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

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

STATE SURVEY REPORT

NAME OF FACILITY: Regal Heights Healthcare & Rehab Center **DATE SURVEY COMPLETED:** May 23, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from May 14, 2025, through May 23, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. the facility census on the first day was one hundred and sixty-seven (167). The investigative sample totaled thirty-five (35) residents. Abbreviations/definitions used in this report are as follows: ADON – Assistant Director of Nursing; DON – Director of Nursing; NHA – Nursing Home Administrator; SW – Social Worker.	Cross refer to the CMS-2567-L survey completed May 23, 2025: F550, F551, F559, F600, F609, F641, F644, F656, F658, F677, F685, F689, F693, F695, F759, F880, F883, F887 and F940	6/12/2025
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**		

Provider's Signature Barbara Troy RN Title Director of Nursing Date 6/12/2025

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	are hereby adopted and incorporated by reference. This requirement was not met as evidenced by: Cross refer to the CMS-2567-L survey completed May 23, 2025: F550, F551, F559, F600, F609, F641, F644, F656, F658, F677, F685, F689, F693, F695, F759, F880, F883, F887 and F940.	Cross refer to the CMS-2567-L survey completed May 23, 2025: F550, F551, F559, F600, F609, F641, F644, F656, F658, F677, F685, F689, F693, F695, F759, F880, F883, F887 and F940	
3201.7.0 3201.7.5	Plant, Equipment and Physical Environment Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code. 6-202 Functionality 6-202.15 Outer Openings, Protected. (A) Except as specified in (B), (C), and (E) and under (D) of this section, outer openings of a FOOD ESTABLISHMENT shall be protected against the entry of insects and rodents by: (1) Filling or closing holes and other gaps along floors, walls, and ceilings; (2) Closed, tight-fitting windows; and (3) Solid, self-closing, tight-fitting doors. This requirement was not met as evidenced by: Based on interview and record review, the facility failed to provide a vermin proof environment for food storage and preparation. Findings include:	**3201.7.5 Plant, equipment and physical environment** A-The door gap found under the outermost double door that leads to the outside trach docking platform was fixed by the maintenance department on 6/12/25. B- Outermost doors that lead to the outside and to the outside trash area have the potential to be affected by this deficient practice. C- Maintenance Director/designee educated maintenance staff on importance of checking all outermost doors for possible areas of penetration to ensure prevention of insects and rodents from entering the facility. RCA: Maintenance department failed to identify an outermost door that had the potential to allow insects and rodents to enter the facility. Maintenance department did not have a formalized preventative maintenance measure (PM) in place at the time of the occurrence for checking outermost doors for areas of penetration.	6/12/2025

Provider's Signature Bethann Troy RN Title Director of Nursing Date 6/12/2025

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3201.7.7 **3201.7.7.5**	5/16/25 10:31 AM - During the kitchen tour with E46 (District Food Service Manager) and E47 (Maintenance Director), the surveyor found a gap under the outermost double door that leads to the outside trash docking platform. Due to the nature of kitchen waste transport through the doors and the hallway, vermin can potentially come inside the building. The finding was confirmed with the E46 and E47. 5/16/25 11:35 AM - Finding was reviewed with E1 (NHA). **Equipment and Supplies** **The facility shall provide safe storage for residents' valuables.** This requirement was not met as evidenced by: Based on interview and record review, it was determined that for one (R160) out of four residents reviewed for personal property, the facility failed to provide safe storage for the resident's valuables. Findings include: The facility's Resident's Admission Packet stated under "... Exhibit L, Facility Resident's Rights and Responsibilities... 23. Every resident shall have the right to use their personal clothing and possessions where reasonable and shall be entitled to have security in their storage and use...". Review of R160's clinical record revealed: 2/27/25 – R160 was admitted to the facility. 4/29/25 – F4 (family representative) filed a complaint/grievance report with E1 (NHA)	New process: Maintenance director initiated a preventative maintenance measure (PM) for outermost door checks monthly. Maintenance will check for gaps in door sweeps and gaskets around the door that have the potential to allow insects and rodents to enter the facility. Initial sweep of all outermost doors was conducted and maintenance department found one door with a potential area of penetration around the door gasket. Door gasket was replaced. D-Maintenance director/designee will perform monthly PM's on all outermost doors to ensure prevention of insects and rodents form entering the facility. Results of monthly PM's on outermost doors will be brought to the QAPI steering committee and safety meetings for further evaluation or recommendation.	

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NAME OF FACILITY: Regal Heights Healthcare & Rehab Center DATE SURVEY COMPLETED: May 23, 2025

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	that stated, "... [R160] reporting money ($25) missing from the purse...". E1 conducted a search the room/area on 4/29/25 without a successful outcome. The facility indicated that if the missing funds were not located, reimbursement would be issued to the resident. 5/15/25 10:30AM – During an interview, R160 stated that her purse was in her drawer and $25 was missing when she checked to pay for her hair appointment. R160 explained that she did not have a key to lock the drawer. 5/15/25 12:00PM - During an interview, E22 (SW) acknowledged the grievance and progress on resolving the incident. E22 indicated that the facility was in the process of issuing a reimbursement check in the amount of $25 made payable to F4, and steps were taken to secure resident's personal property by repairing the drawer and ensuring that the resident has the key to lock and secure her personal property. 5/23/25 2:30PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).		6/12/2025
3201.7.0 **3201.7.1.14.1**	**Title 16 Health and Safety** **4202 Control of Communicable and Other Disease Conditions** **Control of Specific Contagious Diseases** **Physicians and other health care providers who give immunizations shall report information about the immunization and the person to whom it was given for addition to the immunization registry in a manner**	**32.1.7.1.14.1 Control of Specific Contagious Diseases** A-R51, R105, R367, R419-vaccines have been documented in Delaware's online Immunization registry-DELVAX. B- Residents residing at the facility have a potential to be affected by this deficient practice.	

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	prescribed by the Division Director or designee. **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for four (R51, R105, R367, R419) out of ten residents reviewed for vaccinations, the facility failed to document the vaccines given in the facility in DELVAX, Delaware's online immunization registry. Findings include: 1. Review of R51's clinical record revealed: 3/30/23 – R51 was admitted to the facility. 10/30/24 – The facility administered the Covid 19 (Comirnaty) vaccine to R51. The facility failed to document R51's COVID vaccine in DELVAX. 2. Review of R105's clinical record revealed: 3/30/22 – R105 was admitted to the facility. 10/21/24 – The facility administered the influenza vaccine to R105. 10/31/24 – The facility administered the COVID 19 (Comirnaty) vaccine to R105. The facility failed to document R105's COVID vaccine in DELVAX. 3. Review of R367's clinical record revealed: 5/10/12 – R367 was admitted to the facility.	C- DON/designee will educate current administrative nursing staff on reviewing new admissions and readmissions and their current vaccinations and to documents vaccinations in the DELVAX system accurately. RCA: Facility's Infection Preventionist at the time failed to accurately document residents' vaccinations in Delaware's online Immunization registry-DELVAX. **Infection preventionist, DON, ADON and staff development participated in a training regarding data entry training into the Immunization Registry, DELVAX, on 6/5/25.** New process: During clinical meeting Infection Preventionist and clinical team will review new admissions and readmissions and their current vaccinations for accurate documentation in the medical record. Vaccinations will then be documented in the DELVAX system. D- DON /designee will perform weekly audits on new residents and readmitted residents to ensure that vaccinations have been reviewed and accurately documented in the DELVAX system. Weekly audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100%	

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	4/18/24 – The facility administered the PCV20 vaccine to R367. 10/24/24 – The facility administered the influenza vaccine to R367. 11/1/24 – The facility administered the Covid 19 (Comirnaty) vaccine to R367. The facility failed to document R367's vaccines in DELVAX. 4. Review of R419's clinical record revealed: 7/30/22 – R419 was admitted to the facility. 3/28/24 – The facility administered the PCV20 vaccine to R419. 10/31/24 – The facility administered the COVID 19 (Comirnaty) vaccine to R419. The facility failed to document R419's vaccines in DELVAX. 5/20/25 2:45 PM – The facility was unable to provide evidence of these residents' vaccinations were documented in DELVAX. 5/21/25 11:30 AM – During an interview, E2 (DON) stated that the facility was between a full-time infection preventionist (IP). E2 stated, "The new IP will start at the end of May." 5/23/25 2:30 PM – Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 May 14, 2025 through May 23, 2025. The facility census on the first day was one hundred and sixty-seven (167). In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from May 14, 2025 through May 23, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. the facility census on the first day was one hundred and sixty-seven (167). The investigative sample totaled thirty-five (35) residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; AP - antibiotic prophylaxis; the practice of prescribing antibiotics prior to an invasive procedure in effort to prevent a resultant infection; BIMS - Basic Inventory of Mental Status, a structured assessment tool aimed at evaluating cognition in the elderly. BIMS score of 0-7 is reflective of severe cognition deficit, 8-12 reflects	F 000		

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

Electronically Signed | 06/12/2025

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

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F 000	Continued From page 1 moderate cognition deficit and 13-25 score is reflective of normal cognition; CNA - Certified Nurse's Aide; CPAP - continuous positive airway pressure; a mode of therapy where a machine delivers pressurized air to an individual via a facial/nasal mask to prevent apnea events while they sleep; DELVAX - a confidential online computer system used in Delaware by doctors, nurses, schools and practices to keep track of their patients/students immunizations; DPOA - Durable Power of Attorney/legal document that allows a person to appoint someone to manage his/her financial and legal affairs on his/her behalf, even if he/she becomes incapacitated. There are two types of DPOAs: one for financial and one for medical and are usually contained in separate documents; DO - doctor of osteopathy; DON - Director of Nursing; EMR - electronic medical record; EMT - emergency medical technician; FNE - forensic nurse examiner; HS - hour of sleep; IE - infective endocarditis; LPN - Licensed Practical Nurse; LVAD - Left ventricular assist device; an implantable continuous-flow pump medical device for advanced stage heart failure that directs blood from the left ventricle to the ascending aorta; MDS - Minimum Data Set; a federally mandated, comprehensive, standardized, clinical assessment of all residents in Medicare/medicaid nursing homes that evaluates functional capabilities and health needs; NHA - Nursing Home Administrator; PASRR - Preadmission Screening and Resident Review/screening for evidence of serious mental illness and/or intellectual disabilities,	F 000		

