed for accidents the facility failed to provide supervision for R47 to prevent an accident. The resident was left unsupervised during care and fell off the bed resulting in a head injury and needed to be sent to the hospital for evaluation and treatment. Findings include: R47's clinical record revealed: 12/18/23 - R47 was admitted to the facility with diagnoses including but not limited to multiple sclerosis, paraplegia and hypothyroidism. 12/19/23 - A review of R47's care plan for falls documented ... "1. Potential for falls r/t (sic) decreased mobility ... 2. Bed in lowest position when care is not being provided ...3. Bed mobility extensive assist ... 4. Increased rounding (was added to the interventions on 7/16/24 as a result	F 689	R47 was reviewed by interdisciplinary care team to determine individualized plan of care related to fall. Plan of care was reviewed and revised. Current residents who reside at the facility have the potential to be affected by this same deficient practice. The Director of Nursing or designee will review residents who experienced a fall in the prior 14 days to ensure their plan of care is individualized to the resident's care needs related to falls. The root cause analysis indicates the nurse aide failed to reposition the resident in the bed before she stepped away to moisten a wash cloth for care. The Director of Nursing or designee will in-service nursing assistant staff on	3/18/25

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F 689	Continued From page 63 of the fall)." 12/19/23 - A review of R47's care plan for ADLs (Activities for Daily Living) revised 1/13/25 dcoumented... "1. Unable to do own ADLS without assistance R/T (sic) MS (sic) and generalized weakness." 1/16/24 - A review of R47's care plan for ROM/Contractures revised 1/13/25 documented... "1. Maintain proper joint alignment while in bed or in chair." 6/25/24 - 9/25/24 R47's quarterly MDS assessment documented [R47] was dependent for rolling left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed). 7/16/24 6:00 AM - Review of a facility provided incident report documented "Resident had a fall out of bed an aide was cleaning her up and went to grab something and patient rolled out of the bed. The CNA called for help and the patient was found on her back on the floor. Patient was noted to be A&O (sic) after the fall but was found with a small laceration to the back of the head with scant amount of bright red blood noted. 7/16/24 7:14 AM - E42's (RN) health status note documented, "s/p (sic) unwitnessed fall 6:00 AM reported that resident fell out of the bed at which time this nurse went to room to assess where she was lying on the floor next to the bed on her back, with legs towards the head of the bed. Neurological checks initiated, AAO x3. VSS (sic). Resident reports hitting back of head, laceration to the back of head noted, with scant amount of bright red blood. NP (sic) on call made aware,	F 689	ensuring resident are not left unsupervised in bed while receiving care. The DON or designee will audit residents in their room weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure they are not left unsupervised in bed while receiving care. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 689	Continued From page 64 new orders to send to ER (sic). Nursing supervisor called report to ED (sic) and call placed to emergency contact husband voice mail left. 6:50 AM EMTs (sic) arrived and transported resident to the hospital via stretcher, VSS (sic). 7/16/24 11:12 AM E43's (RN) health status note documented, "Resident returned from hospital at 9:35 AM. CT (sic) of head without IV contrast results no intracranial injury or hemorrhage. Skin glue applied to laceration to the back of the head." 1/17/25 11:34 AM - During a telephone interview E37 (CNA) stated, "Yes I was working on the 11-7 shift and it was my last rounds the facility doesn't use disposable washcloths, I had already rolled [R47] on to her right side to change her, but I didn't have enough washcloths and she was already laying on her side from when I started to change her, but I noticed that she was having a bowel movement and I didn't have enough wash cloths so I stepped right into the bathroom to wet some more washcloths and I left her on the right side that's the side I had rolled her onto when I started to change her, I stepped into the bathroom I should have put the bed down I was only leaving her for a second or two, she was stable on her right side, so I felt it was okay leaving her. I heard the fall when I went into the bathroom, I went straight to her, I yelled out for the nurse to let her know she had fell." 1/22/25 2:15 PM - E5 (RD) stated, "[R47] has limited range of motion when bending her hips, knees and both shoulders." 1/22/25 2:23 PM - During an interview E44 (COTA) stated, "[R47] can't use her left arm we	F 689		

