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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

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F 755	Continued From page 89 12/30/24 9:02 AM - An order administration note in R32's clinical record documented, "medication (lactulose) ordered not delivered, nurse called pharmacy." 12/31/24 9:59 AM - An order administration note in R32's clinical record documented, "medication (lactulose) ordered, not delivered, will notify supervisor and call pharmacy." 12/31/24 3:09 PM - An order administration note in R32's clinical record documented, "med (lactulose) not delivered, pharmacy called and said it would arrive by 3:00 pm, was not delivered." December 2024 - Review of R32's MAR lacked evidence the resident received the ordered doses of lactulose on 12/30/24 and 12/31/24. 1/13/25 9:30 AM - During an interview R32 stated "One time I had no lactulose for the three days. I was worried because without it I get confused, but I didn't." 1/17/25 11:45 AM - Review of pharmacy refill request for R32 revealed the request for lactulose was made on 12/30/24. The same date as the missed dose on 12/30/24. 1/17/25 11:48 AM - E2 (DON) confirmed that a delay in ordering resulting in R32's missed doses of lactulose. 1/23/25 8:42 AM - E2 provided the surveyor with an undated pharmacy memorandum regarding refilling of medications. The memorandum read the following "Attention Nursing Personnel" then listed pharmacy contact information as well as a	F 755	The Director of Nursing or designee will review the current procedure for medication reordering with the pharmacy provider and revise the process to include automatic medication refills to ensure depleted medications are refilled timely and available for administration. The DON or designee will audit Lactulose administration to ensure medication is administer per physician's orders 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. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 755	Continued From page 90 table of timeframe's to order medications and expected delivery time. The memorandum also indicated that "STAT orders must be called into the pharmacy to notify the pharmacy that it's a STAT order". 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2, and E4(CCS).	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		3/18/25

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F 758	Continued From page 91 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R27) out of five residents reviewed for unnecessary medications, the facility failed to limit an as needed (PRN) psychotropic medication to 14 days. Findings include: Review of R27's clinical record revealed: 10/14/24 - R27 was admitted to the facility diagnoses including but not limited to visual hallucinations, auditory hallucinations, and vascular dementia with psychotic disturbance. 10/21/24 - An admission MDS assessment documented a BIMS score of 14 indicating R27 is cognitively intact and also documented R27 had physical, verbal, and other behaviors not directed	F 758	R27 no longer resides in the facility. The facility has no opportunity to resolve the alleged deficiency. Current residents with orders for as needed Ativan have the potential to be affected by this alleged deficient practice. The Director of Nursing or designee will review current orders for PRN Ativan to ensure there is a 14-day stop date. The root cause analysis indicates that the medication did not have a stop date at the time of ordering due to a knowledge deficit for staff. The Director of Nursing or designee will in-service licensed nursing staff on	

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F 758	Continued From page 92 at others. 11/13/24 8:49 PM - A physician's order documented alprazolam (anti-anxiety) 0.5mg: Give 0.5mg by mouth every eight hours as needed for anxiety with an "indefinite" stop date. 1/17/25 2:57 PM - An interview with E11 (NP) confirmed the order did not have a fourteen day stop date. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 758	obtaining a 14-day stop date for residents ordered as needed anti-anxiety medications. The DON or designee will review newly ordered anti-anxiety medications daily in clinical meeting to ensure there is a stop date. The Director of Nursing or designee will audit new orders to ensure as needed medications have a stop and stop date 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. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R299 and R46) out of five residents reviewed for unnecessary medication, the facility failed to ensure residents were free from a significant medication error when staff failed to administer insulin. Additionally, staff failed to conduct finger stick blood sugar monitoring, which included sliding scale insulin coverage based on the results. The facility's failure placed the residents at risk for a serious adverse outcome including diabetic ketoacidosis, diabetic coma or even death from untreated elevated blood sugar. Due to this failure an Immediate Jeopardy (IJ) was called on	F 760	R299 no longer resides in the facility. The facility has no opportunity to resolve the alleged deficient practice. R46's physician is aware of the doses of Insulin Glargine not administered with no new orders. R46 has insulin available and is receiving insulin according physicians orders. Current residents with orders for insulin have the potential to be affected by this alleged deficient practice. The Director of Nursing or designee completed a full	3/18/25

