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

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

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Pike Creek

DATE SURVEY COMPLETED: April 18, 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. A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 04/14/25 to 04/18/25 Survey Census: 158 Sample Size: 49 Supplemental Residents: 12		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed April 18, 2025: F563, F584, F610, F623,		

Provider's Signature Brandi Wilson Title LNHA Date 5/23/25

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	F657, F684, F686, F689, F755, F759, F809, F812 and F925.	Cross Refer to the CMS 2567-L survey completed April 18, 2025: F563, F584, F610, F623, F684, F686, F689, F755, F759, F809, F812, and F925.	June 2, 2025

Provider's Signature Brandi Wilson Title LNHA Date 5/23/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. BUILDING _____ B. WING _____	C 04/18/2025

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

(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 A Recertification Emergency Preparedness Survey was conducted by Healthcare Management Solutions on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality on 04/14/25 through 04/18/25. The facility was found to be in compliance with 42 CFR 483.73.	E 000		
F 000	INITIAL COMMENTS A Recertification and Complaint survey was conducted by Healthcare Management Solutions, LLC on behalf of the State of Delaware, Department of Health and Social Services, Division of Health Care Quality. The facility was found not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates: 04/14/25 to 04/18/25 Survey Census: 158 Sample Size: 49 Supplemental Residents: 12	F 000		
F 563 SS=D	Right to Receive/Deny Visitors CFR(s): 483.10(f)(4)(ii)-(v) §483.10(f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time;	F 563		6/2/25

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

Electronically Signed | 05/14/2025

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

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F 563	Continued From page 1 (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to allow family visitation for one out of 49 sampled residents (Resident (R)10). The facility restricted visitation of R10's family member (Family Member (F) 4). This failure violated R10's right as a resident of the facility. Findings include: During an interview on 04/18/25 at 12:33 PM, the Administrator stated the facility did not have a visitation policy. Observation on 04/18/24 at 8:30 PM revealed a sign was posted at the facility entrance that read, "Recommended visiting hours 10:00 AM - 7:00 PM."	F 563	1. R10 no longer resides in the facility. R10 was sleeping at 100:00pm when the visitor tried to gain access therefore, she was not negatively impacted by this deficient practice. 2. All residents who reside in the facility have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A facility wide sweep of all residents residing in the facility was completed and no other residents were affected by this deficient practice. A root cause analysis was conducted, and	

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F 563	Continued From page 2 Review of R10's undated "Admission Record," in the electronic medical record (EMR) under the "Profile" tab revealed R10 was admitted to the facility on 03/19/25. Review of R10 admission "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 03/22/25, located in the EMR under the "MDS" tab revealed the facility assessed R10 to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. During an interview on 04/14/25 at 2:25 PM, F4 stated R10 had almost fallen out of bed twice at night and he had caught her. F4 stated he visited R10 in the evening and at night to make sure R10 was safe, and to make sure her needs were met such as making sure R10 got her pain medications, assistance she needed in the evening/at night, and to follow up on everything. F4 stated he did not sleep while in R4's room and the curtain was pulled between R10 and her roommate. F4 stated he was quiet and did not disturb R10's roommate. F4 stated one of the reasons they chose the facility was because it allowed 24-hour visitation. F4 stated he was told about a week ago that he could no longer visit at night due to R10 having a roommate. F4 stated R10 wanted him there in the evenings/nights. F4 stated there was an incident about a week ago when Registered Nurse (RN) 2 was working at night and told him he could not visit R10, and if he did not leave, she was going to call the police. F4 stated he was denied visitation and left the building without visiting R10. F4 stated the facility recently posted "recommended" visiting hours by the entry door into the facility.	F 563	it was determined that the nursing supervisor failed to allow visitation to a resident based on the late hour of the evening. The visitor appeared with a mask, sunglasses, and a hoodie. The RN Supervisor's judgement at the time was to deny entry into the building. The Staff Developer/designee will educate the nursing supervisors on visitation rights. 4. The Social Services Director/designee will audit five random residents to ensure that they have not had any issues receiving visitation. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 563	Continued From page 3 During an interview on 04/15/25 at 11:02 AM, R10 stated when she was admitted to the facility, she was very weak. R10 stated the mattress was much narrower than what she was used to at home, and she almost fell out of bed twice, but F4 had caught her. R10 stated she felt safer when F4 was there at night. R10 stated the facility advertised they were open 24 hours, and she thought visitation was allowed. R10 stated the staff recently told her F4 could come after 9:00 AM but could not stay past 8:00 PM. R10 stated one-night last week F4 came to visit her, and they would not let him visit and if he did not leave, told him they would call the police. R10 stated this was upsetting to her. Review of R10's "Progress Notes" including Nursing, Physician, Social Services, etc. from admission through 04/18/25, located in the resident's EMR under the "Progress Notes," tab revealed no documentation about F4's visitation, about him being disruptive or causing any concern. There was no mention at all of F4 in the "Progress Notes." During an interview on 04/15/25 at 6:30 PM, RN2 stated F4 had a history of coming in at 9:00 PM and leaving at 11:00 PM or visiting during the night. RN2 stated F4 recently came in at 10:00 PM, and she told him that R10 had a roommate, and he needed to respect her sleep. RN2 stated she told F4 he could not visit and that she would call the police if he did not leave. RN2 stated F4 looked homeless and scary, he wore black clothing, a mask, sunglasses, and pushed a cart. RN2 stated the staff recently put the sign up for recommended visiting hours due to F4's visits. RN2 stated she was only aware of one other	F 563		

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F 563	Continued From page 4 family that visited at night. During an interview on 04/16/25 at 9:27 AM, Licensed Practical Nurse (LPN) 14, the Unit Manager for DelCastle stated she had been notified by nursing staff that F4 was staying at the facility at night. LPN14 stated the administrative team discussed it and agreed it was not appropriate for F4 to be visiting at night. LPN14 verified R10's roommate had not complained about F4's visits. LPN14 stated F4 could visit at night if R10 wanted to come out to the dining room common area. During an interview on 04/17/25 at 11:36 AM, Certified Nursing Assistant (CNA) 16 stated R10's roommate had not complained about F4 being in the room; however, CNA16 stated the room was small and F4 was sometimes in the way. CNA16 stated there were some families on Limestone unit that spent the night, but those were private rooms. During an interview on 04/18/25 at 9:33 AM, Social Services (SS) stated she had been recently hired. She stated she was not aware that F4 was not allowed to visit at night. SS stated the visitation hours posted were recommended hours. SS stated families should not be told they could not come in. SS stated F4 visited at night and brought stuff with him; she denied he caused problems. SS stated she had not heard of any concerns from R10's roommate about F4's visits. During an interview on 04/18/25 at 10:51 AM, Director of Nursing (DON) 1 stated the facility had 24-hour visitation and recommended visiting hours. The DON stated the staff spoke with F4 about the recommended visiting hours. She	F 563		

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F 563	Continued From page 5 stated the facility had lounge areas and F4 could visit after hours in the lounge with R10. During an interview visit on 04/18/25 at 12:33 PM, Administrator1 stated the posted hours were recommended visiting hours. Administrator1 stated it was not appropriate for F4 to visit at night in R10's room considering R10 had a roommate, and this violated the roommate's rights. Administrator1 verified R10's roommate had not alleged a concern about F4's visits.	F 563		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		

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F 584	Continued From page 6 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a homelike environment was maintained for one resident (Resident (R) 90) out of 49 sampled residents. Facility nursing staff disposed of a soiled brief in R90's trash can which caused urine odor in the resident's room. This had the potential to create odors throughout the facility. Findings include: Review of R90's undated "Admission Record," located in the resident's electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted on 10/15/22 with multiple diagnoses that included vegetative state, acute respiratory failure, and nontraumatic intracerebral hemorrhage. Review of R90's annual "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 10/18/24, located in the EMR under the	F 584	Past noncompliance: no plan of correction required.	