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F 689	Continued From page 65 have worked with her on positioning in bed anytime I have worked with her I have had to reposition her in the bed." E44 also stated, "[R47] would not have had enough strength to remain laying on her side in the bed without rolling off the bed." 1/23/25 3:18 PM - Findings were confirmed with E1 (NHA). 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 689		
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	F 690		3/18/25

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F 690	Continued From page 66 (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: Based on interview and record review it was determined that for four (R4, R27, R61, R64 and R3) out of seven residents reviewed for bowel and bladder, the facility failed to respond to or provide services to maintain or restore bowel and bladder continence. Findings include: 1. Review of R4's clinical record revealed: 12/5/24 - R4 was admitted to the facility. 12/5/24 - A care plan was initiated for R4 but lacked evidence of addressing continence and plan of care related to continence. 12/5/24 3:30 PM - A bowel and bladder evaluation documented that R4 was continent of urine and lacked documentation regarding bowel continence. 12/12/24 - An admission MDS documented that R4 was always continent of bladder and occasionally continent of bowel and that no toileting program was indicated. The MDS also documented that R4 required partial or moderate	F 690	R4, R27 and R61 no longer resides in the facility. The facility has no opportunity to resolve the alleged deficient practice. A bowel and bladder pattern record has been initiated for 3 days for R64 to determine a pattern of bowel and bladder continence to initiate a toileting program. R3 has a urinary catheter in place as a result of obstructive uropathy. Upon further observation R3□s drainage bag has been below bladder level and draining appropriately. Current residents who reside at the facility have the potential to be affected by this same deficient practice. The Director of Nursing or designee will review current residents coded as having mixed continence within prior 7 days. Residents with mixed continence will have a 3-day patterning evaluation initiated to determine if a bowel and bladder training program is indicated. If indicated the DON	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 67 assistance for toileting. 12/2024 - A review of the December CNA documentation record revealed that R4 was continent of bowel four times out of eighty opportunities. 1/2025- A review of the January CNA documentation record revealed that R4 was continent of bowel eight times out of forty six opportunities. 1/9/25 9:07 AM - An admission bowel and bladder evaluation documented that R4 was continent of urine and incontinent of bowel. The evaluation documented that a toileting program was not in use to manage R4's bowel continence. 1/13/25 2:16 PM - An interview with R4 revealed that he was continent of bowel at home and able to use the toilet independently. R4 stated that he can use a urinal and uses a brief while at the facility. 1/17/25 9:25 AM - An interview with E48 (CNA) confirmed that R4 requires staff assistance with toileting and is continent of urine. E48 stated that R4 is normally incontinent of bowel and does not use any assistive devices. E48 stated that R4 was not on a toileting program to her knowledge. 1/21/25 10:47 AM - An interview with E17 (RN, UM) confirmed that R4 was not on a toileting program and does not use assistive devices to maintain continence. There was no evidence that the facility attempted to maintain bowel function for R4.	F 690	or designee will determine and initiate the plan. The root cause analysis indicated the licensed nurse failed to assess the resident for a toileting plan upon the completion of the initial 3-day patterning. The Director of Nursing or designee will review and revise the current procedure for bladder management. After the revisions to the process the DON or designee will in-service the licensed nursing staff on the revised process. The DON or designee will audit new admission for bowel and bladder continence and for changes to ensure residents identified with mixed continence have a toileting plan weekly for three weeks until 100% compliance is achieved, then monthly for three months with a goal of 100% compliance to be achieved and sustained. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 690	Continued From page 68 2. Review of R27's clinical record revealed: 10/14/24 - R27 was admitted to the facility. 10/14/24 - A care plan was initiated (R27) for incontinence of bowel and bladder with no memory recall and/or ability to retrain with the goal that R27 will be clean, dry, and comfortable with no skin breakdown for ninety days. The interventions included bowel and bladder assessments upon admission and quarterly, call bell within reach, check resident every two hours, and encourage highest level of independence of toileting as possible. 10/21/24 10:58 AM - A bowel and bladder assessment documented that R27 was incontinent of urine and was wet one to two times a day and continent of stool. The evaluation documented that a toileting program was not in use to manage R27 urinary continence. 10/21/24 - An admission MDS documented that R27 was dependent for toileting and requires assist of one for ADLs. The MDS also documented that R27 was frequently incontinent of bowel and bladder and that a urinary toileting program was initiated with no improvement. 10/2024 - A review of the October CNA documentation record revealed that R27 was continent of urine nine times out of fifty seven opportunities. 11/2024 - A review of the November CNA documentation record revealed that R27 was continent of urine eleven times out of ninety two opportunities.	F 690		