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F 760	Continued From page 93 1/23/25 at 11:52 AM. The IJ was abated on 1/23/25 at 11:00 PM. Findings include: 1. Review of R299's clinical record revealed: 10/4/24 5:00 PM - R299 was admitted with diagnoses including but not limited to diabetes mellitus. 10/4/24 - A discharge summary from hospital documented R299 had a diagnosis of diabetes mellitus, orders for insulin, and orders to monitor blood sugar. 10/4/24 - R299's medication administration record (MAR) lacked evidence of a blood glucose reading at dinner time and bed time. The MAR also lacked evidence of coinciding sliding scale insulin administration based on blood glucose reading. 10/5/24 12:04 AM - A telephone physician's order for Lispro (insulin) was entered into the electronic medical record. The order read as follows: Insulin Lispro (1 unit dial) subcutaneous solution pen-injector 100 unit/mL: Inject as per sliding scale: 0-150 = 0 units; 151-200 = 2 units; 201-250 - 4 units; 251-300 = 6 units; 301-350 = 8 units; 351-400 = 10 units; greater than 400 give 10 units and call MD; give subcutaneously before meals and at bed time. 10/5/24 - An admission MDS documented R299 was diabetic and was receiving insulin. 10/5/24 8:00 AM - R299's MAR documented a blood glucose of 432 mg/dL (normal blood glucose is 80 mg/dL to 120 mg/dL) and fifteen units of Lispro was administered.	F 760	house audit of current residents with orders for insulin. Current residents have insulin available for administration. The root cause analysis indicates the licensed nurse failed to enter the medications into the electronic record timely for a newly admitted resident. The root cause analysis indicates the facility did not have insulin available in the backup pharmacy kit. The Director of Nursing or designee met with the pharmacy and medical director to discuss backup pharmacy kit content and Insulin was added to the backup pharmacy supply and is available for use. The Director of Nursing or designee will in-service licensed nursing staff on the process for verifying and entering new orders for newly admitted residents. The Director of Nursing or designee will audit residents with orders for inulin 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 insulin is administered per the physician's order. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 760	Continued From page 94 10/5/24 11:30 AM - A progress note documented "Patient's (R299) family observed giving patient medications from home. Supervisor educated family that medications from home could not be given because there is no way to tell what exactly was given. Family stated patient needed pain medication. Supervisor explained to family the procedure with pain medications and informed them they were being delivered today. [Provider Group] NP and DON made aware." 10/5/24 untimed - A pharmacy manifest documented R299's medications were delivered to the facility. The manifest lacked evidence that R299's Lispro was delivered or ordered. 10/5/24 5:00 PM - A progress note documented that R299 was discharged. 1/16/25 2:20 PM - A copy of the emergency facility medication stock revealed that insulin was not available for emergency use. 1/17/25 8:30 AM - An interview with E2 (DON) confirmed that Lispro is not available in the facility emergency medication stock. 1/22/25 10:55 AM - An interview with FM1 revealed that at 9:00 PM on 10/4/24 R299 had not received bed time medications and FM1 notified the staff. FM1 stated that staff told her that medications needed to be ordered and were not available at this time. 1/22/25 11:03 AM - An interview with FM2 revealed that FM2 requested to speak to a supervisor after dinner on 10/4/24 to address multiple concerns. FM2 stated that the supervisor	F 760		

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F 760	Continued From page 95 confirmed that R299's medications would not be delivered until 10/5/24 in the morning. 1/22/25 11:35 AM - An interview with E3 (ADON) stated the expectation for medication reconciliation and submission of orders is within an hour of admission. The primary nurse is expected to call the on call provider to review medication orders and input into the electronic medical system. E3 confirmed that R299 did not receive a blood glucose check on 10/4/24 at 5:00 PM or 9:00 PM and coinciding sliding scale insulin. 1/23/25 2:13 PM - An interview with E16 (LPN) revealed that E16 was unable to recall details of R299's admission. 1/23/25 3:34 PM - An interview with E17 (RN, UM) revealed that E17 was unaware of the expectation of reconciling medications within an hour of admission and unable to recall details of R299's admission. 2. Review of R46's clinical record revealed: 11/17/22 - R46 was originally admitted to the facility with several diagnoses including diabetes. 11/15/24 - A physicians order was written for R46 to receive Insulin Glargine inject 20 units at bedtime for diabetes. 11/22/24 - An annual MDS assessment documented that R46 was cognitively intact and received insulin injections. 12/23/24 9:09 PM - An orders administration note in R46's clinical record documented that the	F 760		

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F 760	Continued From page 96	F 760		

ordered Insulin Glargine was not given due to "awaiting for delivery".