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F 000	Continued From page 2 developmental disabilities or related conditions to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while they are there; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; SBE - subacute bacterial endocarditis; UM - Unit Manager.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her	F 550		7/8/25

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F 550	Continued From page 3 rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for two (R136 and R163) out of four residents reviewed for dignity, the facility failed to ensure that staff treat each resident with respect and dignity. Findings include: 1. 5/16/25 9:00 AM - During a medication pass observation, E16 (LPN) was seen administering medications to R163 who was lying in bed, via PEG/feeding tube (a tube that is passed into a patient's stomach through the abdominal wall). R163's bedroom door was left opened and she was visible from the hallway by visitors and staff walking by. R163's bed curtain was not pulled out to cover her and provide privacy. 5/16/25 9:20 AM - Finding was discussed with E16 who confirmed that she should have shut the door or pulled the curtain for privacy as a way to treat R163 with dignity and respect while administering her medications. 5/22/25 5:00 PM - Finding was discussed with E1	F 550	A-For R163 the deficient practice of leaving the door open and not using the privacy curtain while administering medications via peg tube was unable to be corrected due to being past the time of occurrence. For R136 the deficient practice of leaving a blue sling used for mechanical lift transfers was left under her while she was sitting in her wheelchair was unable to be corrected due to having past the time of occurrence. B- Residents requiring medications through a peg tube and residents needing the use of a blue sling for transfers via mechanical lift have the potential to be affected by this deficient practice. C- Staff Educator/designee will educate current licensed staff and new orientees on providing privacy	

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F 550	Continued From page 4 (NHA) and E2 (DON). 2. Review of R136's clinical record revealed: 12/1/23 - R136 was admitted to the facility with diagnosis of dementia. Observations of R136 during the survey include: - 5/14/25 4:32 PM - R136 was sitting on a blue-colored sling in her wheelchair in the B-Wing dining/activity room. - 5/20/25 11:40 AM - R136 was sitting on a blue-colored sling in her wheelchair outside the Social Worker's office after having participated in an activity. - 5/20/25 1:02 PM - R136 was sitting on a blue-colored sling in her wheelchair and seated at the table in the B-Wing dining room while lunch was being served. 5/20/25 1:13 PM - During an interview, E39 (LPN/UM) confirmed that the resident's sling is not to remain under the resident when sitting in the wheelchair during the day. The facility failed to provide R136, a dependent resident, with dignity as evidenced by multiple observations where a blue sling, used for mechanical lift transfers, was left under her while she sat in her wheelchair. 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 550	during medication administration via peg tube. Staff educator/designee will educate nursing staff on removing blue slings utilized for transfers via mechanical lift to remove once resident is seated in wheelchair as resident allows. RCA: Facility failed to ensure the resident's right for a dignified existence and privacy was upheld by closing the door or by pulling the privacy curtain during medication administration via peg tube. Employee noted that she knew that she should have shut the door or pulled the curtain for privacy as a way to treat resident with dignity and respect while administering her medications, however she failed to do so. Facility failed to remove the blue sling used for mechanical lift transfers out from under the resident while she sat in her wheelchair, Employee failed to realize that leaving a sling under resident is a dignity concern. E16 was verbally educated on 5/22/25 by the ADON regarding the proper way to provide privacy during a medication administration via peg tube. E16 voiced understanding at the time. D- DON /designee will perform daily audits of residents to ensure residents privacy during care including during medication administration via peg tube. DON /designee will perform daily audits of residents who require the use of a blue sling for	

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F 550	Continued From page 5	F 550	transfers via mechanical lift will be completed ot ensure that slings are not left under residents while up in wheelchair, as resident allows. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F550 Resident Rights and Privacy	
F 551 SS=D	Rights Exercised by Representative CFR(s): 483.10(b)(3)-(7)(i)-(iii) §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to	F 551		7/8/25

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F 551	Continued From page 6 exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law	F 551		

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REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

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F 551	Continued From page 7 or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined for one (R95) out of three residents reviewed for participation in care planning, the facility failed to ensure the correct resident representative was invited to participate in R95's care planning conferences. Findings include: Review of R95's clinical record revealed: 11/19/20 - A durable power of attorney (DPOA) financial only document appointing P6 was signed and notarized by R95. 7/1/21 - R95 was admitted to the facility for long-term care. 7/8/21 - The facility's form entitled Preferred Intensity of Medical Care and Treatment was signed by F3 (R95's family member). 7/1/24 8:29 AM - A care conference review documented the following: - R95 had "severe cognitive impairment". - R95's resident representative was P6 (R95's DPOA-financial only). P6 was invited, but did not attend. The documented stated, "No RSVP". - "Does Resident and or Resident/Representative agree with Plan of Care established? YES".	F 551	A-For R95 the deficient practice to ensure the correct resident representative was invited to participate in her care planning conference was updated to reflect the appropriate individual who will receive care conference notification. B-Residents residing at the facility who are not their own responsible party have the potential to be affected by this deficient practice. C-Nursing Home Administrator/Designee will educate admissions director/designee to ensure that the correct first point of contact/resident representative is correctly documented in the resident's profile. Also, will educate if an individual is added after admission that the resident profile is reviewed to ensure that the appropriate person is noted as resident representative. RCA: Facility failed to update residents' profile to reflect the appropriate resident representative for receiving medical care and treatment on behalf of the resident. A resident representative was added	

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F 551	Continued From page 8 - Under the social work section, it was documented that "... Nursing reported fall on 6/12/24 and [R95] was sent to the hospital. [F3, family member] was informed...". - "Code Status Reviewed? Yes, No changes required." 9/19/24 6:17 PM - A care conference review documented the following: - R95 had "severe cognitive impairment". - R95's resident representative was P6 (DPOA-financial only). P6 was invited, but did not attend. The documented stated, "No RSVP". - "Does Resident and or Resident/Representative agree with Plan of Care established? YES". - "Code Status Reviewed? Yes, No changes required." 12/16/24 10:56 AM - A care conference review documented the following: - R95 had "cognitive impairment". - R95's resident representative was P6 (DPOA-financial only). P6 was invited, but did not attend. The documented stated, "No RSVP". - "Does Resident and or Resident/Representative agree with Plan of Care established? YES". - "Code Status Reviewed? Yes, No changes required." 3/7/25 10:43 AM - A care conference review documented the following: - R95 had "cognitive impairment". - R95's resident representative was P6 (DPOA-financial only). P6 was invited, but did not attend. The documented stated, "No RSVP". - "Does Resident and or Resident/Representative agree with Plan of Care established? YES". - "Code Status Reviewed? Yes, No changes required."	F 551	after admission and the resident profile was not updated and reviewed for accuracy. D- DON /designee will perform daily audits of new admissions and readmissions as well as current residents who have had an update to their profile to ensure that the first point of contact is correct. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F551 Rights exercised by representative	

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F 551	Continued From page 9 5/22/25 at 4:41 PM - During an interview, E20 (BOM) confirmed that R95's profile had P6 (DPOA-financial) incorrectly listed as the facility's first point of contact/resident representative. As a result, R95's care conference invitation letters were incorrectly and repeatedly sent to P6 and not to F3 (R95's family member). The facility failed to ensure that the correct Resident Representative, F3, was able to excerise the resident's rights on behalf of R95 with respect to medical care and treatment. 5/23/25 2:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 551		
F 559 SS=D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R87) out of four (4)	F 559	A-For R87 facility failed to provide the family with a written explanation of why	7/8/25

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F 559	Continued From page 10 residents reviewed for personal property, the facility failed to provide the family with a written explanation of why R87 moved rooms at the facility's request on 1/23/25. Findings include: 2/23/22 - R87 was admitted to the facility on the C wing with diagnoses including, but was not limited to, dementia. 2/23/22 - 1/23/25, R87 resided on the C wing of the facility. 1/23/25 - R87's room was changed, and she was moved to the A wing of the facility. 5/15/25 2:56 PM - During an interview, F1 (R87's husband) stated, "They (the facility staff) told me on a Thursday around 11:30 AM that they were going to move my wife's room. It was [E20] (Admission office) who told me. When I asked why, my wife has been on C wing for 3 years, we went to the office (admissions) and... the DON (E2) came in and said it was because she (R87) was hollering. But she has been hollering for years. I had built relationships with the staff on C wing, and they knew my wife. By 2 PM, a lady with a clipboard came in (my wife's room) and they started moving her. I thought it would happen in a few days. I did not get any paperwork or sign anything...". 5/15/25 3:30 PM - A review of R87's progress notes revealed no documentation regarding the 1/23/25 room change. 5/16/25 10:30 AM - A review of the Notice of Room Change document provided by the facility regarding R87's move did not demonstrate the required explanation in writing of why the move	F 559	residents room was moved, was unable to be corrected due to being past the time of occurrence. B-Residents who require a room change have the potential to be affected by this deficient practice. C- Administrator/designee will educate Admissions director/designee on importance of notification and documentation of resident room move to the resident and the residents representative prior to resident room move being initiated. Facility developed an in-house room transfer notice for resident and resident representative to review and sign prior to room move. RCA: Facility failed to notify resident representative in writing as to why the facility was requesting a room move. Facility failed to document conversation with resident representative in the medical record. D- DON /designee will perform daily audits of room moves to ensure proper written notification has been completed. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the	

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F 559	Continued From page 11 was required. 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 559	audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F559 notify of room change	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R167) out of six (6) residents reviewed for abuse, the facility failed to ensure that R167 was protected from verbal abuse. Findings include: Review of R167's clinical records revealed: 11/12/24 - R167 was admitted to the facility with diagnoses including end stage renal failure, heart failure and morbid obesity.	F 600	A-For 167, resident has been discharged from the facility 4/30/25. B- Residents residing at the facility have the potential to be affected by this deficient practice. C- Staff Educator/designee will educate current staff and new orientees on Recognizing abuse/Neglect with immediate reporting including Verbal Abuse. Facility also participated in an in-service	7/8/25