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F 690	Continued From page 69 12/2024 - A review of the December CNA documentation record revealed that R27 was continent of urine eleven times out of ninety five opportunities. 1/2025 - A review of the January CNA documentation record revealed that R27 was continent of urine five times out of fifty two opportunities. 1/17/25 9:33 AM - An interview with E48 (CNA) confirmed that R27 is staff assist of one for toileting and confirmed that resident is incontinent of bowel and bladder. E48 confirmed that R27 does not use a bed pan or commode for toileting and was not on a toileting program. 1/21/25 10:47 AM - An interview with E17 (RM UM) confirmed that R27 was not on a toileting program and does not use assistive devices to maintain continence. There was no evidence that the facility attempted to maintain bladder function for R27. 3. Review of R61's clinical record revealed: 12/27/24 - R61 was admitted to the facility. 12/27/24 - A care plan was initiated for incontinence of bowel and bladder with no memory recall and/or ability to retrain with the goal that R61 will be clean, dry, and comfortable with no skin breakdown for ninety days. The interventions included bowel and bladder assessments upon admission and quarterly, call bell within reach, check resident every two hours, and encourage highest level of independence of toileting as possible	F 690		

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F 690	Continued From page 70 12/27/24 11:28 PM - A bowel and bladder assessment documented that R61 was occasionally incontinent of bowel and bladder and was a candidate for scheduled or prompted voiding. 12/2024 - A review of the December CNA documentation record revealed that R61 was incontinent of urine four times out of fourteen opportunities. 1/2025 - A review of the January CNA documentation record revealed that R61 was incontinent of urine twenty eight times out of forty seven opportunities. 1/3/25 - An admission assessment documented that R61 was dependent for toileting. The MDS also documented that R27 is occasionally incontinent of bowel and bladder and was not on a toileting program. R27 is also a BIMS of 15 indicating fully competent. 1/13/25 10:31 AM - An interview with R61 revealed that she was continent at home and is usually incontinent at the facility due to staff taking too long to answer the call bell. 1/17/25 9:41 AM - An interview with E28 (CNA) confirmed that R61 is a one person assist for toileting and is occasionally incontinent. E28 confirmed that R61 will use the toilet if staff assists her. 1/21/25 10:47 AM - An interview with E17 (RM UM) confirmed that R61 was not on a toileting program and does not use assistive devices to maintain continence.	F 690		

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F 690	Continued From page 71 There was no evidence that the facility attempted to maintain bladder function for R61. 4. Review of R64's clinical record revealed: 11/27/24 - R64 was admitted to the facility. 11/27/24 - A bladder and bowel evaluation documented R64 as frequently incontinent of both bowel and bladder. The evaluation also documented R64 was a candidate for scheduled or prompted voiding. 11/2024 - A review of the November CNA documentation record revealed that R64 was incontinent of urine two out of eleven opportunities and incontinent of bowel zero times out of eleven opportunities. 12/4/24 - An admission MDS documented R64 was a partial or moderate assist for toileting and R64 was occasionally incontinent of bladder and always continent of bowel. The MDS also documented R64 was not on a toileting program. 12/8/24 - A care plan documented that R64 had bladder incontinence related to activity intolerance, dementia, and impaired mobility with a goal of R64 being continent during waking hours through the review date. Interventions included checking R64 as needed and as required for incontinence and notify the provider of any possible medical causes for incontinence. 12/2024 - A review of the December CNA documentation record revealed that R64 was incontinent of urine fifteen times out of ninety six opportunities and incontinent of bowel seven	F 690		