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F 584	Continued From page 7 "MDS" tab, revealed R90 was always incontinent of bowel and bladder. Observation on 04/17/25 at 5:45 PM with Licensed Practical Nurse (LPN) 6 revealed a soiled brief in R90's trash can in his room. During an interview at this time, LPN6 confirmed the soiled brief in the trash can was saturated with urine. LPN6 stated she was not aware of nursing assistants disposing of briefs in the trash can until now. During an interview on 04/17/25 at 6:23 PM, Certified Nursing Assistant (CNA) 13 confirmed he was assigned to R90 and had changed his brief earlier. CNA13 stated he disposed of soiled brief in R90's trash can in his room. CNA13 also stated he should have placed the brief in the plastic trash bag and then taken it to the soiled utility room, but he was asked to assist another nursing assistant and so he had not gone back to his room to remove it yet. CNA13 indicated this practice caused R90's room to smell like urine. Observation on 04/18/25 at 9:50 AM with the Assistant Director of Nursing (ADON) and LPN21 revealed a urine-soaked brief was in R90's trash can in his room. During an interview at this time LPN21 confirmed the brief was in the trash can, but she did not know what the nursing assistants were trained to do after removing briefs from residents. During an interview on 04/18/25 at 9:45 AM, LPN6 stated she trained the nursing assistants on removing briefs and taking them to the soiled utility room for disposal. LPN6 also stated CNA20 had already changed several residents and had disposed of their briefs in the trash can prior to	F 584		

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F 584	Continued From page 8	F 584		

the training.

During an interview on 04/18/25 at 10:20 AM, CNA20 stated she changed R90's brief at 8:00 AM, disposed of it in the trash can, but had not taken the trash bag to the soiled utility room yet. CNA20 also stated she had not been trained to take urine-soaked briefs out of the room during orientation at the facility.

During an interview on 04/14/25 at 8:50 PM, Family Member (F) 9 stated the CNAs were disposing of R90's briefs in the trash can and he could smell feces and urine when he visited several times a week.

During an interview on 04/18/25 at 10:13 AM, the Staffing Coordinator stated incontinence care was discussed, and competencies were provided; however, the competency and discussion did not include disposal of briefs. The Staffing Coordinator also stated disposing of soiled briefs in the soiled utility room was a standard of practice that all nursing assistants should have learned in their CNA courses.

During an interview on 04/18/25 at 10:15 AM, Housekeeper (HK) 1 stated she had observed briefs disposed of in residents' trash cans on the unit while she was cleaning their rooms.

During an interview on 04/18/25 at 10:34 AM, Director of Nursing (DON) 1 stated she did not know what the standard was when CNA20 was hired, but soiled briefs and wipes should be placed in the clear trash bag and then disposed of in the soiled utility room.

During an interview on 04/18/25 at 2:21 PM, the

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F 584	Continued From page 9 Administrator stated she expected staff to dispose of the briefs in the dirty utility room on the units to decrease smells to create a homelike environment. The Administrator also stated she did not have a homelike environment policy.	F 584		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 interview, record review, and review of facility policy, the facility failed to thoroughly investigate an allegation of an injury of unknown origin for one resident (Resident (R) 101) of 17 residents reviewed for abuse. Findings include: Review of a facility policy titled "Abuse, Neglect, Mistreatment, Exploitation, and Reasonable	F 610	1. R101 still resides in the facility and was not negatively impacted by this deficient practice. 2. All residents who experience an injury of unknown origin have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3.	6/2/25

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F 610	Continued From page 10 Suspicions of Crime," dated 01/03/25 indicated ". . .The NHA [Nursing Home Administrator] or designee shall investigate allegations and report to appropriate regulatory agencies and/or law enforcement. . .All persons identified as involved in or with knowledge of the occurrence will be interviewed. . ." Review of R101's "Admission Record" located in the resident's electronic medical record (EMR) under the "Profile" tab indicated the resident was admitted to the facility on 04/25/23. Review of R101's "Care Plan" located in the resident's EMR under the "Care Plan" tab dated 01/17/24 indicated the staff were to assist the resident with repositioning in bed as ordered. Review of R101's "Physician Orders" located in the resident's EMR under the "Prog Note" tab dated 02/20/25 indicated the resident was ordered to have two staff members to assist with bed mobility (side to side). Review of R101's quarterly "Minimum Data Set (MDS)," and located in the resident's EMR under the "MDS" tab with an assessment reference date (ARD) of 04/02/25 indicated the staff could not determine the resident's "BIMS" score. The resident was totally dependent on all activities of daily living by staff. Review of R101's hospital records, dated 05/08/24, indicated the resident had a history of chronic left shoulder dislocation. The hospital records revealed the resident had a CT scan, of the resident's right shoulder, which revealed the resident had a fractured humerus or scapula. The scan stated that the resident had osseous (bone)	F 610	3. A review of all residents who have experienced an injury of unknown origin was completed and no other residents were affected by this deficient practice. A root cause analysis was conducted, and it was determined that the Director of Nursing failed to obtain witness statements following the incident of injury of unknown origin. The Nursing Home Administrator/designee will educate the Director of Nursing on ensuring that witness statements are obtained following any injury of unknown origin. 4. The Nursing Home Administrator/designee will review all injuries of unknown origin to ensure that the required witness statements have been obtained. The audit process will be conducted daily x 3 weeks until compliance is consistently reached 100% of the time during three consecutive weeks. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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	085054	A. BUILDING _____ B. WING _____	C 04/18/2025

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F 610	Continued From page 11	F 610		

structures were mildly demineralized diffusely. There was evidence of an anterior-inferior dislocation of the humeral head in relation to the glenoid (the shallow socket of the shoulder). The remainder of the visualized osseous structures appear intact without evidence of other acute osseous abnormality or suspicious osseous lesion. Mild osteoarthrosis was demonstrated. The resident was not a candidate for surgery.

Review of a document provided by the facility titled "Facility Incident Investigations" dated 05/14/24 indicated that the facility reported the injury of unknown origin for R101 to the State Survey Agency (SSA) timely and a follow-up five-day summary. There was no evidence that the facility interviewed potential witnesses (staff) as part of their internal investigation. This investigation was completed by the former Director of Nursing (DON) 2.

During an interview on 04/17/25 at 3:24 PM, DON2 remembered R101's injury of unknown origin and stated that he typically did collect witness statements and would go back at least 48 hours to gather statements from the staff who worked with the resident.

During an interview on 04/17/25 4:23 PM, the Clinical Consultant and the current Administrator stated they could not locate any staff interviews for the injury of unknown origin which involved R101.

During an interview on 04/18/25 at 10:25 AM, the current DON1 confirmed she was the facility's abuse coordinator. DON1 stated she would gather witness statements, interview the suspect, if there was and decide what happened.

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F 623 SS=C	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or	F 623		6/2/25

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F 623	Continued From page 13 (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice.	F 623		

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F 623	Continued From page 14 If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure one of four sampled residents reviewed for hospitalization (Resident (R) 162) and R162's representative were notified of the reasons in writing for R162's transfer to the hospital on 10/14/24. Additionally, there was no evidence that the Ombudsman was notified of the transfer/discharge. This failure placed all residents at risk of not being informed of their appeal rights and process after they are discharged from the facility. Findings include: Review of the facility's policy titled, "Resident and Ombudsman Notification of Transfer or Discharge," dated 01/03/25 revealed, "It is the policy of [Corporation name] to provide residents/resident representatives and the ombudsman with a notice of transfer/discharge as required by Center for Medicare & Medicaid	F 623	1. R162 no longer resides in the facility. R162 was not negatively impacted by this deficient practice. 2. All residents who reside in the facility and are required to be transferred to the hospital have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A facility wide sweep of all residents who reside in the facility and experienced a transfer to the hospital was completed and no other residents were affected by this deficient practice. A root cause analysis was conducted, and it was determined that the Admissions Director failed to provide the	