12/24/24 8:42 PM - An orders administration note in R46's clinical record documented, that the ordered Insulin Glargine was not given due to being "on order".

12/28/24 8:48 PM - An orders administration note in R46's clinical record written by E9 (LPN) documented, "this med was reordered on 12/22, and this nurse call[ed] the pharmacy [to] ask for [Insulin Glargine] pen to be delivered the next day because the resident was out of this meds. The pharmacist hang up in my face....sic Supervisor and the DON is aware of the situation. Still no delivery."

December 2024 - Review of R46's MAR lacked evidence that R46 received the ordered dose of 20 units Insulin Glargine at bedtime on 12/23, 12/24, 12/28, and 12/29. It is unclear how R46 received the insulin on 12/25, 12/26, and 12/27 when the refill had not been delivered and there were no insulins in the back up medication/Pixus.

1/16/25 10:23 AM - During an interview E7 (LPN) explained that all medications are "Reordered in the software if low and that we have insulin in the reserve/emergency box."

1/16/25 10:37 AM - During an interview E2 (DON) stated that refills "Can take 24 to 48 hours but that the pharmacy delivers at least twice a day to the facility". E4 (CCS) then stated "We did identify some issues and have been working with them to improve." E2 then stated "We started working to improve at least a few weeks ago."

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F 760	Continued From page 97 1/17/25 8:30 AM - E2 (DON) provided a pharmacy order summary that indicated a request for a refill of R46's Insulin Glargine medication was sent on 12/22/24. 1/17/25 10:20 AM - During an interview with E9 (LPN) the re-ordering process was clarified and E9 stated that to refill medications staff "Clicks on re-order meds to go straight to the pharmacy and maybe call to make sure you have it for the next day. If they have in the Pixus you can go to the supervisor for the Pixus. Insulin is not usually in the back up so most of the time we reorder that. The first time I ordered and called they said it was too early and we need a supervisor. I did go to the [DON] and he said he would take care of it. When I came back the med was not there and I called again and the pharmacy hung up on me." 1/17/25 10:41 AM - E2 (DON) provided the surveyor an inventory list of emergency medications held in the facility and confirmed Insulin Glargine was not on the list. 1/17/25 12:05 PM - During an interview E11 (NP) confirmed knowledge of R46's missed doses of the Insulin Glargine. E11 stated, "They called me and I told them to monitor." E11 then showed the surveyor a composition note book with a dated hand written note regarding R46's missed doses of insulin. 1/23/25 8:42 AM - E2 provided the surveyor with an undated pharmacy memorandum regarding refilling of medications. E2 stated it was part of an education to staff provided "a month ago and it's improved things." The memorandum read the following "Attention Nursing Personnel" then listed pharmacy contact information as well as a	F 760		

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F 760	Continued From page 98 table of timeframe's to order medications and expected delivery time. The memorandum also indicated that "STAT orders must be called into the pharmacy to notify the pharmacy that it's a STAT order". 1/23/25 1:53 PM - During an interview E13 (agency LPN) was unable recall R46 being out of the ordered insulin Glargine, E13 (LPN) stated, "They are often out of medications at that facility and some people use other residents insulin's but I don't." 1/23/25 1:56 PM - During an interview E14 (agency LPN) was unable to recall R46 being out of the ordered insulin Glargine. E14 stated, "If the resident is out then we have to give it depending whatever the insulin is. They keep a lot of insulin in the refrigerator and sometimes if its not then I guess we call the pharmacy and the doctor but I haven't run into that situation." The four missed doses of the ordered Insulin Glargine for R46 placed the resident at risk for having a serious adverse outcome including diabetic ketoacidosis, diabetic coma or even death. 1/23/25 11:52 AM - Based on interviews and review of the facility documentation and other sources, an Immediate Jeopardy was called and reviewed with the facility leadership including E1 (NHA) and E4 (Corporate Clinical Support). 1/23/25 11:00 PM - The facility's Immediate Jeopardy was abated at this time. The acceptable abatement plan included implementation of new policies titled "Verifying Diabetic Medications for New Admit Residents" and "Diabetic Medication	F 760		