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F 690	Continued From page 72 times out of ninety six opportunities. 1/2025 - A review of the January CNA documentation record revealed that R64 was incontinent of urine fourteen times out of fifty two opportunities and incontinent of bowel ten times out of forty eight opportunities. 1/13/25 12:26 PM - An interview with FM3 revealed that R64 was occasionally incontinent of bowel and bladder while at home and FM3 expressed concern that she had come in to visit and found R64 soaked in urine on multiple occasions. 1/17/25 9:22 AM - An interview with E28 (CNA) confirmed that R64 is an assist of one staff for toileting and R64 remains continent if staff encourages R64 to toilet. E28 did not recall R64 being on a toileting schedule or program. 1/21/25 10:47 AM - An interview with E17 (RN, UM) confirmed that R64 was not on a toileting program. There was no evidence that the facility attempted to maintain bladder or bowel function for R64. 5. Review of R3's clinical record revealed: A CDC recommendation to prevent infection included: "Maintain the bag below the level of the bladder". (https://www.cdc.gov Indwelling Urinary Catheter Insertion and Maintenance). 9/26/23 - R3 was admitted to the facility with obstructive uropathy. 12/16/24 - R3 had a physician order for a foley catheter.	F 690		

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F 690	Continued From page 73 1/2/25 - A quarterly MDS assessment documented that R3 was dependent on staff for ADL's and had an indwelling catheter. 1/13/25 - 08:52 AM - During an observation, R3's foley catheter drainage bag was noted to be lying on the foot of R3's bed. 1/13/25 8:57 AM - During an interview, E58 (CNA) confirmed that R3's foley catheter drainage bag was on the bed. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 690		
F 692 SS=D	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	F 692		3/18/25

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F 692	Continued From page 74 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R11 and R91) out of two residents reviewed for tube feeding the facility failed to implement current professional standards of practice, to maintain acceptable parameters of nutritional status. Findings include: for R11 the facility failed to label R11's tube feeding bottle to discern the tube feeding's date and time of expiration per standard of care. For R91, the facility failed to obtain an order for R91 to resume her tube feeding at the time of readmission to the facility. Findings include: 1. Review of R11's clinical record revealed: 10/2/23 - R11 was admitted to the facility with quadriplegia. 12/22/24 - A discharge MDS assessment documented that R11 required tube feeding for nutrition. 1/14/25 10:40 AM - An observation of R11's tube feeding bottle not labeled with a time or date of when the tube feeding had been initiated. 1/14/25 10:42 AM - During an interview, E12 (LPN) confirmed that the tube feeding was not labeled with date and time that the bottle had been hung and started. 2. Review of R91's clinical record revealed: 11/5/24 - R91 was admitted to the facility with	F 692	R91 no longer resides in the facility. The facility has no opportunity to resolve the alleged deficient practice. R11's tube feeding container has been observed to contain the date and time the feeding was opened to determine expiration of the contents. Residents requiring tube feeds have the potential to be affected alleged deficient practice. The Dietitian or designee will review current residents with tube feeding to ensure tube feeding regimen is in place. The Director of Nursing or designee will audit current residents with tube feeding orders to ensure container is labeled and dated per facility policy. The root cause analysis indicates the R91□s POA is very involved in the care of the resident. The admitting nurse reviewed the specialized ingredients of the feeding formula with the POA per his request and he stated that he wanted to discuss with the dietitian prior to starting the feeding. The licensed nurse failed to obtain the physicians order for the tube feed and document the POA refusal for it to be administered. The root cause analysis indicates the licensed nurse initiating the tube feeding for R11 did not date and time the container per facility policy. The DON or designee will in-service	

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F 692	Continued From page 75 ALS. 11/12/24 - R91's admission MDS admission assessment documented that R91 required tube feeding for nutrition. 1/13/25 11:51 PM - A nursing progress note included that R91 was readmitted to the facility at 4:23 PM. 1/14/25 - During an interview, FM4 stated that R91 did not have any tube feeding since the day before (1/13/25). Review of the readmission physician orders revealed that the facility lacked evidence of a tube feeding order upon return on 1/13/24. 1/14/25 10:47 AM - During an interview, E50 (LPN) confirmed that R91 did not have a physician order to resume her tube feeding since her 1/13/25 readmission. 1/14/25 12:30 PM - A physician order for R91's tube feeding became an active order. R91 did not have an active physician order for approximately 20 hours. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support) at the exit conference.	F 692	licensed nursing staff on the policy for enteral tube feeding. The Dietitian or designee will audit newly admitted residents weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure residents are receiving their ordered tube feeding per physician's orders. The results of these audits will be reviewed at QAPI to determine if follow up action is needed. The Director of Nursing or designee will audit current residents with tube feeding weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure the containers are labeled and dated per facility policy. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy	F 695		3/18/25