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F 623	Continued From page 15 Services (CMS) ..." Review of R162's undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on 09/23/24. Review of R162's admission "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 09/29/24 in the EMR under the "MDS" tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated the resident was severely cognitively impaired. Review of R162's "Nurse's Note," dated 10/10/24 and located in the resident's EMR under the "Progress Notes" tab revealed the resident had a fall. Review of R162's "Nurse's Note" dated 10/14/24 located in the resident's EMR under the "Progress Notes" tab revealed, "Daughter wishes for patient to be sent to ER [emergency room] for eval. 911 was called, NP called report to ER [Emergency Room]. 911 arrived to facility at 1221 [12:21 PM], was transported to ER with all appropriate paperwork." A request was made on 04/18/25 of administration for R162's transfer notice provided to the resident, responsible party, and ombudsman; no evidence of the resident, responsible party, or ombudsman notification was provided as of the survey exit on 04/18/25. During an interview on 04/17/25 at 11:11 AM, the Admission Director (AD) stated she completed the bed hold notices when residents were sent to	F 623	representative with the transfer reason in writing. The Staff Developer/designee will educate the Admissions Department on ensuring that all residents who experience a transfer to the hospital will have their representative notified of the reasons in writing. 4. The Nursing Home Administrator/designee will review all residents who are discharged to the hospital to ensure that their representatives receive written notification. The audit process will be conducted daily x 3 weeks until compliance is consistently reached 100% of the time during three consecutive weeks. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. 1. R162 no longer resides in the facility. R162 was not negatively impacted by this deficient practice. 2. All residents who reside in the facility and are required to be transferred to the	

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F 623	Continued From page 16 the hospital but had nothing to do with the transfer/discharge notices. The AD stated she thought nursing staff might have provided the transfer/discharge notices to the resident/responsible parties. During an interview on 04/18/25 at 9:24 AM, Social Service (SS) 1 stated this was her second week of employment and she had not been completing the transfer notices for residents going to the hospital and did not know who was responsible. During an interview on 04/18/25 at 10:50 AM, Director of Nursing (DON) 1 stated the facility did not complete a transfer/discharge form that was provided to the resident or responsible party for emergent transfers to the hospital. The DON stated families/responsible parties were notified by phone of transfers by nursing; however, nothing was provided in writing. During an interview on 04/18/25 at 11:40 AM, Licensed Practical Nurse (LPN) 19 stated she contacted families when residents were transferred to the hospital; however, did not provide anything in writing to the resident or responsible party/family. During an interview on 04/18/25 at 1:19 PM, LPN18 stated when a resident was sent to the hospital, the family was called. A transfer/discharge form was not provided in writing to the resident or responsible party/family.	F 623	hospital have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A facility wide sweep of all residents who reside in the facility and experienced a transfer to the hospital was completed and no other residents were affected by this deficient practice. A root cause analysis was conducted, and it was determined that the Social Services Director failed to provide the Ombudsman with notification of a residents transfer to the hospital. The Staff Developer/designee will educate the Social Services Department on ensuring that all residents who experience a transfer to the hospital will have Ombudsman notification. 4. The Nursing Home Administrator/designee will review all residents who are discharged to the hospital to ensure that the Ombudsman is notified. The audit process will be conducted daily x 3 weeks until compliance is consistently reached 100% of the time during three consecutive weeks. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved,	

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F 623	Continued From page 17	F 623	reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		6/2/25

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F 657	Continued From page 18 Based on observation, interview, record review, and facility policy review, the facility failed to revise a person-centered care plan related to falls for one resident (Resident (R) 141) out of nine residents reviewed for accident. This had the potential for the residents to have injuries related to falls due to care needs not being identified. Findings include: Review of R114's "Admission Record" located in the "Profile" tab of the electronic medical record (EMR) revealed he was admitted to the facility on 10/13/23 with diagnoses which included anoxic brain damage and persistent vegetative state. Review of R114's "Care Plan" located in the resident's EMR under the "Care Plan" tab revealed a problem area, "Actual Fall," initiated on 12/27/24 with interventions, dated 12/02/24, for perimeter mattress and bilateral fall mats to reduce the likelihood of any fall-related injury. Another problem area, "The resident is at risk for falls," initiated on 10/13/23 had interventions which included, "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed" and "Keep pathway to the bathroom clear and clutter free" both initiated 10/13/23. Review of R114's quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 01/16/25 and located in the "MDS" tab of the EMR revealed R114 was in a persistent vegetative state with no discernible consciousness. R114 had functional limitation in range of motion to both upper and lower extremities and was dependent on staff for rolling side to side. R114 had a fall with injury since the	F 657	1. R114 no longer resides in the facility. R114 was not negatively impacted by this deficient practice. 2. All residents who reside in the facility with a potential for falls care plan have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A 100% audit of resident fall care plans was initiated to identify any plans not updated following a change in condition. Any discrepancies were addressed and corrected. A root cause analysis was conducted, and it was determined that the Assistant Director of Nursing failed to update the fall care plan following a fall occurrence. The Staff Developer/designee will educate the Assistant Director of Nursing on timely care plan updates. 4. The Director of Nursing/designee will audit five random residents who have experienced a fall occurrence to ensure that they have had care plan revisions. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If	

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F 657	Continued From page 19 last assessment. During an observation on 04/14/25 at 11:42 AM, R114 was observed in bed on an air mattress, not a perimeter mattress, and without fall mats in place. During a concurrent observation and interview on 04/15/25 at 3:26 PM, Certified Nursing Assistant (CNA) 13 and CNA19 repositioned R114 in bed. R114 was observed to be totally dependent on staff for mobility with no discernible response to verbalizations. R114 wore splints due to contractures of both hands. CNA13 reported that R114 had no fall mats or perimeter mattress since he really had no movement. During an interview on 04/17/25 at 2:00 PM, Licensed Practical Nurse (LPN) 6 who was the Unit Manager for R114's unit stated the Assistant Director of Nursing (ADON) reviewed falls for care planning interventions, and the MDS Coordinator completed general care planning. During an interview on 04/18/25 at 10:46 AM, MDS Coordinator (MDSC) 1 stated falls were discussed daily in the morning meeting and nursing, usually the ADON, updated the Care Plan interventions. For day-to-day changes in fall interventions, the unit managers updated the Care Plans. The MDSCs reviewed and revised the care plans with each quarterly, annual, or significant change MDS assessment. If a resident had a fall intervention which was not being used, the unit managers or ADON reviewed this since they were more directly involved in care. Care plans were expected to be person-centered. During an interview on 04/18/25 at 11:27 AM, the	F 657	compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 657	Continued From page 20 ADON stated she had been in and out of the ADON role. She usually spearheaded the fall interventions. Falls were discussed in the morning meeting and a root cause analysis was determined. Current fall interventions were reviewed, and if not relevant, they were resolved. The ADON reviewed R114's fall interventions and stated encouraging call light use and keeping pathways clear were prepopulated interventions and could probably be removed. R114 had moved rooms multiple times, so the mattress and fall mats may not have moved with him. If the perimeter mattress and fall mats were not used, the care plan should reflect that and the resident's status. During an interview on 04/18/25 at 1:10 PM,Director of Nursing (DON) 1 stated she expected care plans to be resident-centered and to reflect a resident's current status. If an intervention was no longer in use, it should be resolved. Review of the facility's policy titled, "Care Planning" revised 01/12/23 revealed, "The comprehensive care plans should be reviewed and revised by the interdisciplinary team after each assessment." Review of the facility's "Fall Assessment, Prevention, and Management" policy revised 01/20/23 revealed, "Nursing will complete a post fall clinical evaluation and treatment as necessary, obtain orders and implement resident-centered care plans and interventions ...The plan of care and interventions are reviewed and modified when necessary."	F 657		
F 684 SS=J	Quality of Care	F 684		6/2/25

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F 684	Continued From page 21 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure residents who experienced a change in condition received timely treatment for one of four sampled residents reviewed for a change in condition (Resident (R)162). R162's had a fall at home prior to admission and sustained a subdural hematoma requiring a craniotomy (a surgical procedure where a neurosurgeon makes an opening in the skull to access and remove a blood clot (hematoma) that has formed to relieve pressure on the brain). R162 experienced changes in his condition after a fall he sustained on 10/10/24. On 10/14/24 R162 was emergently transferred to the hospital and was diagnosed with an acute subdural hematoma with a left to right shift requiring a craniotomy and intubation while in the hospital resulting in a delay of care. The Administrator and Director of Nursing (DON) were notified on 04/17/25 at 6:28 PM that Immediate Jeopardy existed. The failure to identify R162 exhibited symptoms of a potential head injury and failure to send R162 to the hospital timely created an immediate	F 684	1. R162 no longer resides in the facility. No immediate actions can be taken for this resident. An abatement was written and accepted by the DHCQ on April 17, 2025. 2. All residents who reside in the facility and experience a fall occurrence have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A sweep of all residents reside in the facility that experienced a fall within the last 30 days were reviewed to validate that they did not experience an unidentified change in condition. No other residents were affected by this deficient practice. A root cause analysis was conducted, and it was determined that the licensed nursing staff failed to identify and notify the physician of a change in condition following a fall. The Staff Developer/designee will educate the	