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F 600	Continued From page 12 2/11/25 - R167's quarterly MDS documented a BIMS score of 15, indicating a cognitively intact status. The MDS also documented that R167 was independent with activities of daily living. 4/2/25 8:00 PM - The facility's investigation documented that R167 wanted to take a shower but there were used towels on the bathroom floor. He requested that the bathroom be cleaned. E6 (CNA) told R167, "If you don't think I am doing my job, then speak to the supervisor." Approximately one hour later, E6 overheard R167 telling his significant other on the phone about the dirty towels in the shower. E6 stated, "Why are you still talking about it? It was a mistake." E6 began to yell profanities at him. Both E6 and R167 then yelled profanities towards each other. This event was witnessed on the phone video by R167's significant other. 4/3/25 9:21 AM - A facility report to the Division documented, "Staff member [E6] CNA got into a verbal confrontation with resident [R167]. Staff member was suspended pending outcome of investigation." 5/19/25 11:13 AM - During an interview E6 stated, "He started cursing and snapping at me, so I cursed back at him." The Surveyor asked E6 whether she had received any training at the facility on abuse, dementia, and resident rights. E6 stated, "We had a lot of training. But it was not like he [R167] had dementia or anything." E6 was terminated from employment at the facility. The facility failed to protect R167 from verbal abuse from a staff member.	F 600	provided by the Delaware Department of Justice on Protecting Patients and Residents on 6/5/25. RCA: Facility failed to ensure that resident was protected from verbal abuse. Employee admitted to receiving training on abuse, dementia and resident rights however employee failed to recognize by her engaging in a verbal altercation with any resident regardless of mentation that it was considered verbal abuse. Employee was terminated as a result of this incident. D-- DON /designee will perform daily observations to ensure that verbal abuse has not occurred. Daily audit will be conducted to ensure that staff is able to verbalize understanding of verbal abuse and reporting immediately to supervisor. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F600 Free from abuse	

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F 600	Continued From page 13 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 600		
F 604 SS=G	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical . . . restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical . . . restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of	F 604	Past noncompliance: no plan of	

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F 604	Continued From page 14 other documentation as indicated, it was determined that for one (R70) out of six residents reviewed for abuse, the facility failed to assure that a physical restraint was used to treat R70's medical symptoms and was not being used for staff convenience. Findings include: R70, a resident with dementia, had two gowns on during the evening shift of 3/31/25. The first gown was on in the correct position. The second gown was oversized and the gown material was gathered and tied in a knot below R70's knees and behind her neck to prevent R70 from exposing herself. R70's oversized gown was not untied and R70 remained in the same position through the evening and night shifts without opportunities for repositioning, incontinence care or release of the knotted oversized gown for mobility. The inability to reposition or straighten one's legs would result in psychosocial harm to a reasonable person. Due to the facility's corrective measures completed on 4/10/25, the facility was notified that R70's incident was a harm past non-compliance. The facility policy titled, "Use of Restraints" (2001) documented, "Policy Statement ... Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the preventions of falls... Policy Interpretation and Implementation ... 1. 'Physical Restraints - ... any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom or restricts normal access to one's body ... " Cross refer F677	F 604	correction required.	

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F 604	Continued From page 15 Review of R70's clinical records revealed: 9/24/19 - R70 was admitted to the facility with diagnoses including dementia, bipolar, anxiety and insomnia. 9/25/19 (revised 6/1/22) - R70 had a care plan for potential for falls related to poor safety awareness with interventions including, but not limited to, allowing R70 to sit in doorway of room when up when possible to experience increased stimulus from other people in the hallway. 9/25/19 (revised 5/1/20) - R70's ADL care plan stated, "[R70] was unable to do own ADLs (Activities of Daily Living) without assist related to cognitive loss and interventions included " ... assist resident to pick out own clothes". 10/21/19 - R70 had a care plan for repetitive statements related to anxiety and memory loss. Interventions included: assessing for unmet needs. 10/21/19 - R70 had a care plan for making sexual comments and/or touches others inappropriately. Interventions included getting involved in activities of choice. 5/7/20 - R70 was care planned for removing clothes over and over in inappropriate places related to cognitive level. Interventions for R70 included approaching in a calm manner and not being judgmental. 8/9/22 - R70 had impaired verbal communication care plan developed related to cognitive loss. R70's interventions included anticipating R70's needs and approaching R70 in a gentle, calm,	F 604		

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F 604	Continued From page 16 friendly, relaxed manner with a smile on the face. 9/27/23 - R70 was care planned for alteration in thought process related to progressive dementia with interventions including allowing R70's choices when appropriate and assisting resident to activities of choice. 2/21/25 - R70's quarterly MDS (Minimum Data Sets) assessment indicated that R70's cognition was severely impaired with short and long term memory problems and had verbal behavioral symptoms occurring 1- 3 days during the review period. R70 was dependent with toileting hygiene and upper/lower body dressing. In addition, R70 was dependent with the following mobility performance: roll left and right, sit to lying to, lying to sitting on side of bed and sit to stand. R70 was always incontinent of urine and bowel. 3/31/25 - R70's CNA Kardex Report for Activities indicated that R70 required assistance in developing/providing a program of activities that was meaningful and of interest including to encourage and provide opportunities for exercises and physical activity. 4/1/25 7:30 AM - A nurse progress note by E13 (LPN) documented, " CNA [E14] reported this morning that the resident's gown was tied up very tightly on the patient. Upon assessment the gown was bunched up and tied up very tightly by the neck and left thigh. It took a considerable amount of force in order to untie the knots, to the point where the gown was torn some ... patient [R70] could not lay down straight when I observed how she was laying." 4/1/25 11:57 AM - A facility incident report	F 604		

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F 604	Continued From page 17 submitted to the State reporting agency documented that on 4/1/25 at 7:30 AM, "... Resident observed in bed with two gowns. One fitted appropriately, second gown oversized and tied incorrectly." 4/1/25 12:01 PM - A skin evaluation note by E13 documented, " ... [R70] had gown tied too tightly (sic) no injuries to skin, no red marks, no skin tears present ..." 4/1/25 - A written statement by E18 (7-3 shift RN, UM) documented, "Made aware by 7-3 charge nurse [E13] ... [R70] was observed in bed with two gowns on. The first gown was on in the correct position. The second gown was oversized and placed on over the first knotted at the right [left when clarified] thigh. [R70] was unable to straighten herself out and was observed in a semi fetal position... " 4/1/25 - A documented phone interview of E12 (11-7 LPN) by E18 revealed that she was made aware of [R70] having on two gowns and gowns being knotted in passing by the day shift nurse as she was leaving. [E12] stated that she did not notice during her shift. 4/1/25 - A documented statement by E14 (CNA) revealed that E14 came in to provide care to R70 who was observed in a semi fetal position with two gowns on, one knotted at the right thigh. E14 immediately notified the nurse [E13]. 4/1/25 - In a joint phone interview with E2 (DON) and E18, E10, the CNA assigned to provide care to R70 in the evening shift (3-11), confirmed "Yes" and that she put two gowns on R70. E10 stated that while R70 was out to bed, R70 kept lifting her gown up in the hallway. Because R70 kept	F 604		

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F 604	Continued From page 18 exposing herself, E10 obtained a second gown and put on R70 and tied the gown just below R70's knees to keep her from exposing herself. 4/1/25 - In a separate statement documentation, a clarification phone interview by E2 and E37 (Admin/Office) revealed that E10 was not aware that putting on two gowns and preventing resident from lifting up the gown by criss-crossing it at the bottom is considered a form of restraint. 4/1/25 - A documented phone interview by E18 with E11, the CNA assigned to provide care to R70 during the night shift (11-7 on 3/31/25 going into 4/1/25) revealed that E11 did not put two gowns on R70. E11 stated that she was unaware if R70 had on two gowns while providing care and from what she can recall the gown was not tied at all during her time of providing care for R70. 4/8/25 - The facility's 5 Day follow up summary documented, " ... [R70] with a past history of dementia, bipolar disorder, anxiety and insomnia ... with severe cognitive impairment ... note (sic) occasional impulsivity with poor safety awareness and mild agitation ... In an attempt to limit resident exposing herself and protect her dignity an oversized gown was placed on resident incorrectly. The gown was oversized and the gown material was gathered and tied in a knot below her knees and behind her neck. [R70] was able to move freely in her gown but was unable to pull up gown exposing herself. During movement in her sleep resident pulled her legs up and they got caught in (sic) gown." 4/10/25 - A psych physician assistant follow up note by P1 (PA) documented, " ... Chief Complaint/Nature of Presenting Problem: F/u	F 604		

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F 604	Continued From page 19 (follow up) dementia, recent med adjustment, recent worsening mood lability/compulsions ... Seen today at request of facility staff due to report of recent increased agitation and restlessness over the past week ... restless and engaging in repetitive movements globally and appears mildly irritable ..." 5/20/25 9:00 AM - In an interview, P1 stated that he saw R70 and had read the nurse's notes about the inappropriate way of tying the oversized gown on R70. P1 stated that it was not the right way to address R70s' increasing behavior of raising her gown exposing herself and that R70 has "intermittent clothing removal, repetitive behaviors". P1 stated, " ... [R70] has severe cognitive impairment and from the psychosocial point, there was no indication of harm." 5/20/25 1:25 PM - In an interview, E27 (PT) stated, " ... [R70] was pretty mobile ... can move and walk at least 40 feet and she has been on the restorative nursing program for ambulation and range of motion when discharged from Physical Therapy caseload in February 2025 . 5/20/25 1:37 PM - During an interview, E13 (7-3 LPN) stated that he was the primary nurse for R70 on 4/1/25. Responding to E14's (CNA) call, he went to R70's room. E11 further stated, " ... I saw [R70] almost on her left side in a fetal position. E14 pulled down the outer gown but the knot around the neck was tied very tight that E14 had to use a pair of scissors to cut it off. I also untied the knot in the bottom of her gown. The hem or bottom of the gown was below the knee and tied around the legs, with the knot on the left side of R70's leg. The knot was tied very tight that it took an amount of time and strength for me to	F 604		

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F 604	Continued From page 20 untie the knot." 5/20/25 1:50 PM - During interview, E14 stated, " ... I went to R70's room on 4/1/25 around 7:30 AM. I saw her gown tied up in a knot and she was in a fetal position. It did not looked right to me so I called [E13]. R70 had on 2 gowns. 1 smaller gown she had on underneath with snaps on the shoulders . The inner gown had ties tied very tightly on her back. She had another oversized gown over the smaller gown. The top part of the outer gown was loose enough to be gathered around the neck and formed a knot. The knot on the right side of the neck was very tight I had to use a pair of scissors to cut it. I checked her incontinence brief and she was soaked in urine and was very soiled." 5/20/25 3:30 PM - In a follow up interview, E13 demonstrated to Surveyor how R70 was found with the double gowns. The following were observed with the Surveyor as the model resident for demonstration purpose: The top part of the outer gown was gathered and tied in a knot on the right side of the model's neck. The lower hem or bottom of the model's outer gown was wrapped around the model's legs and tied in a knot on the left side of the leg. Both knots on the right side of the model's neck and on the left side of the leg were tied so tight that it was very difficult to untie them. 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). 5/22/25 5:15 PM - E1 submitted to the Surveyor documentation of the abatement/corrective action plan with correction completed 4/10/25 at 1:00 PM.	F 604		