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F 760	Continued From page 99 administration for current residents." The proposed plan included education to one hundred percent of working staff and ongoing for the remaining staff currently unavailable and not working, and new hires. Staff confirmed no new admissions were scheduled for the rest of the day. Staff interviews confirmed completion of staff training. Staff confirmed that all current residents had insulin available on hand and current medication orders. E4 stated the facility is in the process of updating identified delivery issues with current pharmacy provider and will add insulin as an emergency medication to the supply. 1/28/25 11:30 AM - The facility's abatement was reviewed with E1 (NHA) and E4 (Corporate Clinical Support). It was determined through observation, interview and record review that the facility met all requirements for abatement on 1/23/25 at 11:00 PM.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		3/18/25

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F 761	Continued From page 100 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based observation, interview and review of other facility documentation, it was determined that for three out of five medication storage refrigerators, the facility failed to facilitate the safe administration of medication to residents and staff. In addition, the facility failed to ensure that testing materials for COVID-19 would accurately reflect residents and employees COVID status. Findings include: 1/21/25 9:02 AM - An observation of the back-up medication refrigerator in the facility conference room revealed that the temperature monitoring logs were incomplete. The following are the incomplete daily temperature log monitoring for the medications stored in the facility conference room refrigerator. - May 2024 - 18 out of 31 days were incomplete. - June 2024 - 10 out of 30 days were incomplete - July 2024 - 8 out of 31 days were incomplete. - August 2024 - 19 out of 31 days were incomplete. - September 2024 - 16 out of 30 days were incomplete. - October 2024 - 9 out of 31 days were incomplete.	F 761	The medications in the back-up refrigerator were removed from the refrigerator and discarded. The COVID-19 testing supply was discarded. The other refrigerators were checked for temperature and added to the log. The refrigerators were cleaned. Current refrigerators containing medications were cleaned and a temperature log was put in place. The root cause analysis indicates the infection control nurse moved the refrigerator to a new location and facility staff were unaware there was medication stored in the refrigerator and therefore there was no temperature monitoring in place. The facility staff failed to follow the process for cleaning, removing expired medications and maintaining temperature logs per process. The Director of Nursing or designee will audit facility medication refrigerators weekly for 3 weekly until 100% compliance is achieved, then monthly for	

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POLARIS HEALTHCARE AND REHABILITATION CENTER	21 W CLARKE AVENUE MILFORD, DE 19963

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F 761	Continued From page 101 - November 2024 - 27 out of 30 days were incomplete. - December 2024 - The facility lacked evidence of any refrigerator temperature monitoring. - January 2025 - The facility lacked evidence of any refrigerator temperature monitoring until the surveyor brought it to the attention of the facility on 1/21/25. 1/21/25 9:17 AM - During an observation and interview, E2 (DON) confirmed the missing temperature monitoring of the conference room refrigerator. Medications that were stored inside of the conference room refrigerator were as follows: - 10 five milliliters of flu vaccines. - 83 single dose pre-filled syringes of flu vaccine. - 17 single dose pre-filled doses of Hepatitis B vaccines. - 2 COVID-19 pre-filled doses of COVID-19 vaccines. 1/21/25 10:33 AM - During an observation and interview with E3 (ADON), it was confirmed that in the Riverwalk number 1 medication refrigerator was a box of Tylenol suppositories that had been expired since October 2024. 1/21/25 10:45 AM - During an observation and interview with E3, it was confirmed that in the Riverwalk number 2 medication room was two holding boxes of COVID-19 testing mediums. One of which the holding boxes had 10 testing mediums that was noted to have approximately ¼ of an inch of water in (one of which had a black substance in it). The other holding box did not have water in it but had a piece of tape on it with the date of 7/10. E3 stated that there was a	F 761	3 months with a goal of 100% compliance to be achieved and sustained to ensure there are no expired medications and the temperature logs are completed. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 761	Continued From page 102 laboratory technician in the building, and we should consult her regarding the test mediums. 1/21/25 11:12 AM - During an observation and interview L1 (Lab Tech) confirmed that the vials of medium were not recommended to be used. L1 stated that she would contact the owner and operator of the lab about how to proceed. The lab owner on the phone with the lab tech stated that the vials should be disposed of in the biohazard trash.	F 761		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined, for one (R64) out of four residents sampled for laboratory services, the facility failed to promptly notify the ordering medical practitioner of laboratory results. Findings include: Cross refer to F580 Review of R64's clinical record revealed:	F 773	R64's lab results were reviewed with physician services and ordered treatment was initiated. Current residents have potential to be affected by this alleged deficient practice. The Director of Nursing or designee completed a full house audit of current	3/18/25