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F 684	Continued From page 22 jeopardy situation resulting in a delay in treatment. Once hospitalized on 10/14/24, R162 had craniotomy surgery due to an acute re-injured subdural hematoma with left to right shift of his brain. The facility's failure to identify R162 was exhibiting signs and symptoms of a head injury and send him to the hospital timely put him at risk for significant injury and potentially death. The facility did not identify any failures from this incident and no corrective measures were implemented to ensure future residents with changes in condition would receive timely treatment. An acceptable Immediate Jeopardy Plan of Removal was provided on 04/17/25 at 8:00 PM and was validated on 04/18/25 at 1:16 PM. The Administrator was notified on 04/18/25 at 1:16 PM that the Immediate Jeopardy was removed. After the removal of the Immediate Jeopardy, the deficiency remained at a scope and severity of a "D".. Findings include: Review of the facility's policy titled, "Alert Charting" dated 01/03/25 revealed "It is the policy of [Name of Facility] to utilize alert charting for residents experiencing changes in condition that warrant heightened observation as determined through nursing judgment ...Residents placed on alert charting are assess by the nurse each shift and assessment data entered into nursing notes ...Document objective data related to the resident's condition i.e. vital signs ...level of consciousness; ...and response or lack of response to treatment ...Report change in resident condition to the physician and the responsible party ..."	F 684	licensed nursing staff on identifying and notifying providers of changes in resident conditions after a fall. 4. The Director of Nursing/designee will audit all residents who sustain a fall to validate the residents are monitored for changes in condition, that changes in condition are identified timely, and the medical provider is notified. The audit process will be conducted weekly for four weeks. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 684	Continued From page 23 Review of the facility's policy titled, "Neurological Checks" dated 01/03/25 revealed "Neurological checks are initiated for residents experiencing a fall (change in plane) with a suspected head injury and/or a change from the resident's neurological baseline ..." Review of R162's undated "Admission Record" in the electronic medical record (EMR) under the "Profile" tab revealed the resident was admitted to the facility on 09/23/24 with a primary diagnosis of traumatic subdural hemorrhage. Review of R162's admission "Minimum Data Set (MDS)" with an assessment reference date (ARD) of 09/29/24 in the EMR under the "MDS" tab revealed R162 was admitted to the facility on 09/23/24 and had a goal of discharging to the community. According to the "MDS" the facility assessed R162 to have a Brief Interview for Mental Status (BIMS) score of four out of 15 which indicated the resident was severely cognitively impaired. R162 had clear speech, was usually understood by others, and sometimes understood others. R162 exhibited no mood or behavioral concerns. Review of R162's "Care Plan" dated 09/25/24 in the EMR under the "Care Plan" tab revealed, "[R162] wishes to be discharged to home/another facility." Interventions in pertinent part were, "Make arrangements with required community resources to support independence post-discharge ..." During an interview on 04/15/25 at 1:37 PM, Family Member (F) 5 stated R162 had been living at home with family when he experienced a fall	F 684		

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getting into her car which resulted in the initial subdural hematoma and craniotomy in September 2024. F5 stated when R162 was admitted to the facility from the hospital, he needed assistance with walking and the goal was for him to get stronger and return home. F5 stated R162 rarely slept while at the facility and was always up, active, and often at the nursing station even at night. F5 stated when she came in to visit R162 on the morning of 10/14/24, he was not responsive at all, and she knew something was seriously wrong. F5 stated she insisted that Nurse Practitioner (NP) 1 send R162 to the hospital.

The facility's Administrator was notified on 04/17/25 at 6:28 PM that Immediate Jeopardy existed related to the failure to identify and respond timely to a change in condition on 10/12/24 after Resident (R) 162 fell and hit his head on 10/10/24. The Immediate Jeopardy began on 10/11/24 when R162 experienced a change in condition.

During an interview on 04/16/25 at 2:44 PM, R162's Personal Care Physician (PCP) 1 stated R162 was able to communicate his needs upon admission but was impaired in cognition.

Review of R162's "Nurse's Note" dated 10/10/24 and located in the resident's EMR under the "Progress Notes" tab revealed R162 was found on the floor of his room after the staff heard a loud thud. The note read, "Pt [Patient] found on floor holding the right side of his face. Pt says he did hit his head. Pt was assessed and able to move all extremities. Pt was assessed by supervisor and then helped off the floor. Pt has a superficial laceration on right side of face near

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right eye. Pt also sustained a skin tear on his lower left arm. The area was cleaned, and a dry dressing was applied. Pt was given an ice pack for facial laceration. NP [Nurse Practitioner (NP)1] made aware of fall and skin injuries ...Pt unable to remember how he fell and what caused his fall ... Wheelchair was in room near where pt was on the floor."

Review of R162's "Nurse's Note" dated 10/10/24 at 5:00 PM and located in the resident's EMR under the " Progress Notes" tab revealed "Resident was found on the floor in front of his bed. Resident was trying to get into bed unassisted and fell ...On call notified and new orders for a CBC [complete blood count], BMP [basic metabolic panel], chest x-ray, and UA [urinalysis] C&S [culture and sensitivity]. Neuro checks initiated ..."

Review of R162's Physical Therapy "Summary of Skill Notes" showed a decline between 10/09/24 and 10/11/24 as follows:
- Review of a PT "Summary of Skill" note dated 10/09/24 provided by the facility revealed R162 walked 118 feet on this date, completed four minutes of standing with support, and performed marching for improved balance.
-Review of a Physical Therapy (PT) "Summary of Skill" note dated 10/10/24 and provided by the facility and signed at 4:57 PM, revealed R162 ambulated ten feet with a rolling walker. In addition, R162 completed 15 minutes on the omni cycle. It was unknown whether therapy occurred before or after R162's fall on this date.
-Review of a PT "Summary of Skill" note dated 10/11/24 at 5:31 PM revealed R162's condition had changed from 10/10/24 as follows, "Pt [Patient] sitting in WC [wheelchair] very drowsy

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F 684	Continued From page 26 with limited eye opening ...increase confusion ...Pt complete x3 STS [sit to stand] and present with difficulty completing task of pivoting. SPT [stand pivot transfer] WC [wheelchair] to recliner with Mod [moderate] of 2 person assist for proper positioning ..." Per the "Summary of Skill" R162 did not walk on this date. The PT who wrote the "Summary of Skill" notes no longer worked at the facility and was unavailable for interview. -Review of the next and last PT "Summary of Skill" note dated 10/14/24 revealed, "Pt encountered in recliner very drowsy with limited eye opening. Pt [unable to] complete transfer to WC on multiple attempts due to increase resistance ..." Review of R162's "Nurse's Note" dated 10/12/24 at 11:38 AM and located in the resident's EMR under the "Progress Notes" tab revealed R162 was experiencing a change in his mental status as follows, "Resident is not able to wake up for medication tried waking him to transfer him to bed but not waking up resident is snoring breathing but will not open eyes not safe to give medication resident vital signs were taken but unable to get temp [temperature] due to him sleeping and not waking up to close his mouth while sleeping tried to take [sic] wake up several times will continue to monitor was not able to eat breakfast will try lunch." Review of R162's "Nurse's Note" dated 10/12/24 at 2:22 PM and located in the resident's EMR under the "Progress Notes" tab revealed, "Resident continue to sleep resident did not eat lunch was able to only take small bite of cheesecake but coughed and then offered ginger ale and water ... could not drink eyes are closed was telling resident to open eyes resident would	F 684		