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F 604	Continued From page 21 Corrective Actions: 4/1/25 - R70's gowns were removed and skin check was performed with no noted areas of concern. - Investigation was initiated and statements were obtained. - Staff directly involved were interviewed and suspended pending investigation. - Incident reported to Division of Healthcare Quality (DHCQ) - Through investigation and interviews it was found that in an attempt to limit [R70] from exposing herself and to protect her dignity, an oversized gown was placed on [R70] incorrectly. The oversized gown gathered and tied in a knot below her knees and behind her neck. [R70] was able to move freely in her gown but was unable to pull up her gown to expose herself. During movement in her sleep it appears [R70] pulled her legs up and they got caught in the gown causing her to be unable to straighten out her legs. This is how she [R70] was found during routine rounding on 4/1/25 7-3 shift. - No other residents were found with gowns tied. - Facility reviewed incident during high risk meeting with Medical Director present. Discussed with Medical Director the events reported and staff statements obtained at that time. - Facility reviewed incident with the Corporate Regional Nurse. 4/10/25 - Facility initiated nursing staff education to promote resident dignity, proper use of a gown and reporting anything found to be out of the ordinary. All nursing staff will be educated prior to next scheduled shift. - Facility initiated audits of residents who are dependent on staff for care to ensure dignity is	F 604		

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F 604	Continued From page 22 being observed an gowns are being used properly. - Audits will continue three times a week until 100% successful audits over three consecutive evaluations, then continue monitoring once a week until 100% successful over three consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for further evaluation or recommendation. - CNAs [E10] and [E11] were terminated for inconsiderate care of a resident. No immediate action required related to facility correction and no further occurrences after the incident on 4/1/25. This was verified by interviews with staff about promoting resident dignity and abuse with use of physical restraints, education, spot inspection for residents wearing gowns and inspection of the facility abuse incident reports. 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). 5/23/25 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 604		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or	F 609		7/8/25

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F 609	Continued From page 23 mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R6 and R22) of six residents reviewed for abuse, the facility failed to report an allegation of abuse within two hours. Findings include: 1. Review fo R22's clinical record revealed: 5/3/25 8:30 AM - A facility incident report documented, "... [R22] presents wit (sic) 2 bruises on the the inner side of the left arm above the elbow. Main bruise is 13.0 x 10.5 and smaller bruise above it is 2.5 x 3.0. [R22] did not know how it occurred. "... RCA (Root Cause Analysis) Summary:... bruises appear that they may have	F 609	A-For R6 and R22, the deficient practice of failing to report an allegation of abuse within 2 hours is unable to be corrected due to being past the time of occurrence. For R22, the deficient practice of failing to report an incident to the state incident reporting center is unable to be corrected due to being past the time of occurrence. B- Residents residing at the facility have the potential to be affected by this deficient practice. C-Staff educator/designee will educate current staff and new orientees on	

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F 609	Continued From page 24 been caused by a hand that may have been facilitating a transfer... [R22] also noted to have been transported to the dentist by family on 4/30/25...also noted to be on aspirin therapy...". 5/20/25 3:00 PM - Review of the state incident report database lacked evidence that the facility reported the incident to the state incident reporting center. 5/22/25 - A written statement by E2 (DON) documented, "I have observed family both daughter and son, have difficulty putting him in car. They seem to have most difficulty with getting him out of his wheelchair when putting him into car. When the son has him alone, he often will hold on to his upper arms and or wrap his arms around him to assist him into and out of the car...". 5/22/25 5:00 PM - Finding was discussed with E1 (NHA) and E2 (DON). 2. Review of R6's clinical record revealed: 3/27/23 - R6 was admitted to the facility with diagnoses including. but was not limited to bipolar disorder. 4/2/25 - R6 was hospitalized with a mental status change and was diagnosed with a urinary tract infection (UTI). 4/12/25 - R6 returned to the facility from the hospital. 5/20/25 10:10 AM - A review of R6's hospital records revealed documentation of R6's allegation to hospital staff regarding this alleged	F 609	Recognizing abuse/Neglect with immediate reporting including proper 2-hour reporting time frames. Incidents of unknow origin need to be reported within 24hours. RCA: In reference to R6, facility was aware that allegation was made, staff conducted an investigation immediately and determine that there was no validity to the allegations made. Facility failed to recognized that any allegation is a reportable incident that needs to be reported within 2 hours. In reference to R22, facility failed to recognize that any injury of unknown origin should have been reported to the state incident reporting center. D- DON /designee will conduct daily audits to ensure reports of abuse have been reported in a timely manner. Daily review of incident reports will be conducted in morning meeting to identify any injuries of unknown origin and reporting to state reporting center if appropriate. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the	

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F 609	Continued From page 25 incident and the hospital's subsequent report to the state agency. 5/20/25 11:35 AM - A review of the facility personnel lists revealed no staff by the name of [name] work at the facility. A review of the staff assignments on the day of the alleged incident revealed there were no Caucasian staff providing care on that wing on that date. 5/20/25 1:52 PM - During an interview, E1 (NHA) stated, "We did not know about the allegation when she was at the hospital. She has made multiple allegations (prior to the 4/2/25 hospitalization) and the story changed several times." 5/21/25 11:09 AM - During an interview, E36 (RNAC) stated, "I was the one that [R6] reported the alleged abuse to. I was doing a pain assessment for her quarterly MDS in late March. Her roommate [R126] was there shaking her head the entire time saying 'No, that did not happen.' I reported it to leadership within two hours. I thought it was reported to the state agency because there was a big investigation." 5/21/25 12:04 PM - During an interview, E2 (DON) stated, "We investigated it twice. We did not think it was anything and we knew [hospital] had reported it so I did not report it." 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 609	audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F609 Reporting of alleged violations	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j)	F 641		7/8/25

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F 641	Continued From page 26 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R14 and R110) out of four residents reviewed for assessments, the facility failed to document each residents' insulin usage. Findings include: 1. Review of R110"s cinical record revealed: 5/24/22 - R110 was admitted to the facility with	F 641	A-For R14 and R110 facility failed to ensure accuracy of the MDS assessment. R14 and R110 MDSs have been modified. B- Residents who utilize insulin have the potential to be affected by this deficient practice. C- Director of Clinical Reimbursement/designee will educate	

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F 641	Continued From page 27 diagnoses including, but were not limited to, diabetes and end stage kidney disease. 12/17/24 - E5 (MD) ordered in R110's EMR, "Insulin Lispro injection solution 100 unit/ml... subcutaneously before meals and at bedtime for diabetes." 2/20/25 - R110's quarterly Minimum Data Set (MDS) documented in Section N - Medications that R100 received 7 days of insulin injections in the look back period but failed to document that R100 was taking a "Hypoglycemic (including insulin)". The facility failed to accurately document R100's High Risk Drug classes in the 2/20/25 MDS. 5/22/25 12:47 PM - During an interview, E36 (RNAC) confirmed that hypoglycemics was not checked on R110's MDS dated 2/20/25. 2. Cross refer to F656 Review of R14's clinical record revealed: Review of R14's April 2025 eMAR revealed that the resident received insulin injections two times a day from 4/10/25 through 4/16/25 for diabetes. 4/16/25 - The quarterly MDS assessment documented that R14 received seven days of insulin injections under Section N - Medications. However, the facility failed to document that R14 was taking a hypoglycemic (including insulin) under the subsection N0415. High-Risk Drug Classes: Use and Indication. 5/22/25 12:47 PM - During an interview, E36	F 641	RNACs on ensuring accuracy of residents MDS assessments. RCA: For R14 and R110 the RNACs did not accurately code residents use of insulin. R14 and R110 MDSs have been modified. D- The Director of Clinical Reimbursement (DCR) will conduct an audit to evaluate the accuracy of medication coding for every new and readmission MDS weekly times 3 until 100% success is achieved over 3 consecutive evaluations. Additionally, The DCR will conduct an audit of residents receiving medications classified as high-risk weekly times 3 weeks to ensure coding accuracy until 100% success is achieved over 3 consecutive evaluations. Results of the audits will be forwarded to the Quality Assurance and Performance Improvement Committee. See attachment F641 accuracy of assessment	

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F 641	Continued From page 28 (RNAC) confirmed the finding. 5/23/25 2:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R92) out of three residents reviewed for PASRR, the facility failed to incorporate the recommendation from the 9/10/24 PASRR level II determination in R92's care plan. Findings include: The facility's policy and procedure for Care of Visually Impaired Resident, last revised March	F 644	A-For R92, Recommendations from the 9/10/24 PASRR have been incorporated in the resident's care plan and the PASRR from 9/10/24 has been scanned into the residents EMR. B- Residents residing at the facility have the potential to be affected by this deficient practice. C- Administrator/Designee will educate	7/8/25

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F 644	Continued From page 29 2021, stated, "... 4. When interacting with the visually impaired resident implement the following procedures: a. Use the resident's name when speaking to him/her so he/she will know you are speaking to him/her. b. Introduce anyone else who may be with you. c. Always speak directly to the resident. d. Assist with ADLs as needed or requested. e. Let the resident know when you leave the room. f. Use large lettering on any distributed written information. 5. To help the resident orient and avoid accidents in the environment implement the following practices: a. Use nightlights to help the resident with dark adaptation problems. b. When the resident dines, describe the location of the place setting and food on the plate according to the clock face (e.g., meat at 12 o'clock, potato at 6 o'clock, etc.). c. Leave doors in the open or closed positions only. A partially closed door may be difficult for the resident to see... e. Attempt to keep the environment consistent by leaving objects in their designated locations. f. Keep lighting bright and at consistent levels. Eliminate as much glare and reflection as possible.". Review of R92's clinical record revealed: 8/26/24 - R92's PASRR level I was completed and referred R92 for a level II evaluation. 9/10/24 - R92's PASRR level II determined that R92 has a PASRR condition with the outcome documented that R92 was approved for nursing	F 644	social services to ensure all recommendations from the PASRR team are reviewed and care planned as needed and ensure the PASRR document is uploaded into the EMR system once reviewed. RCA: Facility failed to ensure the recommendations made by the PASRR team were reviewed and care planned accordingly, this was inadvertently missed by the social worker who reviewed the completed PASRR. D- Social Service /designee will conduct daily audits of PASRR's received to ensure all recommendations have been reviewed and care planned as needed. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F644 coordination of PASRR and assessments	