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F 695	Continued From page 76 care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that for four (R10, R29, R67 and R80) out of seven residents sampled for respiratory care the facility failed to provide respiratory care based on professional standards for R10, R29, R67 and R80's nebulizer mask was not dated and not in a plastic bag when not in use. R10's nebulizer mask was dated 12/26/24. Further review of R10, R29, R67 and R80's records lacked evidence of orders to change and store nebulizer masks. Findings include: A policy and procedure titled "Aerosol Nebulizer Compressor" undated documented "1. Proper cleaning, maintenance and storage will be followed to prevent infections and ensure the longevity of equipment... 2. Follow standard infection control precautions to prevent the spread of infections." 1. R10's clinical record revealed: 9/27/23 - R10 was admitted to the facility. January 2025 - Review of R10's TAR lacked orders when to change and how to store R10's nebulizer mask when not in use. 1/13/25 8:59 AM - An observation of R10's nebulizer mask was dated 12/26/24 and laying on top of the resident's blanket.	F 695	R80, R10, and R67 had their nebulizer mouth piece changed. Plastic bags were supplied and new mouthpiece was placed in a plastic bag when not in use. Residents requiring nebulizer treatments have the potential to be affected by this alleged deficient practice. The Director of Nursing, Infection Control Nurse or designee has obtained a current list of residents with orders for nebulizer treatments. Current residents have their nebulizer mouth piece covered in a plastic bag when not in use. The root cause analysis indicates the licensed nursing staff failed to identify appropriate infection control practices that a plastic bag was not available in the resident room to cover the nebulizer mouth piece when not in use. The Director of Nursing or designee will review and revise the current process for the setup, change, and covering of nebulizer equipment. After the revisions to the process the DON or designee will in-service the licensed nursing staff on the revised process. The Director of Nursing, Infection Control Nurse or designee will audit 5 residents	

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F 695	Continued From page 77 1/13/25 12:38 PM - Another random observation revealed R10's nebulizer mask was laying on the bedside stand and not stored in a plastic bag. 1/13/25 2:48 PM - During an interview the surveyor asked E17 (RN) the process for storing a resident's nebulizer mask when not in use. E17 stated, "I would need to check with someone before I answer that I'm not sure." 1/13/25 2:59 PM - During an interview and observation E35 stated, "nebulizer masks should be stored in a Ziplock bag (plastic bag) when not in use." E35 confirmed [R10's] nebulizer mask was dated 12/26/24 and sitting on top of the resident's bedside table and not in a plastic bag. 2. R67's clinical record revealed: 12/2/22 - R67 was admitted to the facility. January 2025 - Review of R67's TAR lacked orders when to change and how to store R67's nebulizer mask when not in use. 1/12/25 11:11 AM - During an observation R67's nebulizer mask and tubing was attached to the nebulizer machine sitting on the resident's bedside table. The mask was not dated or stored in a plastic bag. 1/13/25 2:42 - During an interview E36 (LPN) stated, "I was trained to store the nebulizer mask at the bedside when not in use, that's what I have been shown." 1/13/25 2:52 PM - During an interview and observation E36 (RN) confirmed R67's nebulizer mask was not dated and attached to the nebulizer	F 695	per week for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure nebulizer mouthpiece is covered when not in use. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 695	Continued From page 78 machine and not stored in a plastic bag. 3. R29's clinical record revealed: 12/6/22 - R29 was admitted to the facility. 1/12/25 9:56 AM - An observation revealed R29's nebulizer mask attached to tubing that was connected to a nebulizer machine. The mask was laying inside of R29's bedside table in a closed drawer and not in a plastic bag. January 2025 - Review of R29's TAR lacked orders when to change and how to store R29's nebulizer mask when not in use. 1/13/25 2:46 PM - During an observation and interview E35 stated, "the resident's mask is laying inside the bedside table drawer, it's not dated, I will take care of this." 4. R80's clinical record revealed: 10/1/24 - R80 was admitted to the facility. 1/13/25 10:18 AM - During an observation R80's nebulizer mask was attached to the nebulizer machine not dated or stored in a plastic bag. January 2025 - Review of R80's TAR lacked orders when to change and how to store R80's nebulizer mask when not in use. 1/13/25 2:56 PM - During an observation and interview E35 stated, "Oh I can see [R80's] mask from the hallway, it's not in a bag, I don't know why but I will take care of it." 1/13/25 3:25 PM - Findings were confirmed with	F 695		