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F 684	Continued From page 27 mumble but not verbalize using words resident son was here and notified him of the situation that he did not eat breakfast or lunch and was not able to get medications this shift on the on call NP [Nurse Practitioner] was notified and he said can hold medication for 24 hr [hours]." Review of R162's "Nurse's Note" dated 10/12/24 at 9:10 PM and located in the resident's EMR under the "Progress Notes" tab revealed, "Patient slept most of the shift. Alert. Not oriented. Open eyes to voice. Vitals wnl [within normal limit]. Med [medications] melatonin/buspirone on hold." Review of R162's "Nurse's Note" dated10/13/24 at 3:07 PM and located in the resident's EMR under the "Progress Notes" tab revealed "Resident post fall resident was on nuero [sic] checks resident was more awake and alert this shift ate about 50-75% breakfast did not eat lunch son was here and offered but refused this morning when he was done eating breakfast I tried taking vital signs and giving medication but resident was pushing me away and saying no resident speech was not clear was not able to communicate clear this shift ...resident was also very weak and unable to do two person assist to take to the bathroom had to use the sit and stand lift to use the bathroom ..." Review of R162's "Nurse's Note" dated 10/14/24 at 12:21 PM and located in the "Progress Notes" tab revealed, "Patient is noted with increased lethargy this shift. NP evaluated; patient's daughter was at bedside. Daughter wishes for patient to be sent to ER [emergency room] for eval. 911 was called, NP called report to ER. 911 arrived to facility at 1221, was transported to ER with all appropriate paperwork."	F 684		

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F 684	Continued From page 28 Review of R162's NP's "Encounter" note dated 10/14/24 and located in the resident's EMR under the "Progress Notes" tab revealed, "Nursing reporting that patient has increased lethargy and generalized confusion. Patient is currently out of bed to the chair and awakens to verbal commands, but does not communicate needs and has increased confusion. Patient's daughter is at the side of the chair and requesting patient to be sent to the hospital for acute change of mental status. Patient awakens eyes to verbal commands and unable to follow simple commands, even with redirection. Nursing reports acute change in mental status overnight... 1. Acute delirium: Pt with acute onset of change in overall mentation. Pt is not currently at baseline, and workup is still pending including urinalysis. Family at the bedside and requesting patient to be sent to the hospital for further evaluation. Discussed with nursing staff and orders given to send the patient to the ED." Review of R162's "Neurological Flow Sheet" provided by the facility and initiated on 10/10/24 at 4:30 PM and completed on 10/13/24 on the 7:00 AM - 3:00 PM shift, revealed a change in R162's level of consciousness that started on the 7:00 AM - 3:00 PM shift on 10/12/24 with a change from "fully conscious - awake, aware and oriented" to "lethargic - responds slowly to verbal stimuli" that persisted through 10/13/24, the end of the monitoring period. In addition, the "Neurological Flow Sheet" revealed a change in R162's speech from "clear" to "slurred" that started on 10/12/24 on the 7:00 AM - 3:00 PM shift and persisted through 10/13/24, the end of the monitoring period.	F 684		

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F 684	Continued From page 29 Review of 162's hospital "ED [Emergency Department] Physician Record" dated 10/14/24 and provided by the facility revealed, "I reviewed the patient's CT head once it was available in the [name] system and on my interpretation, I am concerned for a large left sided subdural hematoma with midline shift. I immediately active a trauma alert given the patient's age, intracranial hemorrhage, and altered mentation ..." Review of R162's hospital "CT [computed tomography] Head" Scan dated 10/14/24 and provided by the facility revealed, "Impression: Left cerebral convexity and left parafalcine subdural hematoma measuring up to 15 mm in thickness resulting in 7 mm left to right midline shift." During an interview on 04/15/25 at 5:59 PM, Registered Nurse (RN) 2 stated LPN12 should have contacted the Unit Manager regarding the change in condition (change in level of consciousness) observed on 10/12/24 (Saturday). RN2 stated there was no NP in the facility on the weekends at the time of the change in R162's mental status occurred. RN2 stated, considering R162's history of a subdural hematoma and change in level of consciousness, she would have had R162 sent to the hospital on 10/12/24. During an interview on 04/16/25 at 11:15 AM, LPN12 stated on 10/12/24, she could not wake R162 up for breakfast and he did not eat lunch or dinner either. In addition, he refused to take his pills. LPN12 stated she was concerned R162 was experiencing a change in condition and was aware the change in cognition could be a trigger for a head injury from the fall on 10/10/24. LPN12 stated she conveyed all information to the weekend on call NP on 10/12/24 who instructed	F 684		

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her to hold medications for 24 hours and monitor him. LPN12 stated the NP did not instruct her to send R162 to the hospital. LPN12 stated R162 was a little better on 10/13/24 as he was able to eat breakfast and was more alert.

During an interview on 04/16/25 at 1:14 PM, NP1 stated she assessed R162 on 10/10/24 after his fall and on 10/14/24 when notified he experienced a change in condition. NP1 stated when she evaluated R162 on 10/14/24, he was different from his baseline and had experienced an acute change in cognition. NP1 stated R162 was not usually sleepy and had previously been more alert and able to communicate his needs. She stated on 10/14/24 R162 was not making sense. When reviewing the description of R162 documentation by LPN12 on 10/12/24, NP1 stated LPN12's documentation of symptoms was similar to the acute change in mental status that she witnessed on 10/14/24 when she sent the resident out to the emergency room.

During an interview on 04/15/25 at 10:22 AM, Forensic Nurse (nurses who conduct comprehensive medical examinations to assess injuries, document findings, and determine the need for medical intervention) (FN) 3 from the hospital stated R162 was admitted to the hospital on 10/14/24 with subdural hematoma. A craniotomy was performed and R162 had to be intubated (tube inserted inside the windpipe through the mouth or nose). FN3 stated the hospital staff was concerned regarding the delay in sending R162 to the hospital after he started exhibiting signs and symptoms of a change in condition on 10/12/24. FN3 stated when R162 arrived at the hospital, he had obvious signs of injury to his forehead and staff were unable to

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F 684	Continued From page 31 wake him for more than a few seconds. R162 was unable to communicate verbally and was groaning and coughing when he arrived. FN3 stated R162 was placed onto hospice services while in the hospital. During an interview on 04/17/25 at 1:20 PM, FN4 stated there were three CT scans taken for R162 following his initial fall in 09/10/24. FN4 stated the first CT scan on 09/10/24 showed the hematoma measured 25 mm thickness; the 09/17/24 CT scan was not measured but showed marked improvement; the 10/14/24 CT scan showed a 15 mm thickness with a seven mm shift. FN4 stated the shift was due to the bleeding pushing the left side of the brain to the right-side accounting for the shift from left to right. FN4 stated R162 had a re-injury of the subdural hematoma, based on the CT scan dated 10/14/24 with a craniotomy recommended and performed to relieve the pressure. FN4 stated, due to the previous subdural hematoma in September 2024, R162 was at increased risk and should have been sent to the hospital right away on 10/14/24 after hitting his head when he fell on this date. During an interview on 04/17/25 at 2:38 PM, NP1 reviewed the Emergency department report and the CT scan for R162 both dated 10/14/24. NP1 stated the documentation revealed an intracranial bleed and that an intervention was needed to alleviate the pressure. She stated the midline shift was the concern and indicated that something acute had occurred. NP1 reviewed the Therapy Note dated 10/11/24 showing a decline in R162's cognition the day after the fall and stated if she had known about that, she would have had R162 sent to the hospital at that time.	F 684		

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F 684	Continued From page 32 During an interview on 04/15/25 at 1:37 PM, Family Member (F) 5 stated R162 went onto hospice while in the hospital due to his deteriorated condition and was discharged from the hospital to a different nursing facility where he passed away a few months later. Review of the facility's Immediate Jeopardy Removal Plan dated 04/17/25 revealed the facility took the following actions: "-RI62 no longer resides in the facility. No immediate actions can be taken for this resident. -The facility Medical Director was made aware of the immediate jeopardy citation on April 17, 2025. -All residents who have fallen within the last 72 hours were assessed by a medical provider for changes in condition on April 17, 2025. -All current residents who have fallen within the last 30 days were reviewed to validate that they did not experience an unidentified change in condition on April 17, 2025. -Immediate education of all licensed nurses other than those on leave on identifying and notifying providers of changes in condition after a fall was initiated and completed by the DON/ designee on April 18, 2025. Any staff on leave will be educated prior to their next scheduled shift. -Audits will be conducted by the DON [Director of Nursing]/ designee on residents who sustain a fall to validate that residents are monitored for changes in condition, that changes in condition are identified timely, and the medical provider is notified. The facility QAPI committee through ad hoc will monitor weekly for four weeks to review any trends, findings, issues, or concerns and develop plan of action for follow up or resolution."	F 684		