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F 644	Continued From page 30 facility services. Specifically, the level II documented, "If you are admitted to a Medicaid certified nursing facility, What services and supports are nursing facility staff required to provide for you?... Rehabilitative services: You will need to be provided the following services and/or supports:... Services or Accommodations for the Visually Impaired...". Review of R92's comprehensive care plan revealed a impaired vision care plan, last revised on 11/24/21, as follows, "[R92] has impaired vision related to diabetes/dense cataract's. She had a vision consult 11/22/21. She declines cataract surgery. Approaches: - arrange consultation with eye care practitioner as required (11/23/21); - she may be able to see better in a well lit room etc. (revised 11/23/21); - she may prefer to have her personal item's arranged the way she likes, in order to promote independence (11/23/21). R92's comprehensive care plan lack evidence of incorporation of her PASRR level II recommendation to provide accommodations for her visual impairment that include, but are not limited to, activities of daily living, activities, nursing care and treatments, care plan conferences and reviewing/signing any medical or financial facility documents, if necessary, as she is her own resident representative. 5/20/25 11:50 AM - During an interview, E22 (SW) provided the surveyor with R92's last annual eye consultation dated 9/13/24 and stated that the resident did not want cataract surgery. At the request of the surveyor, E22 obtained a copy of R14's 9/10/24 PASRR level II from the PASRR	F 644		

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F 644	Continued From page 31 website as this document was not readily accessible in R14's EMR. 5/22/25 1:00 PM - During an interview, the surveyor reviewed the 9/10/24 PASRR level II recommendation with E39 (LPN/UM) for accommodations for R14's vision impairment. 5/23/25 2:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 644		
F 656 SS=D	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	F 656		7/8/25

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F 656	Continued From page 32 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (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 two (R22 and R14) out of 35 sampled residents, the facility failed to develop a person centered care plan to address an identified need for R22. For R14, the facility failed to initiate a care plan for R14's diagnosis and treatment of diabetes. Findings include: 1. Review of R22's clinical record revealed: 12/13/22 - R22 was admitted to the facility with diagnoses including peripheral vascular disease with a need for assistance with personal care and a non - pressure ulcer of the left ankle. 12/13/22 - A care plan was developed for R22's risk for skin breakdown related to decreased	F 656	A-For R22 and R14, Care plans have been updated to address identified needs. B- - Residents who have a need for a person-centered care plan have the potential to be affected by this deficient practice. C- DON/designee will educate current administrative nursing staff on the importance of updating the residents care plan with noncompliance related to stated interventions documented in the care plans. DON/designee will educate licensed staff and new orientees on updating residents care plan in reference diabetes and insulin use. RCA: Facility failed to do a	

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F 656	Continued From page 33 mobility and fragile skin.R8's interventions included: encourage [R22] to wear long pants to prevent injury. 5/21/25 - R22's CNA Kardex (a CNA plan of care for individual resident) documented. "... for safety in resident's dressing, encourage [R22] to wear long pants to prevent injury...". 5/21/25 12:00 PM - R22 was observed in the hallway sitting on his wheelchair wearing short pants. E17 (CNA) approached R22 and began to maneuver R22's wheelchair and started wheeling R22 into the dining room. 5/21/25 12:00 PM - When asked if R22 was to wear short pants while having lunch in the dining room, E17 responded, "Yes, he can wear short pants." 5/22/25 8:50 AM - R22 was observed in his room sitting on his wheelchair and wearing the same short pants he wore the day before. Long pants were folded on his bed and a pair of pants lying on the floor. 5/22/25 9:00 AM - When asked whether he wanted to wear short pants or long pants, R22 responded, "I don't know. This is all I can wear (pointing down on his short pants)." 5/22/25 9:30 AM - In an interview, E29 (LPN) stated, "[R22] has a non compliance behavior with the care we provide. Sometimes he wants to dress for the weather with just short pants on like what is wearing know. We know we need to encourage him to wear long pants as he has no safety awareness and he could easily hit himself and bump against anything and could get a skin	F 656	person-centered comprehensive care plan for Diabetes and use of insulin. Resident did have a care plan for diabetes listed under the nutritional focus. Facility failed to update the comprehensive care plan to include residents' noncompliance in wearing long pants to protect his skin. D- DON /designee will perform daily audits of any noted noncompliance with care planned interventions to ensure care plan has been update to include noncompliance. Daily audits during clinical meeting to review new admissions and readmissions for a diagnosis of Diabetes and insulin use to ensure that personalized care plans have been developed. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F656 develop and implement care plan	

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F 656	Continued From page 34 tear...". Follow up review of R22's comprehensive care plan lacked evidence of an individualized care plan with approaches for R22's non compliance with wearing long pants. 5/22/25 5:00 PM - Finding was discussed with E1 (NHA) and E2 (DON). 2. Cross refer to F641, example 2 Review of R14's clinical record revealed: 8/19/24 - R14 was admitted to the facility with a diagnosis of diabetes. Review of R14's comprehensive care plan lacked evidence of an individualized care plan with approaches for R14's diabetes diagnosis and use of insulin. 5/22/25 12:55 PM - During an interview, E39 (LPN/UM) confirmed the finding. 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 656		
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:	F 658		7/8/25

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F 658	Continued From page 35 Based on record review and interview, it was determined that for one (R65) out of thirty-five sampled residents, the facility failed to have a comprehensive care plan in complaince with the standard of practice regarding R65's dental cleanings and risk for infective endocarditis. Findings include: "Subacute Bacterial Endocarditis Prophylaxis -Infective endocarditis is an infection of the heart's endocardial surfaces involving one or more heart valves... Several risk factors can predispose patients to infective endocarditis, including structural heart disease, prosthetic heart valves, indwelling cardiovascular device...". National Library of Medicine, STATPEARLS 2025, Updated February 10, 2024 [Hospital] "LVAD Heartmate Discharge Binder-... Important Information Regarding Dental Procedures- Please let your dentist know that you have an artificial heart pump and will need prophylactic antibiotics for any procedure that invades the gums. This includes basic dental cleaning. There is the potential that bacteria could invade the blood stream and possibly contaminate the LVAD...". 7/12/18 - R65 was admitted to the facility with diagnoses including but not limited to, stroke affecting left side and presence of a heart assist device. 12/9/24 - P4 (dentist) documented a Dental Consult note in R65's EMR, "# 9 (tooth) facial and #11 (tooth) facial have fixable decay... Recommendations: I will return to clean teeth and place resin fillings where decay of on teeth #'s 9 & 11."	F 658	A-For R65, Care plan was updated to include risk for infective endocarditis related to dental cleanings. Order was obtained for antibiotics prior to dental procedures. B- Residents who are at risk for infective endocarditis have the potential to be affected by this deficient practice. C- DON/designee will educate current administrative nursing staff on the importance of updating residents care plan who have a risk for infective endocarditis and use of prophylaxis antibiotic use prior to dental procedures. RCA: Facility failed to update the comprehensive care plan to include residents risk for infective endocarditis and use of prophylaxis prior to dental procedures. Facility failed to identify that recognize that residents at risk for endocarditis would benefit from the use of prophylaxis antibiotic prior to dental procedures. D- DON /designee will perform weekly audits on new residents and readmitted residents to ensure that anyone who is at risk of developing endocarditis will have an appropriate care plan and an order for prophylaxis antibiotic prior to dental procedures. Weekly audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance	

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F 658	Continued From page 36 5/21/25 - A review of R65's orders lacked evidence of a prophylactic antibiotic order for the dental appointment in December 2024. A review of R65's care plan revealed that R65 was not care planned to receive SBE (subacute bacterial endocarditis) prophylaxis prior to dental procedures. The facility failed to meet the standard of practice for SBE antibiotic prophylaxis for dental procedures. 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 658	is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. see attachment F658 Professional standards LVAD dental	
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, interview and record review, it was determined that for one (R70) out of 35 sampled residents, the facility failed to provide incontinence care to a resident who was unable to carry out out activities of daily living. Findings include: Cross refer F604 Review of R70's records revealed: 9/24/19 - R70 was admitted to the facility.	F 677	A-For R70, the deficient practice could not be corrected due to being past the time of occurrence. B- Residents residing at the facility who are dependent for incontinence care have the potential to be affected by this deficient practice. C- DON/Designee will educate current C.N.A staff and new orientees on importance of completing C.N.A flowsheets after incontinence care is provided. RCA: Facility failed to ensure C.N.A flow	7/8/25

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F 677	Continued From page 37 9/25/19 (revised 5/1/20) - R70's ADL care plan stated, "[R70] was unable to do own ADLs (Activities of Daily Living) without assist related to cognitive loss and interventions included "... toileting schedule as resident allows...". 9/25/19 (revised 10/18/23) - R70 was care planned for incontinence of bowel and bladder related to cognition and interventions included "... encourage highest level of independence of toileting as possible and toilet at regular intervals if able". 2/21/25 - R70's quarterly MDS assessment indicated that R70's cognition was severely impaired with short and long term memory problems. R70 was dependent with toileting hygiene and was always incontinent of urine and bowel. 5/20/25 1:50 PM - During interview, E14 stated, "... I went to [R70's] room on 4/1/25 past 7:30 AM. I saw her gown tied up in a knot and she was in a fetal position... I checked her incontinence brief and she was soaked in urine and was very soiled." 5/20/25 2:00 PM - Review of R70's 3/31/25 going into 4/1/25 11-7 shift CNA flowsheet lacked evidence that R70's Bladder Continence and Toilet Use was completed. 5/21/25 9:22 AM - During a telephone interview, E11 (CNA) confirmed that she was the CNA assigned to provide care to R70 on 3/31/25 going into 4/1/25 11-7 shift. E11 further confirmed that she did not provide incontinence care to R70. E11 stated, "I checked the back of her incontinence brief and I felt that she was dry so I did not	F 677	sheets were complete. E11 did not properly check resident for incontinence during her 11-7 shift. It was noted that she did not perform incontinence care properly as she only checked the back of her brief with her hand. D- Don/designee will perform daily audits of those residents who are dependent on incontinence care to ensure appropriate care has been provided. Daily audits will be conducted to ensure C.N.A flow sheets have been completed. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F677 ADL care provided for dependent residents	