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F 773	Continued From page 103 11/27/24 - R64 was admitted to the facility. 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. 1/13/25 4:30 PM - A physician's order for R64 documented a chest xray 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) 800-160mg give one tablet two times a day for left base infiltrate (pneumonia) for five days. 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 promptly reporting abnormal lab results to the medical provider. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 773	residents with orders for laboratory testing to ensure physician services are made aware of results. The root cause analysis indicates the Nurse Practitioner has a preference to review her own ordered laboratory testing in the electronic health record so the test was not opened by facility staff because it shows and reviewed causing the NP to believe she reviewed the results. The Director of Nursing or designee will review the current process for reviewing and reporting laboratory test results. After review and revision, the licensed nursing staff and physician services will be educated on the process. The Director of Nursing or designee will audit facility ordered laboratory tests weekly for 3 weekly until 100% compliance is achieved, then monthly for 3 months with a goal of 100% compliance to be achieved and sustained to ensure licensed nurses review and report results to physician services. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services	F 791		3/18/25

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F 791	Continued From page 104 The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for	F 791		

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F 791	Continued From page 105 reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R27) out of seven sampled residents for dental services, the facility failed to assist the residents in obtaining routine dental services. Findings include: Review of R27's clinical record revealed: 10/12/24 - An admission packet for R27 documented that R27 elected to receive dental services through the facility. 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. The MDS also documented that R27 does not have dentures, broken teeth, or any abnormal mouth issues. 1/13/25 9:11 AM - An interview revealed that R27 wanted to see the dentist and stated she had not seen one since before she was admitted to the facility. 1/15/25 3:29 PM - A review of the electronic medical records lacked evidence that R27 had received dental services. 1/21/25 8:26 AM - An interview with E1 (NHA) confirmed that R27 had not received dental services because the dentist only comes to the facility once a year. E1 stated that the dentist had	F 791	R27 no longer resides in the facility. The facility has no opportunity to resolve the alleged deficient practice. Current residents have the potential to be affected by this alleged deficient practice. The Director of Nursing or designee will complete an audit of current residents for their preference to see the dentist. The root cause analysis indicates the resident was admitted on 10/14/24 and indicated on the nursing admission assessment that she would not require dental services due to being admitted for short-term stay, however when interviewed by surveyor she indicated she would like to see the dentist. The DON or designee will review the process for dental consults on admission. Upon review and revision, The DON will in-service licensed nursing staff on the process for dental consults/visits. The Director of Nursing or designee will audit facility residents with a preference to see the dentist weekly or 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 dental preferences have been honored. The results of these audits will be reviewed at QAPI to determine if follow up action is needed.	

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F 791	Continued From page 106 not come for the annual visit yet. 1/24/25 1:30 PM - Findings were reviewed with E1, E2 (DON), and E4 (Corporate Clinical Support).	F 791		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that for one (R64) out of one residents reviewed for nutrition the facility failed to provide fluid in a form designed to meet the individuals needs. Findings include: Review of R64's clinical record revealed: 11/27/24 - R64 was admitted to the facility. 12/4/24 - An admission MDS assessment 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 that were all thin liquids. R64 was actively eating and drinking when observation occurred; During this time R64 was observed drinking the thin liquids resulting in coughing.	F 805	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	3/18/25

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F 805	Continued From page 107 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 (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 provide R64 fluid in a form designed to meet individual needs. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Clinical Support).	F 805	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.	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		3/18/25

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F 812	Continued From page 108 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 1/13/25 10:26 AM - During a tour of the kitchen, the surveyor observed E15 (Account Manager) test the sanitizer level of the solution in two red sanitizing buckets. When E15 tested the sanitizing solution, the test strips from each of the buckets indicated that the level of chemical concentration in the buckets was not at a sufficient level to provide proper sanitization. 1/13/25 10:28 AM - During a tour of the walk-in freezer there were several discarded food items,	F 812	Sanitizing buckets were immediately drained and fresh solution dispensed. The fresh solution was tested to ensure an accurate level of concentration. All debris was immediately removed from the freezer floor and appropriately discarded. Ecolab was called immediately, they on site shortly after to repair the machine. All food items were removed, logs are updated. Residents who reside at the facility have potential to be affected by this deficient practice. The Food Services Director/designees will conduct daily rounds to check logs and record checklists.	