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F 684	Continued From page 33 During an interview on 04/17/25 at 8:16 PM, DON1 stated the training consisted of educating nurses on clinical evaluations, subjective versus objective data, level of consciousness, and provider notification of changes in condition. DON1 stated if the nurses did not agree with the provider, such as whether to send a resident to the hospital, they were to notify the DON, and the DON would notify the Medical Director. The Medical Director will make the final decision for the resident. During an interview on 04/17/25 at 8:19 PM, LPN14 verified she had been trained by DON1 and verbalized understanding of the training when asked specific questions. During an interview on 04/17/25 at 8:21 PM, LPN7 verified she had been trained by the DON and verbalized understanding of the training when asked specific questions. During an interview on 04/17/25 at 8:24 PM, RN7 verified she had been trained by the DON and verbalized understanding of the training when asked specific questions. During an interview on 04/18/25 at 9:11 AM, the Director of Rehabilitation (DOR) and Interim DOR stated they started educating therapy staff last night about change of condition, and how therapy staff should communicate this information to nursing. Therapy was to notify and inform nursing and bring the information to department heads in the morning meetings.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		6/2/25

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F 686	Continued From page 34 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to obtain wound treatment orders and provide wound care upon admission to the facility for one of eight residents reviewed for pressure ulcers (Resident (R) 170). Findings include: Review of the facility's policy titled "Pressure Ulcer Prevention and Management," revised 01/17/23, provided by the facility revealed "Policy: It is the policy of the facility to promote skin integrity through the recognition, treatment and prevention of pressure ulcers. Purpose: To identify residents at risk for skin breakdown and develop an individualized plan of care for prevention, recognition, and treatment of pressure ulcers ..." Review of R170's undated "Admission Record" located in the electronic medical record (EMR) under the "Profile" tab revealed she was admitted	F 686	1. R170 no longer resides in the facility. R170 was not negatively impacted by this deficient practice. 2. All residents who reside in the facility and require wound care have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A facility wide sweep of all residents residing in the facility that require wound care treatments was completed and no other residents were affected by this deficient practice. A root cause analysis was conducted, and it was determined that the Wound Care Nurse failed to obtain wound care treatment orders. The Staff Developer/designee will educate the	

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F 686	Continued From page 35 to the facility on 03/05/25 with multiple diagnoses which included displaced comminuted fracture of shaft of the left femur, encounter for other orthopedic aftercare, and history of falling. Review of R170's "Admission Assessment," dated 03/05/25, located in the EMR under the "Evaluations" tab revealed she was admitted with a stage 2 pressure ulcer on the sacrum and a new dressing was applied. Review of R170's "Weekly Skin Check," dated 03/06/25, located in the EMR under the "Evaluations" tab revealed an existing skin issue on the sacrum. Review of R170's "Weekly Skin Check," dated 03/10/25, located in the EMR under the "Evaluations" tab revealed an existing skin issue wound on sacrum. Review of R170's "Encounter Note," dated 03/08/25, located in the EMR under the "Prog Notes" tab revealed "Chief complaint/Nature of presenting problem: pain, wound sacrum History of Present Illness: ...Patient was also assessed due to wound to sacrum area that was bleeding and nursing instructed to cleanse and apply dressing. Surrounding areas to wound deep red and nursing instructed to return patient to prevent further breakdown ...Sacral Wound start and continue with daily dressing to wound consult wound team per facility schedule continue with q [every] turns ..." Review of R170's "Physician's Orders," dated 03/11/25, located in the EMR under the "Orders" tab revealed an order to cleanse sacrum with normal saline, apply collagen and cover with a dry	F 686	Wound Care Nurse on ensuring that treatment orders are obtained. 4. The Director of Nursing/designee will audit all residents who experience new alterations in skin integrity to ensure that treatment orders are obtained. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 686	Continued From page 36 dressing one time a day every Monday, Wednesday, and Friday and notify the provider for signs/symptoms of infection and complications. Review of R170's "Medication Administration Record (MAR)," dated March 2025, located in the EMR under the "Orders" tab revealed there was no documented treatment provided to the sacral wound until 03/12/25. Review of R170's "Wound Consult," dated 03/12/25, located in the EMR under the "Misc" tab revealed an unstageable pressure wound on the sacrum measuring "6 centimeters (cm) length x 8 cm width x undetermined cm depth (48 square cm)" and was debrided. Review of R170's "Wound Consult," dated 03/19/25, located in the EMR under the "Misc" tab, revealed an unstageable sacral wound measuring "7 cm length x 9.5 cm width x undetermined cm depth (66.5 square cm)" and was debrided. During an interview on 04/16/25 at 2:19 PM, the Assistant Director of Nursing (ADON) confirmed R170 had a sacral wound upon admission and there was no alert charting completed on the wound, or a treatment order obtained for the wound until 03/11/25. The ADON stated the former wound nurse saw R170 when she was admitted to the facility and documented the wound on her sacrum. The ADON also stated she should have seen R170 on 03/06/25 and 03/07/25 but she resigned from the position without obtaining a treatment order. The ADON stated Licensed Practical Nurse (LPN) 12 notified her of the sacral wound without a treatment order	F 686		

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F 686	Continued From page 37 on 03/10/25 after she completed R170's skin check. The ADON indicated she interviewed the nurses that were assigned to R170 over the weekend (03/08/25 and 03/09/25) and they statec they provided treatments to the wound on the sacrum without an order but did not document it and did not notify the provider. During an interview on 04/16/25 at 2:43 PM, LPN8 stated he was assigned to R170 on 03/06/25 and performed a skin check on her legs so he did not know she had a sacral wound. During an interview on 04/16/25 at 3:36 PM, LPN12 verified she was assigned to R170 and observed the sacral wound when she completed the skin assessment on 03/10/25. LPN12 stated there was no treatment order in place. LPN12 stated she notified the nurse practitioner and informed the ADON. LPN12 also stated the sacral wound was not passed onto her in nursing report and she did not see alert charting on it in the progress notes. LPN12 stated R170 was placed on the wound rounds on 03/12/25. During an interview on 04/16/25 at 3:50 PM, the Wound Physician stated he was not aware that there were no treatments in place for R170's wound on her sacrum until 03/11/25. The Wound Physician confirmed he saw R170 on 03/12/25 and on 03/19/25, the sacral wound was unstageable, and he debrided it. During an interview on 04/17/25 at 5:34 PM, the Director of Nursing (DON) 1 stated she was informed by the ADON that LPN12 reported to her that R170 had a wound to her sacrum withou: treatment orders and that LPN12 reported it to the Nurse Practitioner.	F 686		

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F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that two of 10 residents reviewed for accidents (Resident (R) 114 and R90) were provided supervision to prevent accidents. Both residents were planned for two staff for bed mobility and transfer but only one staff provided care. R114 was harmed when injuries from the all required emergecy room treatment with stitches to a laceration to the skull. R90 sustained minimal injuries. Verification of training and binder review confirmed the incident with R114 was corrected 12/3/24 and determined to be past-non compliance. The citation for R90 was a D level finding was verified as corrected on 3/21/24. Findings include: 1. Review of the facility's policy titled, "Care Planning" revised on 01/12/23 revealed that "The services provided or arranged by the facility, as outlined by the comprehensive care plan, must: Be provided by qualified persons in accordance with each resident's written plan of care." Review of R114's "Admission Record" located in the "Profile" tab of the EMR revealed he was	F 689	Past noncompliance: no plan of correction required.	