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F 677	Continued From page 38 change her". 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). 5/23/25 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	F 677		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R22) out of one sampled resident reviewed for hearing/vision, it was determined that the facility failed to ensure that R22 received proper treatment and assistive device to maintain hearing abilities. Findings include: Review of R22's clinical record revealed: 12/13/22 - Resident was admitted to the facility.	F 685	A-For R22, physicians order was obtained for nursed to put hearing aid in left ear and care plan was updated 5/22/25. B- Residents residing at the facility who have a hearing deficit have the potential to be affected by this deficient practice. C- DON/designee will educate current licensed staff and new orientees on ensuring residents who have a hearing deficit receive proper treatment	7/8/25

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F 685	Continued From page 39 12/19/22 - R22's admission MDS indicated that R22's cognition was intact, had adequate hearing and did not use a hearing aid. 1/18/23 - R22 had a care plan developed for impaired verbal communication related to hard of hearing with interventions including to assess [R22's] hearing and vision, and if deficits are noted, refer resident for further evaluation and treatment. 3/13/23 - R22's quarterly MDS indicated that R22 had minimal difficulty with hearing and did not use a hearing aid. 1/18/23 - R22 had a care plan developed for impaired verbal communication related to hard of hearing with interventions including to asses [R22's] hearing and vision, and if deficits are noted, refer resident for further evaluation and treatment. 11/16/23 12:37 PM - A social worker progress note documented, "... [R22] goes to the VA (Veterans Affairs) for any vision/dental/hearing issues...". 5/3/24 - R22's quarterly MDS indicated that R22 had moderate difficulty with hearing and did not use a hearing aid. 7/29/24 - R22's quarterly MDS indicated that R22 had moderate difficulty with hearing and did not use a hearing aid. 10/3/24 - R22's annual MDS indicated that R22 had moderate difficulty with hearing and did not use a hearing aid.	F 685	and assistive devices to maintain hearing abilities. RCA: R22 sees an outside provider for his hearing needs and is transported by family. Documentation has not always been received after appointments and facility failed to follow up with the provider to obtain documentation. D- Don/designee will perform audits of current and new residents who have a hearing deficit to ensure proper treatment and resident is provided assistive devices as needed. Audits will be completed until we consistently reach 100% success over 3 consecutive weeks. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. see attachment F685 Treatment to maintain hearing	

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F 685	Continued From page 40 1/17/25 - R22's quarterly MDS indicated that R22 had moderate difficulty with hearing and did not use a hearing aid. 1/15/25 12:09 PM - A social worker progress note documented, "... [R22] is HOH (hard of hearing), no aids...". 3/31/25 - R22's quarterly MDS indicated that R22 had moderate difficulty with hearing and did not use a hearing aid. 5/14/25 9:00 AM - During an interview, R22 was observed repeatedly asking this Surveyor to raise her voice. R22 stated, "I can not hear you! I have a hearing aid on my drawer but I don't have it on with me". A hearing aid sitting on the charger box was noted on the resident's bedside table. 5/15/25 10:00 AM - Review of R22's physician's order did not indicate R22's use of a hearing aid. 5/15/25 11:15 AM - R22 was observed self propelling his wheelchair in the unit's hallway. R22 did not have a hearing aid applied on either ears. 5/22/25 8:45 AM - R22 was observed sitting on his wheelchair watching TV with no hearing aid on. R22 requested Surveyor to get the hearing aid lodged on the charger box on R22's bedside table. 5/22/25 9:10 AM - A follow up review of R22's hard of hearing care plan did not include R22's use of a hearing aid. 5/22/25 9:40 AM - In an interview, E29 (LPN) stated that she is not aware of R22's use of	F 685		

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F 685	Continued From page 41 hearing aid. E29 confirmed that R22 has a hearing loss but did not have an order for the use of hearing aid. E29 further confirmed that the use of a hearing aid was not included in R22's hard of hearing care plan interventions. 5/22/25 10:55 AM - During a telephone interview, P2 (NP) confirmed that R22 has a hearing loss and hard of hearing. P2 further confirmed that R22 uses a hearing aid. When asked why there was no physician order indicated for the use of R22's hearing aid, P2 stated that she will talk to E3 (ADON) and will have the order clarified. 5/22/25 11:45 AM - Findings were confirmed by E3 who also said she updated R22's care plan and obtained physician's order for nurses to put hearing aid on R22's left ear after surveyor's intervention. 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). 5/23/25 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.	F 685		
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	F 689		7/8/25

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F 689	Continued From page 42 by: Based on observation, interview, and record review, it was determined that for one resident (R108) out of four (4) residents reviewed for accidents, the facility failed to ensure that R108 received adequate supervision and assistance to prevent accidents to the extent possible. R108 was left sitting on the side of the bed during care and fell to the floor. R108 sustained a large hematoma on her forehead and was sent emergently to hospital. Findings include: Review of R108's clinical records revealed: 3/22/24 - R108 was admitted to the facility with diagnoses including dementia, major mood disorder and age-related osteoporosis. 3/24/24 - R108's fall care plans included, "Potential for (actual) falls r/t (related to) poor safety awareness Resident will not sustain or be injured from falls X 90 days." The interventions included, "Bed in lowest position when care is not being provided." 2/24/25 - E108's annual MDS documented a BIMS score of "00", indicating a completely impaired cognitive status, and was completely dependent on staff for dressing and undressing of both lower and upper extremities. R108 required substantial/maximum to move from lying to sitting. The MDS defined substantial/maximal assistance as, "Helper does more than half of the effort. Helper lifts or holds trunk or limbs and provides more than half the effort." 3/27/25 12:56 PM - A facility incident report	F 689	A-Resident R108 no longer resides at the facility. B-Residents residing at the facility who require assistance with lying to sitting at the side of the bed without back support have the potential to be affected by this deficient practice. C-DON/designee will educate current nursing staff and new orientees on those residents who require assistance with lying to sitting at the side of the bed without back support and provide alternative options to prevent accident or injuries. RCA: E7 failed to ensure R108 received adequate supervision and assistance to prevent an accident. R108 required assistance with bed mobility and was left alone sitting on the side of the bed for a short time while the E7 retrieved a clothing item from her closet. Facility will identify those residents who require assistance with lying to sitting at the side of the bed without back support and update resident tasks as appropriate. D-- Don/designee will perform daily audits of those residents who require assistance with sitting at the side of the bed without back support. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until	

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F 689	Continued From page 43 submitted to the Division documented, "Resident [R108] had an unwitnessed fall at approximately 11:05 AM. Resident was observed lying on her left side next to the bed and bedside table. Resident AOx1 [alert and oriented times 1] to self which is her baseline. Hematoma noted to left side of forehead, facial grimacing noted as well...order obtained to send resident to the ER for further evaluation." 3/27/25 4:47 PM - R108's clinical records documented, "Patient was sent to the emergency room. She was evaluated and returned to Regal Heights .... Patient with an intact hematoma left side of her head. Her neurological status is at baseline." 3/28/25 10:39 AM - R108's clinical records documented, "Left side of forehead remains swollen and bruised." 3/29/25 2:09 AM - R108's clinical records documented, "Resident continues to be monitored s/p [status post] unwitnessed fall with hematoma sustained to left side of face. Swelling remains to the area with some tenderness when touched..." 3/29/25 5:50 PM - R108's clinical records documented, "Continues to be monitored s/p unwitnessed fall with hematoma sustained on left side of face. Hematoma noted with swelling and tender to touch." 5/19/25 1:30 PM - During an interview, E7 (CNA) stated, "I was helping [R108] to get dressed and I realized that I did not have a top for her. She was sitting on the side of the bed, and I went to the closet to get a top and I heard a noise. I ran over	F 689	100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F689 Free of accident hazards	

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F 689	Continued From page 44 and saw that the resident had fallen to the floor." The Surveyor asked E7 how much help R108 needed to sit up in bed. E7 stated, "She needed a lot of help because she was weak." The Surveyor also asked E7 if the resident was in her line of vision when she went to the closet. E7 stated, "No, the curtain was pulled so I could not see her. I know now that I should not leave a resident sitting on the side of the bed." 5/19/25 2:00 PM - During an interview, E8 (CNA) stated, "I only worked with the resident (R108) a couple of times. She needed total assistance because of her poor balance." 5/19/25 2:30 PM - During an interview, E9 (CNA) stated, "She (R108) sometimes sits up but she is kind of weak at other times. She must be positioned correctly in wheelchair because she leans a lot." The facility failed to ensure that R108 received adequate supervision and assistance to the extent possible to prevent accidents. 5/23/25 2:30 PM - Findings were reviewed at the Exit conference with E1 (NHA), E2 (DON) and E4 (Regional nurse) in attendance.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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-	F 693		7/8/25

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F 693	Continued From page 45 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy and procedures it was determined that the facility failed to provide the appropriate care and services to one (R163) out of one sampled resident who had a PEG/feeding tube through the abdomen into the stomach for medication administration. Findings include: Cross refer F759 Review of R163's clinical record revealed: 3/28/25 - R163 was admitted to the facility. 3/31/25 - R163 had a care plan developed for potential for alteration in nutrition/hydration related to NPO (eating nothing by mouth) status and traumatic brain injury requiring tube feeding for nutrition/hydration. R163's interventions included tube feeding and flushes as ordered. 3/28/25 - R163 had a physician's feeding tube	F 693	A- For R163, the deficient practice could not be corrected due to being past the time of occurrence. B-Residents residing at the facility who have a feeding tube have the potential to be affected by this deficient practice. C-DON/designee will educate current licensed staff and new orientees on proper medication administration via feeding tube. RCA: Employee noted to not flushing with 5ml of water in between medications as she thought flushing the tube with 30ml prior or medication administration and post administration was sufficient. On 5/22/25, Employee was educated on proper medication administration via feeding tube, a competency was performed on administration medication through a	