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F 812	Continued From page 109 including a breaded fish patty, a hash brown, and several other debris items laying on the freezeer floor. 1/13/25 10:53 AM - During the rinse cycle the automatic dishwashing machine temperature was too low. Several test trials revealed a max temp of 130 degrees Fahrenheit. The temperature in this type of warewashing machine must be geater than 180 degrees Fahrenheit for proper sanitization during the rinse cycle. 1/13/25 12:30 PM - The refrigerator in the first nourishment room contained two turkey and cheese sandwiches with a creation date of 1/7/25, which should have been discarded before 1/10/25. The refrigerator in the second nourishment room contained an undated/labeled jar of spinach dip and an opened package of processed cheese food dated 10/24/24. 1/13/25 12:52 PM - The refrigerator in the dining room contained an opened half used bottle of prune juice with no date label, as well as several other opened and unopened items with room numbers, but no date lables. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4 (Corporate Support)	F 812	The root cause analysis indicates that the Dietary Director/staff failed to ensure safe storage, preparation and sanitation of food items. The Dietary Director/Designee will conduct daily checks and complete checklist and logs. All Dietary staff must participate in and complete scheduled in-services including Cleaning and Sanitizing In-service; Cleaning Procedures In-services; Cold food storage Policy; Environment Policy and Procedure; Receiving and Storage of Food In-service.). Ongoing daily rounds are/will be conducted. The Dietary Director/designees will record daily logs and complete checklists. These logs and checklists will be reviewed on a daily basis until 100% compliance is achieved. A summary of these audits will be sent to the NHA and reviewed at QAPI for the next 3 months to determine if any further action steps are needed.	
F 941 SS=D	Communication Training CFR(s): 483.95(a) §483.95(a) Communication. A facility must include effective communications as mandatory training for direct care staff. This REQUIREMENT is not met as evidenced by:	F 941		3/18/25

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F 941	Continued From page 110 Based on record review and interview it was determined that for two (E28 and E49) out of six employees reviewed, the facility failed to ensure that mandatory communication training was completed. Findings include: 1/15/25 - A review of the facility training worksheets lacked evidence of required communication training for the following staff: E28 date of hire 6/29/23 - no record of communication training. E49 date of hire 12/11/23 - no record of communication training. 1/22/25 10:46 AM - 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 941	No residents were identified as being directly impacted by lack of effective communication education by identified direct care staff. Potentially all residents could be affected by lack of education on effective communication by identified direct care staff. The root cause analysis identified the cause as being that not all direct care staff completed their assigned RELIAS mandatory education on effective communication . The DON or designee will ensure that all staff who did not complete required education for effective communication will complete the training. All new hires will finish required education on effective communication prior to beginning training on the unit with a preceptor. The DON or designee will track education completion via attendance sheets and/or Relias compliance reports weekly until 100% compliance is achieved. Education compliance will be reported to QAPI monthly for the next 3 months with a goal of 100% compliance to be achieved and sustained.	
F 942 SS=D	Resident Rights Training CFR(s): 483.95(b) §483.95(b) Resident's rights and facility responsibilities. A facility must ensure that staff members are	F 942		3/18/25