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F 689	Continued From page 39 admitted to the facility on 10/13/23 with diagnoses which included anoxic brain damage and persistent vegetative state. Review of R114's "Care Plan" located in the resident's EMR under the "Care Plan" tab revealed an intervention dated 10/13/23 to: "Assist with transfers and repositioning in bed as ordered." Review of R114's "Order Summary Report" located in the resident's EMR under the "Orders" tab revealed an order dated 04/05/24 for "Bed Mobility [side to side]: assist of two." Review of R114's "Transfer Status Sheet" dated 04/05/24 and located in the "Misc" tab of the EMR revealed R114 required assist of two with rolling side to side. Review of R114's "Fall Risk Evaluation," dated 10/14/24 and located in the "Evaluations" tab of the EMR revealed R114 was not at risk of falling. Review of R114's annual "MDS" assessment with an ARD (assessment reference date) of 10/16/24 and located in the "MDS" tab of the EMR revealed R114 was in a persistent vegetative state with no discernible consciousness. R114 had functional limitation in range of motion to both upper and lower extremities and was dependent on staff for rolling side to side. Review of a facility provided "Incident Report," dated 11/28/24 and completed by LPN11 revealed CNA14 reported R114 fell out of bed during care. R114 was observed lying on the floor next to the bed, bleeding from the left side of his head. R114 went out to the emergency room for	F 689		

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F 689	Continued From page 40	F 689		

evaluation.

Review of R114's "Progress Notes," located in the "Progress Notes," tab of the EMR revealed:

A "Nurses Note" dated 11/28/24 at 2:42 PM which documented R114 fell onto the floor during care around 12:55 PM. R114 was assessed and an injury to the left side of his head was cleaned and a pressure dressing placed. 911 was called, and R114 left for the hospital at 1:27 PM.

An "Orders - General Note from eRecord" dated 11/29/24 at 12:04 PM which documented R114 returned to the facility at 8:55 AM. R114 had a laceration with stitches on the back left side of his head from the 11/28/24 fall.

During an interview on 04/15/25 at 11:53 AM, CNA14 reported she had rolled R114 by herself on 11/28/24 when providing incontinence care. CNA14 had raised the bed to working height, rolled R114 away from her, and reached to grab wipes and a clean brief when R114 slowly fell out of bed. CNA14 reported R114 was supposed to be assisted by two staff to roll but that when she was unable to find someone to assist, she had provided care alone.

During a concurrent observation and interview on 04/15/25 at 3:26 PM, CNA13 and CNA19 repositioned R114 in bed. R114 was observed to be totally dependent on staff for mobility with no discernible response to verbalizations. CNA13 reported R114 had little movement, but residents in his state coughed or spasmed at times with rolling, which could cause them to move. When asked how staff knew how to transfer or position residents, CNA13 opened R114's closet door to

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F 689	Continued From page 41 reveal his "Transfer Status Sheet" which showed R114 required two staff for rolling side to side. During an interview on 04/16/25 at 12:14 PM, LPN11 stated she was notified by a CNA on 11/28/24 that R114 had fallen from the bed. When LPN11 lifted R114's head, she felt blood or her glove and got another nurse to further assist with assessing. CNA14 reported to LPN11 that when R114 was rolled on his side for incontinence care, he jerked and fell off the bed. He likely coughed or something. CNA14 was the only staff in the room providing care when R114 fell. R114 was supposed to have two staff when rolling. During an interview on 04/16/25 at 6:00 PM, DON1 stated she expected staff to follow the plan of care for rolling, transferring, and ambulation. Nursing staff were educated to look for the plan of care inside the resident's closet doors. If the plan of care stated to roll with the assist of two staff, she expected two staff to be utilized. Review of a facility provided binder revealed the facility started a Quality Assurance and Performance Improvement (QAPI) plan following the 11/28/24 fall. An "Action Plan" titled "Resident Staff Assisted Bed Mobility" was initiated on 11/29/24. Certified staff received re-education on utilizing the ordered amount of staff assistance with bed mobility from 11/29/24 to 12/03/24. Audits were completed on utilizing the required staff assistance with bed mobility three times weekly until compliance was consistent at 100% for three consecutive audits. Following this, audits were completed weekly until consistent compliance was achieved over three consecutive weeks. Finally, monthly audits were performed,	F 689		

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F 689	Continued From page 42 which began in January 2025. The last audit form in the binder was dated 01/10/25. 2. Review of R90's undated "Admission Record" located in the EMR under the "Profile" tab revealed he was admitted on 10/15/22 with multiple diagnoses which included vegetative state, acute respiratory failure, tracheostomy, contractures, gastrotomy, and nontraumatic intracerebral hemorrhage. Review of R90's annual "MDS" assessment with an ARD of 10/18/24, located in the EMR under the "MDS" tab revealed R90 was not interviewable and could not be assessed for mental status. The MDS indicated that R90 was dependent on staff for eating, oral hygiene, toileting, shower, upper and lower body dressing, personal hygiene, rolling, and transfers. Review of R90's "Care Plan," dated 02/24/23, located in the EMR under the "Care Plan" tab revealed a focus of "ADL self-care performance deficit r/t [related to] vegetative state" with interventions of "Picture in closet for positioning" dated 01/18/24, and "Transfer: The resident requires Mechanical Lift (Hoyer) with 2 staff assistance for transfers (dated 02/24/23)." Review of R90's "Nurses Note," dated 02/22/25, located in the EMR under the "Prog Note" tab revealed "Charge nurse came in to the Unit and reported to the nursing supervisor that resident has a fall during provision of care. Nursing supervisor ran to resident's room. Resident has contractures of the upper limbs and very limited movement in lower extremities. No evidence of bones fracture. Resident presented: excoriations of the right side of forehead, small	F 689		

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hematoma/elevation of the middle of the forehead, scant amount of dry blood on the inferior lip, small skin tear on right shoulder. Resident was resistant to mouth evaluation."

Review of R90's "Nurses Note," dated 02/22/25, located in the EMR under the "Prog Note" tab revealed " ... Resident was assessed by NPs [nurse practitioners] and new order received to send resident to the Hospital for evaluation and treatment ..."

Review of R90's "Nurses Note," dated 02/22/25, located in the EMR under the "Prog Note" tab revealed "pt [patient] returned from hospital s/p [status post] fall. no new orders received. pt vitals are stable. no signs of distress noted. no signs of pain or discomfort. call bell within reach ..."

Review of R90's "Facility Reported Incident (FRI)," dated 02/22/25, provided by the facility revealed the five-day report was sent to the State Survey Agency (SSA) on 02/28/25 which documented CNA10 stated she was cleaning the resident and went to turn him, and he rolled off the bed.

During an interview on 04/14/25 at 8:50 PM, Family Member (F) 9 stated there was an incident on 02/22/25 when two staff were not present when turning R90 in bed during care. F9 also stated the CNA told him that she was giving a bath to R90, then she turned him away from her and he fell off the bed onto the floor. F9 stated the CNA stated R90 had a few scraps on him but no injuries.

During an interview on 04/17/25 at 3:33 PM, DON1 confirmed she completed R90's fall

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F 689	Continued From page 44 investigation and concluded CNA10 did not wait for another nursing assistant to assist her in providing care to the resident on 02/22/25, which was the required level of assistance per the care plan. DON1 also stated the care plan was posted in each resident's armoire. DON1 indicated R90 returned from the hospital with no injuries. DON1 also indicated CNA10 was suspended during the investigation and terminated after the investigation was concluded. DON1 stated training was provided to all staff on 02/24/25 then auditing was conducted which included observations of the nursing assistants providing care to the residents. Training was provided to all nursing staff on 02/24/25 on patient transfer status and bed mobility by the DON. Audits were conducted three times weekly by the Staffing Coordinator from 02/24/25 to 03/21/25 through observations on each floor of assistance required with bed mobility per the QAPI Plan.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and	F 755		6/2/25