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F 693	Continued From page 46 order to flush tube with 5 ml (milliliters) of water between each medication. 3/28/25 - R163 had a physician's feeding tube order to flush with 30 ml of water before and after each medication. 4/3/25 - R163's MDS (Minimum Data Set) assessment indicated that R163 had an intact cognition and is dependent with the use of the feeding tube for nutrition and hydration. 5/16/25 8:45 AM - 9:08 AM - During a medication pass observation, E16 (LPN) crushed eight medications and mixed together with approximately 30 ml of water. In a separate medication cup, E16 mixed a liquid medication with approximately 15 ml water. After checking the peg/feeding tube for placement, E16 flushed R163's feeding tube with 30 ml water, and began administering all the prepared medications followed by another 30 ml water to flush. 5/16/25 9:15 AM - During interview, E16 confirmed that she administered R163's medications all at the same time and not one medicine at a time. When asked why the 5 ml of water was not flushed in between medication per physician's order, E16 replied, "I did not flush 5 ml of water between each medication. I already flushed it with 30 ml of water before and after the medication pass." The facility failed to flush R163's feeding tube with 5 ml (milliliters) of water between each medication. 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON).	F 693	feeding tube and nurse demonstrated ability to follow proper procedure. D- Don/designee will perform daily audits of those residents who have a feeding tube to ensure proper medication administration is being performed. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F693 Tube feeding Mgmt	

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F 693	Continued From page 47 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 693		
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 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 record review and interview, it was determined that for two (R1 and R81) out of three residents reviewed for respiratory, the facility failed to have the CPAP(a repiratory device the deliers continuous positive airway pressure) settings written in the orders. Findings include: 1. Review of R21's clinical record revealed: 12/13/24 - R21 was admitted to the facility with diagnoses including but not limited to, obstructive sleep apnea. 12/13/24 - P2 (NP) ordered in R21's EMR, "CPAP on at HS (hour of sleep), off in AM in the morning and at bedtime apply." The facility failed to order the CPAP machine settings required for R21's care. 2. Review of R81's clinical record revealed:	F 695	A-For R1 and R81, the CPAP orders were updated to include the settings in the orders B-Residents residing at the facility who are ordered a CPAP have the potential to be affected by this deficient practice. C- DON/designee will educate current licensed staff and new orientees on ensuring residents who are ordered a CPAP have the settings for the device in the physician orders. RCA: Facility failed to ensure that residents who had a physician order for a CPAP had the settings included in the physician orders. Facility staff was unaware that the settings should be included in the physician orders. D- DON /designee will perform weekly audits on new residents and readmitted	7/8/25

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F 695	Continued From page 48 7/8/24 - R81 was admitted to the facility with diagnoses including but not limited to, obstructive sleep apnea. 8/3/24 - E5 (DO) ordered in R81's EMR, "CPAP on at HS, off in AM, settings at bedtime apply and in the morning remove." The facility failed to order the CPAP machine settings required for R81's care. 5/22/25 11:07 AM - During a telephone interview, P5 (respiratory therapist) stated, "Those two residents brought their home CPAP machines (to the facility). Likely their settings came from a sleep center. So all you have to do to find out the settings is plug the machine in and turn it on. The doctor is the person who enters the settings on the CPAP orders." 5/22/25 2:35 PM - During an interview, E2 (DON) confirmed that the CPAP orders for R21 and R81 did not contain the necessary settings for the machine. 5/23/25 2:30 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 695	residents to ensure that anyone who is ordered a CPAP have the settings for the device in the physician orders. Weekly audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F695 Respiratory CPAP	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced	F 759		7/8/25

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F 759	Continued From page 49 by: Based on observation, record review, and interview it was determined that the facility failed to ensure that it was free of medication error rate of 5 percent or greater. During medication pass observation on 5/16/25, 9 medication errors out of fourty four opportunities were identified, resulting in a medication error of 20.45% and affecting 1 resident (R163). Findings include: Cross refer F693 Observation of R163s' medication pass via the peg/feeding tube (a tube that is passed into a patient's stomach through the abdominal wall) revealed the following: 5/16/25 8:45 AM - E16 (LPN) opened the drawer of the medication cart and pulled out R163's morning medications. E16 proceeded to open the following medications and put into the medication cup: - Aspirin 81 mg capsule 1 cap - Multivitamin tablet 1 tab - Vitamin B12 1,000 mcg 1 tab - Vitamin D3 25 mcg 2 tablets - Gabapentin 300 mg 1 capsule - Magnesium Oxide 400 mg 1 tablet - Dantrolene Sodium 25 mg 1 capsule - Midodrine HCL 5 mg 1 tablet 5/16/25 8:48 AM - E16 poured the oral medications into the pill crusher pouch and then used the pill crusher to crush the capsules and tablets all together and in one batch. The 10 ml of Valproic Acid 250 mg/ml was poured in a separate medication cup. 5/16/25 9:06 AM - E16 entered R163's room, put	F 759	A-For R163, the deficient practice of administering medications via peg tube incorrectly resulting in multiple medication errors was unable to be corrected due to being past the time of occurrence. B- Residents residing in the facility who have a peg tube have the potential to be affected by this deficient practice. C- DON/designee will educate current licensed staff and new orientees on proper medication administration via feeding tube. RCA: Employee failed to properly administer medications via peg tube, employee noted to not flushing with 5ml of water in between medications as she thought flushing the tube with 30ml prior or medication administration and post administration was sufficient. On 5/22/25, Employee was educated on proper medication administration via feeding tube, a competency was performed on administration medication through a feeding tube and nurse demonstrated ability to follow proper procedure. D- Don/designee will perform daily audits of those residents who have a feeding tube to ensure proper medication administration is being performed. Daily audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three	

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F 759	Continued From page 50 on gloves and proceeded to check the peg/feeding tube for placement. E16 flushed the tubing with approximately 30 ml of water. Next, E16 dissolved the crushed medications in 30 ml water and E16 also mixed the 10 ml Valproic Acid separately in approximately 15 ml water. 5/16/25 9:08 AM - E16 was observed pouring all of R163's prepared medications into R163's peg/feeding tube which was flushed down with approximately 30 ml water. 5/16/25 9:15 AM - During interview, E16 confirmed that she administered R163's medications all at the same time and not one medicine at a time. 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 759	times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F759 Free of medication error	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F 880		7/8/25

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F 880	Continued From page 51 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

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F 880	Continued From page 52 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documentation, it was determined that the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The facility failed to have proper PPE (Personal Protective Equipment) worn for two employees after direct resident contact during bedside patient care observations. In addition, the facility failed to perform hand hygiene and change gloves for one employee during a wound dressing change observation. Findings include: The facility policy titled, "Enhanced Barrier Precautions" (2001) documented, " ... 1. Enhanced barrier precautions (EBPs) are used as infection prevention and control interventions to reduce the spread of multi-drug resistant organisms (MDROs) to residents ... 2. ... 3. Gloves and gowns are applied prior to performing the high contact resident care activities ... 4. Personal protective equipment (PPE) is changed	F 880	A-For R163 and R 149, the deficient practice could not be corrected due to being past the time of occurrence. B- Residents residing at the facility have the potential to be affected by this deficient practice. C- DON/Designee will educate current nursing staff and new orientees on proper use of PPE with resident on enhanced barrier precautions and proper application of PPE. DON/designee will educate licensed staff and new orientees on proper procedure for changing gloves during a wound dressing change. DON/designee will conduct competencies with licensed nursing staff on proper procedure for changing gloves during a wound dressing change. RCA: Employee E16 failed to wear a gown with a resident on Enhance Barrier	

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F 880	Continued From page 53 and hand hygiene performed before caring for another resident. Review of the CDC (Centers for Disease Control and Prevention) Enhanced Barrier Precautions poster posted on the doors of R163 and R149 indicated that everyone must clean their hands before entering and when leaving the room ... Providers and staff must also wear gloves and gown for the following High - Contact Resident Care Activities: - Dressing - Bathing/Showering - Transferring - Changing Linens - Providing Hygiene - Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy - wound Care: any skin opening requiring a dressing Cross refer F684 1. 4/9/25 - R163 had a physician's order for enhanced barrier precautions every shift. 5/16/25 8:45 AM - During a medication pass observation, E16 (LPN), proceeded to administer and pour a small cup of liquid medications into R163's peg/feeding tube (a tube that is passed into a patient's stomach through the abdominal wall). E16 did not wear a gown. The facility failed to apply complete enhanced barrier precaution when E16 did not wear a gown while administering medications on R163's feeding tube. 5/16/25 9:10 AM - Observations were reviewed	F 880	precautions while administering medication via a peg tube. Employee noted that she should have worn the gown during medication administration. Employee E17 failed to properly use the PPE when assisting another employee with resident care. Employee failed to secure the ties of the gown around her neck and on her back. Employee noted to be in a hurry to put on the PPE and didnt secure it properly causing the gown to keep falling while performing care. Employee E16 failed to change gloves during a wound dressing change, employee noted that she did not change her gloves after she removed the soiled dressings and before she started applying the clean dressing. Employee E16 was educated and a competency on dressing changes was performed on 6/9/25. Employee was able to demonstrate appropriate procedure. D- DON/designee will perform daily audits of those residents who are on enhanced barrier precautions to ensure proper application of PPE. DON/designee will perform daily audits on wound dressing changes to ensure proper glove changes during wound dressing change. Daily audits will	

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F 880	Continued From page 54 with E16, who also confirmed and stated, " ... I should have worn the gown ... " 5/22/25 5:00 PM - Finding was discussed with E1 (NHA) and E2 (DON). 2. 4/11/25 - R149 had a physician's order for enhanced barrier precautions every shift. Right Upper Buttock 2.a. 5/16/25 2:00 PM - During a wound dressing change observation, E19 (LPN) donned her gloves and proceeded to remove and discard R149's soiled wound dressing on her right upper buttock. Without removing the contaminated gloves, E19 started cleaning R149's open area with a wound cleanser. E19 continued to use the same contaminated gloves and proceeded to apply the medication, medical grade honey to the base of the wound and secured it with a clean bordered gauze. Right Lower Buttock 2.b. 5/16/25 2:15 PM - During a wound dressing change observation, E19 (LPN) donned her gloves and proceeded to remove and discard R149's soiled wound dressing on her right lower buttock. Without removing the contaminated gloves, E19 started cleaning R149's open area with a wound cleanser. E19 continued to use the same contaminated gloves and proceeded to apply the medication, medical grade honey to the base of the wound and secured it with a clean bordered gauze. Right Calf 2.c. 5/16/25 2:20 PM - During a wound dressing change observation, E19 (LPN) donned her	F 880	be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue three times a week until 100% success over 3 consecutive evaluations, and then continue monitoring once a week until 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F880 Infection prevention and control	

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F 880	Continued From page 55	F 880		

gloves and proceeded to remove and discard R149's soiled wound dressing on her calf. Without removing the contaminated gloves, E19 started cleaning R149's open area with a wound cleanser. E19 continued to use the same contaminated gloves and proceeded to apply the medication, medical grade honey to the base of the wound and secured it with an abdominal pad a rolled gauze.