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F 695	Continued From page 79 E1 (NHA). 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 695		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R85) out of three residents reviewed for pain, the facility failed to provide pain management according to professional standards of practice. R85 was not provided pain medication, causing unrelieved pain for approximately sixty four hours resulting in harm. Findings include: Cross refer F657. April 2002 - The pain management standards by the American Geriatrics Society included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management.	F 697	R85 is receiving pain medication per physician□s order. R85 has an appointment with outside first state orthopedics for pain management scheduled for February 26th 2025. Residents who reside in the facility who have pain have the potential to be affected by this alleged deficient practice. The Director of nursing or designee has reviewed current residents who experience pain to ensure their care plans reflect acceptable pain levels with pain evaluation scales pre and post pain medication administration. The root cause analysis indicates the resident was assessed by the CRNP and narcotic pain medication was discontinued. The Medical Director reassessed the resident and reordered narcotic pain medication to be reinitiated.	3/18/25

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F 697	Continued From page 80 November 2009 - The American Academy of Pain Medicine, "Pharmacological Management of Persistent Pain in Older persons, stated to refer to the previous American Geriatrics Society for specific recommendations for pain assessment in older persons that remain relevant." Review of R85's clinical record revealed: 12/12/24 - R85 was admitted to the facility with diagnoses including but not limited to low back pain, fibromyalgia, muscle weakness, and unspecified abnormalities of gait. 12/12/24 11:09 PM - An admission assessment documented R85 had no complaints of pain, lacked an acceptable level of pain, and lacked treatment for pain. 12/15/24 - A care plan was initiated for R85 that documented potential for alteration in comfort related to pain. The care plan documented the goal as pain medication will be effective in controlling discomfort by next review. The following interventions were included: assess for verbal and non-verbal signs and symptoms of pain, assist with turning and repositioning, medication as ordered and notify the physician if not effective or side effects, and provide disversional activities. 12/19/24 - An admission MDS assessment documented that R85 was on a scheduled pain regimen in the last five days, received PRN (as needed) pain medication, and received no non-medication interventions. The MDS also documented that R85 was having pain frequently, pain occasionally affecting sleep, pain occasionally affecting therapy activities, pain that	F 697	The root cause analysis indicates that nursing failed to develop and implement a care plan to provide and monitor acceptable pain levels and non-pharmacological pain interventions. The Director of Nursing or designee will educate the licensed nursing staff on pain level assessment pre and post pain medication administration and process for notification to physician services of unrelieved pain. The DON or designee will audit newly admitted residents and residents with new pain medication weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure pain assessment scores pre and post pain medication and physician services notification of unrelieved pain. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 697	Continued From page 81	F 697		

was occasionally affecting day to day activities, and a pain score of 10/10 with no verbal description indicator. The MDS also documented that R85 had a BIMS score of 15 indicating R85 is cognitively intact.

12/2024 - A review of the December MAR documented that R85's pain level ranged from a score of 2/10 to 8/10. R85's pain level was noted at 10/10 prior to pain medication administration and scored as effective or score of 8/10 or below post pain medication administration.

1/2/25 5:41 PM - A physician's order documented oxycodone (narcotic pain medication) 10 mg tablet, give one tablet every six hours as needed for pain for six days ending on 1/6/25.

1/6/25 1:25 AM - The Januaury MAR documented R85 received a dose of PRN oxycodone 10 mg tablet documented 10/10 pain and a result of effective post pain assessment. The facility failed to use a pain scale for evaluation of pain with consistent measurement of pain pre and post administration.

1/6/25 - 1/8/25 - A review of the MAR documented R85's pain score was 10/10 every shift. R85 received PRN Tylenol during the aforementioned dates indicating 10/10 pain level and post administration score of ineffective during this time. The MAR lacked evidence of an oxycodone order in place or administered. The facility failed to use a pain scale for evaluation of pain with consistent measurement of pain pre and post administration.