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F 942	Continued From page 111 educated on the rights of the resident and the responsibilities of a facility to properly care for its residents as set forth at §483.10, respectively. This REQUIREMENT is not met as evidenced by: Based on record review and interviews it was determined that for two (E29 and E30) of out of six employees reviewed, the facility failed to ensure resident rights training was ongoing. Findings include: 1/15/25 - A review of the facility training worksheets revealed lack of evidence of ongoing training on resident's rights for the following staff: E29 date of hire 4/10/23 -most recent date of residents rights training 4/11/23. E30 date of hire 10/23/23- most recent date of residents rights training 10/23/23. 1/22/25 10:46 AM - During an interview E1 (NHA) confirmed the findings. 1/24/25 1:30 PM - Findings were reviewed with E1, E2 (DON) and E4 (CCS).	F 942	No residents were identified as being directly impacted by lack of annual resident rights education by staff. Potentially all residents could be affected by lack of education on resident rights by staff. The root cause analysis identified the cause as being that not all staff completed their assigned annual RELIAS mandatory education on resident rights. The DON or designee will ensure that all staff who did not complete required annual education for resident rights will complete the training. All new hires will complete required education on resident rights prior to beginning training on the unit with a preceptor. The DON or designee will track education completion via attendance sheets and/or Relias compliance reports weekly until 100% compliance is achieved. Education compliance will be reported to QAPI monthly for the next 3 months until 100% compliance is achieved and sustained.	
F 944 SS=D	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement.	F 944		3/18/25

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F 944	Continued From page 112 A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (E28 and E47) out of six employees reviewed, the facility failed to ensure that staff completed QAPI training. Findings include: 1/15/25 - A review of the facility training worksheets lacked evidence of required QAPI training: E28 6/29/23 date of hire, no record of training. E47 7/19/23 date of hire, no record of training. 1/22/25 10:46 AM - 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 944	No residents were identified as being directly impacted by lack of QAPI education by identified staff. Potentially all residents could be affected by lack of education on QAPI by staff. The root cause analysis identified the cause as being that not all staff completed their assigned RELIAS mandatory education on QAPI. The DON or designee will ensure that all staff who did not complete required education for QAPI will complete the training. New hires will complete required education on QAPI prior to beginning training on the unit with a preceptor. The DON or designee will track education completion via attendance sheets and/or Relias compliance reports weekly until 100% compliance is achieved. Education compliance will be reported to QAPI monthly for the next 3 months until 100% compliance is achieved and sustained.	
F 945 SS=D	Infection Control Training CFR(s): 483.95(e) §483.95(e) Infection control. A facility must include as part of its infection prevention and control program mandatory	F 945		3/18/25

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

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F 945	Continued From page 113 training that includes the written standards, policies, and procedures for the program as described at §483.80(a)(2). This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (E29 and E30) out of six employees reviewed for required training the facility failed to ensure that infection control training was completed and consistent with policy standards. Findings include: The facility policy on Infection Prevention and Control Plan last updated 2024, indicated there would be "ongoing education for all facility personnel." 1/15/25 - A review of the facility's training worksheet lacked evidence of ongoing infection control training for the following staff: E29 date of hire 4/10/23 most recent infection control training completed on 4/10/23. E30 date of hire 10/23/23 most recent infection control training completed on 10/23/23. 1/22/25 10:46 AM - During an interview E1 (NHA) confirmed the findings. 1/24/25 1:30 PM - Findings were reviewed with E1, E2 (DON) and E4 (CCS).	F 945	No residents were identified as being directly impacted by lack of annual infection control education staff. Potentially all residents could be affected by lack of annual education on infection control by identified direct care staff. The root cause analysis identified the cause as being that not all staff completed their assigned annual RELIAS mandatory education on infection control . The DON or designee will ensure that all staff who did not complete required annual education for infection control will complete the training. All new hires will complete required infection control education in general orientation prior to beginning training on the unit with a preceptor. The DON or designee will track education completion via attendance sheets and/or Relias compliance reports weekly until 100% compliance is achieved. Education compliance will be reported to QAPI monthly for the next 3 months until 100% compliance is achieved and sustained.	
F 946 SS=D	Compliance and Ethics Training CFR(s): 483.95(f)(1)(2) §483.95(f) Compliance and ethics.	F 946		3/18/25