5/16/25 2:30 PM - Observations were reviewed with E16, who also confirmed and stated, " ... Yes I did not change gloves after I removed the soiled dressings and before I started applying the clean dressings.

2.d. 5/16/25 2:35 PM - During an incontinence care observation, E17 (CNA) was observed donning on a gown and the ties were not securely tied around her neck and on her back. E17 assisted E19 (LPN) in removing R149's soiled incontinence brief and as E17 turned R149 towards E17's side, the top of E17's gown dropped and fell on R149's trunk. E17 picked up the top of the gown and put it back on her again, still not securing the ties for the gown to stay in place.

5/16/25 2:45 PM - Observations were reviewed with E17, who also confirmed and stated that she did not securely tie the back of her gown and did not properly use the PPE. E17 further stated, "I did not know I have to wear a gown when doing care for R149. When the nurse [E19] told me, I went in and I was in a hurry to put on my PPE/gown and I was not able to securely tie them around my neck and on my back. The gown kept falling while I was doing care for R149

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F 880	Continued From page 56 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		7/8/25

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F 883	Continued From page 57 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for five (R119, R143, R158, R160 and R267) out of ten residents reviewed for vaccines, the facility failed to ensure that these residents' vaccination status was accurately documented. For four (R119, R143, R158, R267) out of ten residents reviewed for vaccines, the facility failed to offer the four residents the pneumococcal vaccine. For six (R119, R143, R158, R160, R267) out of ten residents reviewed for vaccines, the facility failed to assess and document the residents' influenza vaccine. For R267, the facility failed to check Delvax, where there was documentation of a flu vaccine on 9/18/2024. Findings include:	F 883	A-For R119, R143, R158, R160, and R267, vaccination status has been accurately documented. For R119, R143, R158, and R267, Pneumococcal vaccine has been offered and consents have been obtained. For R267, Delvax was check for residents flu vaccine and recorded in residents medical record. For R119, R143, R158, R160, R267, influenza vaccine- the deficient practice could not be corrected due to being past the time of occurrence. B- Residents residing at the facility have	

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F 883	Continued From page 58 1. Review of R119's clinical record revealed: 2/20/25 - R119 was admitted to the facility. 5/19/25 11:25 AM - A review of R119's EMR revealed no evidence of the facility assessing and offering R119 the influenza and the pneumococcal vaccines. 2. Review of R143's clinical record revealed: 4/14/25 - R143 was admitted to the facility. 5/19/25 11:28 AM - A review of R143's EMR revealed no evidence of the facility assessing and offering R143 the influenza vaccine. 3. Review of R158's clinical record revealed: 2/26/25 - R158 was admitted to the facility. 5/19/25 11:32 AM - A review of R158's EMR revealed no evidence of the facility assessing and offering R158 the influenza and the pneumococcal vaccines. 4. Review of R160's clinical record revealed: 2/27/25 - R160 was admitted to the facility. 5/19/25 11:35 AM - A review of R160's EMR revealed no evidence of the facility assessing and offering R160 the influenza vaccine. 5. Review of R267's clinical record revealed: 5/5/25 - R267 was admitted to the facility.	F 883	the potential to be affected by this deficient practice. C- DON/designee will educate current administrative nursing staff on obtaining resident vaccination consents, proper documentation of resident vaccination status, and use of the Delvax system to obtain vaccination status. RCA: Facilitys Infection Preventionist at the time failed to accurately document vaccination status for some residents, offer pneumococcal vaccine to some residents, failed to assess and document some resident influenza vaccines and failed to utilize Delvax system to check on a residents flu vaccine. Infection preventionist, DON, ADON and staff development participated in a training regarding data entry training into the Immunization Registry, Delvax, on 6/5/25. New process change: Facility will review all current residents vaccination status and document accurately. During clinical meeting Infection Preventionist and clinical team will review new admissions and readmissions and their current immunizations for accurate documentation in the medical record. Consents will be obtained for missing vaccinations and documented accurately. D- DON /designee will perform weekly	

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F 883	Continued From page 59 5/19/25 11:38 AM - A review of R267's EMR revealed no evidence of the facility assessing and offering R267 the influenza and the pneumococcal vaccines. Per the Delvax website, R267 received the influenza vaccine on 9/18/24 and the PPV23 pneumococcal vaccine on 2/17/22. The facility failed to offer R267 the PCV20 pneumococcal vaccine as per CDC recommendations. 5/20/25 2:45 PM - The facility was unable to provide evidence of these residents' vaccination or declination of the vaccines when documentation was requested. 5/21/25 11:30 AM - During an interview, E2 (DON) stated that the facility was between a full-time infection preventionist (IP). E2 stated, "The new IP will start at the end of May." 5/23/25 2;30 PM - Findings were reviewed at the Exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 883	audits on new residents and readmitted residents to ensure that vaccinations have been documented accurately, consents have been obtained and Delvax system utilized for vaccinations. Weekly audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F883 Influenza and Pneumo immunizations	
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff	F 887		7/8/25

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F 887	Continued From page 60 members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or	F 887		

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F 887	Continued From page 61 information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on record review and interviews, it was determined that for three (R143, R158, R160) out of ten residents reviewed for vaccines, the facility failed to assess and offer the COVID vaccine. Findings include: 1. Review of R143's clinical record revealed: 4/14/25 - R143 was admitted to the facility. 5/19/25 11:28 AM - A review of R143's EMR revealed no evidence of the facility assessing and offering R143 the COVID vaccine. 2. Review of R158's clinical record revealed: 2/26/25 - R158 was admitted to the facility. 5/19/25 11:32 AM - A review of R158's EMR revealed no evidence of the facility assessing and offering R158 the COVID vaccine. 3. Review of R160's clinical record revealed: 2/27/25 - R160 was admitted to the facility. 5/19/25 11:35 AM - A review of R160's EMR revealed no evidence of the facility assessing and offering R160 the COVID vaccine. 5/20/25 2:45 PM - The facility was unable to provide evidence of these residents' vaccination	F 887	A-For R143, R158, R160, COVID vaccine was offered and documented in resident medical record. B- Residents residing at the facility have the potential to be affected by this deficient practice. C-DON/designee will educate current administrative nursing staff on offering and obtaining resident COVID vaccination consents. RCA: Facilitys Infection Preventionist at the time failed to accurately offer and obtain residents COVID vaccination consents. New process change: During clinical meeting Infection Preventionist and clinical team will review new admissions and readmissions and their current immunizations for accurate documentation in the medical record. Consents will be obtained for missing vaccinations and documented accurately. D- DON /designee will perform weekly audits on new residents and readmitted residents to ensure that resident COVID vaccines have been	

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F 887	Continued From page 62 or declination of the vaccines when documentation was requested. 5/21/25 11:30 AM - During an interview, E2 (DON) stated that the facility was between a full-time infection preventionists (IP). E2 stated, "The new IP will start at the end of May." 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 887	offered and consents obtained. Weekly audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F887 Covid19 immunizations	
F 940 SS=D	Training Requirements CFR(s): 483.95 §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.71. Training topics must include but are not limited to- This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R65) out of thirty-five sampled residents, the facility failed to provide and evaluate staff for appropriate competencies and skill sets regarding R65's LVAD (left ventricular assist device) as identified in the resident assessment. Findings include:	F 940	A-For R65, the deficient practice could not be corrected due to being past the time of occurrence. B- Residents residing in the facility who an LVAD have the potential to be affected by this deficient practice.	7/8/25

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REGAL HEIGHTS HEALTHCARE & REHAB CENTER	6525 LANCASTER PIKE HOCKESSIN, DE 19707

(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 940	Continued From page 63 5/19/25 1:30 PM - A review of the facility assessment, Section III Resources Needed documented the facility as having "Special Care Needs" population regarding: "dialysis, hospice, ostomy care, tracheostomy care, bariatric care, palliative care, end of life care and LVAD (left ventricular assist device)." 5/19/25 4:21 PM - During an interview, E1 (NHA) stated, "I don't have competencies for the LVAD. [E41], the unit manager, has started some education for the LVAD but we don't have anything formalized. We need to get the staff more education on this." 5/20/25 2:15 PM - During an interview, R65 stated that the staff were knowledgeable about his LVAD. R65 stated that during the weekly drive line exit site dressing change, the staff wear the gowns and gloves. 5/20/25 2:35 PM - During an interview, E41 (LPN) reviewed the tasks involved in caring for a resident with an LVAD. E41 spoke knowledgably about charging the device and changing the batteries as well as about the weekly dressing change and the need for enhanced barrier precautions with care. 5/21/25 9:30 AM - A review of the [Hospital] LVAD Heartmate Discharge Binder revealed twenty-four (24), double-sided pages of pertinent information for the care of a person with an implanted LVAD. The topics covered in this manual included: emergency contact for the [hospital] LVAD team, daily care needs, system maintenance, allowed activities, instructions regarding the LVAD power module, mobile power unit, universal battery charger, the significance of the charge status lights, checking charge status, patient cable, and	F 940	C- DON/designee will educate current licensed staff and new orientees on how to care for a patient who has an LVAD. DON/designee will complete competencies with licensed staff and new orientees on the LVAD. RCA: Facility failed to provide licensed staff with appropriate competencies and skill sets regarding care of a patient with an LVAD. Facility reached out to the LVAD center to provide additional training for staff, training scheduled for 6/19/25. D- DON /designee will perform weekly audits on new residents and readmitted residents to ensure that anyone with an LVAD to ensure staff have been provided appropriate education and competencies. Weekly audits will be completed until we consistently reach 100% success over 3 consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for three months or as needed for further evaluation or recommendation. See attachment F940 training LVAD	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. BUILDING _____ B. WING _____	C 05/23/2025

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F 940	Continued From page 64 system controllers, as well as information regarding dental procedures, traveling, warfarin therapy, nosebleeds and cardiac medications. There were instructions regarding donning sterile gloves to perform the weekly, sterile Drive Line Exit site dressing. 5/23/25 - The facility furnished a two-page HMII (heartmate II) VAD (ventricular assist device) Competency checklist and initiated training for the staff. 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).	F 940		