1/7/25 1:38 PM - A progress noted documented "Patient was unable to do PT today because she

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F 697	Continued From page 82 did not have her pain medication. The order was discontinued per provider. I gave her Tylenol but patient states that does not help at all..." 1/8/25 00:01 AM - A physician's (E20) progress note documented a follow up visit with R85 to discuss pain medication use. The note stated that R85 continues to complain of low back pain and "will be looking at long term use of narcotic pain medication use." E20 documented that he would provide temporary pain medication twice daily as needed and consult to pain management. 1/8/25 5:58 PM - A physician's (E20) order documented oxycodone 10 mg tablet, give one tablet every twelve hours as needed for chronic pain, fibromyalgia for ten days. 1/8/25 7:02 PM - A progress note documented "...Patient has chronic pain and complains of pain being a 10/10. Patient was referred to pain management due to pain and narcotic dependence..." 1/13/25 10:04 AM - An interview with R85 revealed she has had chronic pain in her lower back and was currently on a scheduled pain medication regimen. R85 revealed that recently that her pain medication perscription was no longer active and R85 was without scheduled pain medication for multiple days. R85 stated that when her pain was uncontrolled she was unable to participate in therapy and unable to get out of bed. R85 stated that she reported these pain levels to staff and no medication was ordered during that time. 1/17/25 8:30 AM - An interview with E2 (DON) confirmed that oxycodone is available in the	F 697		

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F 697	Continued From page 83 facility emergency medication stock. 1/17/25 12:11 PM - An interview with E11 (NP) revealed that R85 was under E20's care for pain management. E11 stated that "[R85] is pain medication seeking" and "I will not prescribe [R85] narcotics." Also E11 stated that is why R85 is under E20's care. E11 stated staff did not notify her that R85 was out of pain medication. 1/17/25 12:22 PM - An interview with E25 (scheduler) and E26 (RN UM) confirmed that R85 was referred to pain management with an outside provider and it was ordered on 1/8/25. E26 confirmed that the appointment was made on 1/16/25 due to E26 not being told of the aforementioned appointment. E26 stated R85 will be seen on 2/26/25 by pain management. 1/22/25 2:30 PM - An interview with E27 (RN) confirmed that R85 did not have a current order for pain medication from 1/6/25 to 1/8/25 and notified E11 on 1/7/25. E27 was unable to provide documentation that she reported R85 was out of medication. 1/23/25 2:44 PM - An interview with E20 confirmed he was not notified of the oxycodone prescription being discontinued and did refer R85 to pain management. E20 confirmed he will continue the current pain medication regimen until R85 is seen by pain management. E20 also stated he was unaware that the E11 was notified that R85 did not have any pain medication. 1/23/25 3:00 PM - Review of findings with E1 (NHA) confirmed that the facility did not have an active order for pain medication from 1/6/25 to 1/8/25 and should have consulted the provider	F 697		

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F 697	Continued From page 84 regarding the ineffective pain medication administered in the absence of oxycodone. At this time, E1 confirmed that the facility failed to provide medication to control R85's pain resulting in approximately sixty four hours of severe uncontrolled pain rated at a level of 10 out of 10. 1/24/25 1:30 PM - Findings were reviewed with E1, E2 (DON), and E4 (Corporate Clinical Support).	F 697		
F 710 SS=D	Resident's Care Supervised by a Physician CFR(s): 483.30(a)(1)(2) §483.30 Physician Services A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, nurse practitioner, or clinical nurse specialist must provide orders for the resident's immediate care and needs. §483.30(a) Physician Supervision. The facility must ensure that- §483.30(a)(1) The medical care of each resident is supervised by a physician; §483.30(a)(2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on interview and record review and other documentation as indicated, it was determined that for one (R300) out of five reviewed residents for pressure ulcers, the facility failed to ensure that R300's medical care was supervised by a	F 710	R300 no longer resides in the facility. The facility has no opportunity to resolve the alleged deficient practice. Residents who develop skin alterations	3/18/25