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F 946	Continued From page 114 The operating organization for each facility must include as part of its compliance and ethics program, as set forth at §483.85- §483.95(f)(1) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program. §483.95(f)(2) Annual training if the operating organization operates five or more facilities. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for three (E28, E29, and E30) out of six employees reviewed, the facility failed to ensure that annual training of the compliance and ethics program was completed for an organization operating five or more facilities. Findings include: 1/15/25 - A review of the facility's training worksheet lacked evidence of required training on the facilities compliance and ethics programs for the following staff: E28 6/29/23 date of hire, no record of training. E29 4/10/23 date of hire, last date of training 4/10/23. E30 10/23/23 date of hire, last date of training 10/23/23. 1/23/25 4:34 PM - During an interview E1(NHA) confirmed the findings. 1/24/25 1:30 PM - Findings were reviewed with	F 946	No residents were identified as being directly impacted by lack of annual corporate compliance and ethics education staff. Potentially all residents could be affected by lack of annual education on corporate compliance and ethics by identified direct care staff. The root cause analysis identified the cause as being that not all staff completed their assigned annual RELIAS mandatory education on corporate compliance and ethics . The DON or designee will ensure that all staff who did not complete required education for corporate compliance and ethics will complete the training. All new hires will complete required education on corporate compliance and ethics prior to beginning training on the unit with a preceptor.	

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F 946	Continued From page 115 E1, E2 (DON) and E4 (CCS).	F 946	The DON or designee will track education completion via attendance sheets and/or Relias compliance reports weekly until 100% compliance is achieved. Education compliance will be reported to QAPI monthly for the next 3 months until 100% compliance is achieved and sustained.	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.71 and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for four (E30, E32, E39, and E40) out of five CNA'S reviewed, the facility failed to ensure that the required minimum twelve hours of in-service training was completed. Findings include:	F 947	No residents were identified as being directly impacted by lack of annual 12 hours of CNA education by identified staff. Potentially all residents could be affected by lack of annual 12 hours of CNA	3/18/25

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F 947	Continued From page 116 1/15/25 - A review of the facility training worksheet lacked evidence of the required twelve hours minimum in-service training for the following CNA's: E39 had a hire date of 1/2/23. From 1/2/24 - 1/2/25, 1.05 hours of training were completed. E32 had a hire date of 9/26/23. From 9/26/23 - 9/26/24, 0.0 hours of training were completed. E40 had a hire date of 10/9/23. From 10/9/23 - 10/9/24, 0.0 hours of training were completed. E30 had a hire date of 10/23/23. From 10/23/23 - 10/23/24, 0.0 hours of training were completed. 1/22/25 10:46 AM - During an interview E1 (NHA) confirmed the findings. 1/24/25 1:30 PM - Findings were reviewed with E1, E2 (DON) and E4 (CCS).	F 947	education by identified staff. The root cause analysis identified the cause as being that identified CNAs did not complete their assigned annual RELIAS mandatory education. The DON or designee will ensure that all CNAs, who did not complete required annual Relias education will do so. All new hires will completed required 12 hours on CNA education in general orientation prior to beginning training on the unit with a preceptor. The DON or designee will track education completion via attendance sheets and/or Relias compliance reports weekly until 100% compliance is achieved. Education compliance will be reported to QAPI monthly for the next 3 months until 100% compliance is achieved and sustained.	
F 949 SS=D	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.71. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for two (E28 and E29) out of six staff reviewed, the facility failed to ensure that required behavioral health training was completed in accordance with the Facility Assessment.	F 949	No residents were identified as being directly impacted by lack of behavioral health education by identified staff. Potentially all residents could be affected	3/18/25

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F 949	Continued From page 117 Findings include: The Facility Assessment last updated December 2024, indicated that the facility maintained an average of one to ten residents with behavioral symptoms. Staff training, education and competencies, indicated that "All staff are assigned training and attend training sessions in the facility annually and as designated." 1/15/25 - A review of the facility training worksheet lacked evidence of behavioral health training for the following staff: E28 (DA)- date of hire 6/29/23 no documented behavioral health training. E29 (RN) - date of hire 4/10/23 no documented behavioral health training. 1/22/25 10:46 AM - During an interview E1 (NHA) confirmed the missed training's. 1/24/25 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E4(CCS).	F 949	by lack of behavioral health education by identified staff. The root cause analysis identified the cause as being that only direct care clinical staff were assigned a Relias course related to behavioral health and not all staff that interact with residents, as indicated in the facility assessment. The DON or designee will ensure that all staff, who interact with residents, complete behavioral health training. All new hires will complete required behavioral health education in general classroom orientation prior to starting in their designated areas. The DON or designee will track education completion via attendance sheets and/or Relias compliance reports weekly until 100% compliance is achieved.	