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F 710	Continued From page 85 physician for the care of pressure ulcers. Findings include: Cross refer F686 Review of R300's clincal record revealed: 8/28/24 - R300 was admitted to the facility. 11/4/24 10:40 PM - A practioner (E11) progress note documented that R300 was seen for a follow up visit wound to right heel. The progress note documented that nursing reported black heel with a small amount of drainage and treatment was betadine and dry dressing to cover. The physical exam documented skin as warm and dry. The progress not lacked evidence of physical characteristics of the wound care assessment by the provider. 11/5/24 2:05 PM - A pracitioner (E11) progress note documented that R300 was seen for follow up up visit for antibiotics and ESRD (end stage renal disease). The progress note documented that R300 was started on Keflex for the right heel wound and had no adverse effects or complaints noted. The physical exam documented skin as warm and dry. The progress not lacked evidence of the physical characteristics of the wound assessment by the provider. 11/8/24 11:55 AM - A skin assessment documented R300 had a deep tissue injury unstageable to right heel with the following measurements: 6.2cm L x 5.4cm W x 0cm deep. The wound was documented as necrotic with no drainage, wound odor, and soft boggy tissue with suspected infection. The assessment documented the current treatment as betadine to	F 710	have the potential to be affected by this alleged deficient practice. The Director of Nursing or designee has completed a full house review of current resident's skin to ensure current skin impairments have treatment orders and their care is being supervised by wound care physician services. The root cause analysis indicates the licensed nurse failed to notify the wound care nurse of her findings that included a dry, heavily crusted black scab to the resident's heel. The licensed nurse received an order for treatment from the attending physician group in the facility and failed to get an order to consult wound care NP. The Director of Nursing or designee will review and revise the current procedure for wound care identification and notification. After the revisions to the process the DON or designee will in-service the licensed nursing staff and wound care provider on the revised process. The DON or designee will review the 24-hour report weekly for 3 weeks until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure residents identified with skin impairments have physician services notification, an order to consult wound care NP and a treatment for identified area until seen by wound care NP. The results of these audits will be reviewed at	

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F 710	Continued From page 86 help dry the soft boggy tissue. R300 was on oral antibiotics and xray was ordered to rule out osteomyelitis. Additionally an ultrasound and arterial study was ordered. 1/17/25 12:06 PM - An interview with E11 (NP) confirmed R300 was one of her patients and stated "I do not follow wound care, the wound NP does. I just order the medications related to wound care." The facility lacked evidence that a provider (E11) physically assessed R300's right heel wound per the aforementioned progress notes. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 710	QAPI to determine if follow up action is needed.	
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (E39) out of five CNA's reviewed for annual performance reviews, the facility failed to ensure that the annual performance review was completed at least once every twelve months. Findings include: 1/2/23 - E39's most recent performance review	F 730	Current nurse aides identified had their performance evaluations completed by the Director of Nursing or designee. Current employees have the potential to be affect by this alleged deficient practice. The Director of Human Resources obtain a list of nursing staff without a	3/18/25

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F 730	Continued From page 87 was completed on 1/17/25. The facility lacked evidence of a performance review completed in 2024. 1/15/25 1:21 PM - During an interview E1(NHA) confirmed the findings. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4(CCS).	F 730	performance evaluation in the prior year. The Director of Nursing or designee will complete the evaluations. The root cause analysis indicates there was a change in facility leadership staff resulting in a delay in completing past due evaluations. The HR Director or designee will review and revise the process for nursing assistant evaluations. The HR Director will in-service the nursing leadership team on the process. The HR Director or designee will audit nursing assistant evaluations monthly for 3 months until 100% compliance is achieved and sustained to ensure timely completion. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		3/18/25

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F 755	Continued From page 88 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R32) out of one resident reviewed for medication administration, the facility failed to provide pharmacy services to refill medications to avoid missed doses. Findings include: Review of R32's clinical record revealed: 9/1/23 - R32 was admitted to the facility with multiple diagnoses including cirrhosis of the liver. 8/27/24 - A physician's order was written for R32 to receive lactulose 45ml twice a day for cirrhosis of the liver. 12/7/24 - A quarterly MDS assessment documented that R32 was cognitively intact.	F 755	R32 is receiving her Lactulose per physician's order. R32's physician is aware of her missed doses and no new orders were given as a result of missed does. Current residents with orders for Lactulose have the potential to be affected by this alleged deficient practice. The Director of nursing or designee obtained a list of residents receiving Lactulose to determine residents are receiving their medication per order. The root cause analysis indicates the licensed nurse failed to reorder medication prior to depleting current supply of Lactulose resulting in medication being unavailable for administration.	