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F 755	Continued From page 45 biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to administer medications timely for two of five residents (Resident (R) 41 and R145) reviewed for medication administration out of 49 sampled residents. This had the potential to result in adverse health outcomes. Findings include: 1. Review of R41's "Admission Record," located under the "Profile" tab of the electronic medical record (EMR), revealed R41 was admitted to the facility on 03/01/24 with diagnoses that included hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD), asthma, atrial fibrillation, and constipation. Review of R41's annual "Minimum Data Set	F 755	1. R41 still resides in the facility and was not negatively impacted by this deficient practice. 2. All residents who reside in the facility and have physicians orders for medication have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A facility wide sweep of all residents residing in the facility with physicians orders for medications was completed and no other residents were affected by this deficient practice. A root cause analysis was conducted, and it was determined that the licensed	

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	085054	A. BUILDING _____ B. WING _____	C 04/18/2025

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F 755	Continued From page 46 (MDS)," with an Assessment Reference Date (ARD) of 03/06/25 and located in the "MDS" tab of the EMR, revealed R41 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated intact cognition. Review of R41's "Order Summary Report," dated 04/15/25 and located in the "Orders" tab of the EMR, revealed R41 was to receive the following medications: Acetaminophen 325 milligrams (mg) two tabs three times a day for pain Potassium chloride 20 milliequivalent (mEq) twice daily for hypertension Cyanocobalamin (vitamin B12) 500 micrograms (mcg) daily for supplement Diltiazem HCl extended release (ER) 180mg daily for hypertension Losartan potassium 100mg daily for hypertension Isosorbide mononitrate 30mg daily for hypertension Apixaban 2.5mg twice daily for atrial fibrillation Benzonatate 100mg three times daily for cough Cholecalciferol (vitamin D3) 50mcg daily for supplement Docusate sodium 100mg twice daily for constipation Sodium chloride 1 gram (gm) three times daily for hyponatremia Cetirizine 10mg daily for allergy symptoms Olopatadine HCl ophthalmic solution 0.2% one drop to each eye daily for allergies Breo Ellipta inhalation daily for asthma Review of R41's "Medication Administration Record (MAR)," located in "Orders" tab of the EMR, revealed the potassium, vitamin B12, diltiazem, vitamin D3, sodium chloride, cetirizine,	F 755	nursing staff failed to administer medications timely and consistent with physicians orders. The Staff Developer/designee will educate the licensed nursing staff on administering medications in a timely manner 4. The Staff Developer/designee will monitor five random residents medication passes to ensure that they receive their medications timely and consistent with physicians orders. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. 1. R145 still resides in the facility and was not negatively impacted by this deficient practice. 2. All residents who reside in the facility and have physicians orders for medication have the potential to be impacted by this deficient practice. Further residents will be	

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F 755	Continued From page 47 olopatadine, and Breo Ellipta were scheduled for 9:00 AM. The acetaminophen, losartan potassium, isosorbide mononitrate, apixaban, benzonatate, and docusate sodium were scheduled at 8:00 AM. During an interview on 04/15/25 at 9:30 AM, LPN8 stated he had to administer medications or two floors due to one floor only having one nurse, instead of its normal two nurses. LPN8 stated he started with the more complicated residents who had blood sugar checks and insulin orders. During an observation on 04/15/25 at 10:15 AM, Licensed Practical Nurse (LPN) 8 started to administer R41's morning medications. During an interview on 04/15/25 at 10:25 AM, R41 stated she did not really pay attention to the timing of her medications. During an interview on 04/15/25 at 10:31 AM, LPN13 stated a nurse called off. The facility tried to find another nurse replacement but was unable. LPN13 stated this happened about every two weeks. The two nurses from the other side of the hall floated over to administer medications. Medications were to be administered from an hour before until an hour after their scheduled times, which was difficult when nurses floated. During an interview on 04/15/25 at 3:06 PM, LPN8 stated he was behind that morning due to administering medications in two areas. He felt the morning medication pass should be completed by around 10:00 AM. 2. Review of R145's "Admission Record," locatec under the "Profile" tab of the EMR, revealed R145	F 755	protected from this deficient practice by measures outlined in section 3. 3. A facility wide sweep of all residents residing in the facility with physicians orders for medications was completed and no other residents were affected by this deficient practice. A root cause analysis was conducted, and it was determined that the licensed nursing staff failed to administer medications timely and consistent with physicians orders. The Staff Developer/designee will educate the licensed nursing staff on administering medications in a timely manner. 4. The Staff Developer/designee will monitor five random residents medication passes to ensure that they receive their medications timely and consistent with physicians orders. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI	

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F 755	Continued From page 48 was admitted to the facility on 03/13/25 with diagnoses that included gastrostomy (feeding tube) status and persistent vegetative state. Review of R145's admission "MDS," with an ARD of 03/19/25 and located in the "MDS" tab of the EMR, revealed staff were unable to determine R145's "BIMS" score. Review of R145's "Order Summary Report," dated 04/15/25 and located in the "Orders" tab of the EMR, revealed R145 was to receive the following medications: Enoxaparin sodium injection daily for deep vein thrombosis (DVT) prophylaxis (prevention) Famotidine 20mg every twelve hours for GERD Review of R145's "MAR," located in "Orders" tab of the EMR, revealed the medications were scheduled for 8:00 AM. During an observation on 04/15/25 at 10:05 AM, LPN20 administered R145's medications. During an interview on 04/15/25 at 10:19 AM, LPN20 reported medications should be given one hour before and one hour after they were ordered. LPN20 stated the medications were due to 9:00 AM, so they were late but were not real late. During an interview on 04/16/25 at 6:00 PM, Director of Nursing (DON) 1 stated she expected medications to be given from one hour before until one hour after their scheduled times. The facility had no policy regarding medication administration.	F 755	meetings.	

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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 by: Based on observation, record review, interview, and facility policy review, the facility failed to ensure a medication error rate of less than five percent during medication administration. The facility had two errors in twenty-six opportunities, due to not properly administering medicated eye drops and not priming an insulin pen. This resulted in a seven percent error rate and affected two (Resident (R) 41 and R64) out of five residents observed. Medication errors have the potential to result in adverse health outcomes. Findings include: 1. Review of the facility's policy titled, "Eye Drop Administration" revised August 2020, revealed, "Instill the prescribed number of eye drops into the pouch near the outer corner of the eye. ...Instruct the resident to close their eyes slowly to allow for even distribution over the surface of the eye. The resident should refrain from blinking or squeezing their eyes shut. While the eye is closed, use one finger to compress the tear duct in the inner corner (inner canthus) of the eye for 1-2 minutes. This reduces systemic absorption of the medication. Alternatively, the resident may keep their eyes closed for approximately three minutes ..." Review of R41's "Admission Record," located	F 759	1. R41 still resides in the facility and was not negatively impacted by this deficient practice. 2. All residents who reside in the facility and have physician orders for eye drops have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A facility wide sweep of all residents residing in the facility and have physicians orders for eye drops was completed and no other residents were affected by this deficient practice. A root cause analysis was conducted, and it was determined that the licensed nursing staff failed to administer the eye drops accurately. The Staff Developer/designee will educate the licensed nursing staff on proper eye drop administration including applying pressure at the inner corner of the eye following administration of eye drops. 4. The Staff Developer/designee will audit five random residents with physician orders for eye drops to ensure accurate	6/2/25

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F 759	Continued From page 50 under the "Profile" tab of the electronic medical record (EMR), revealed R41 was admitted to the facility on 03/01/24 with diagnoses that included hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD), and asthma. Review of R41's annual "Minimum Data Set (MDS)," with an Assessment Reference Date (ARD) of 03/06/25 and located in the "MDS" tab of the EMR, revealed R41 had a "Brief Interview for Mental Status (BIMS)" score of 15 out of 15, which indicated intact cognition. Review of R41's "Order Summary Report," dated 04/15/25 and located in the "Orders" tab of the EMR, revealed R41 was to receive olopatadine HCl ophthalmic solution 0.2% one drop to each eye daily for allergies. During an observation on 04/15/25 at 10:15 AM, Licensed Practical Nurse (LPN) 8 instilled one drop of the olopatadine HCl ophthalmic solution into each of R41's eyes. LPN8 blotted each eye with a tissue following administration but did not compress the tear duct nor ask R41 to keep her eyes closed or to compress the tear duct in the inner corner of the eye. During an interview on 04/15/25 at 3:06 PM, LPN8 stated he knew to wait for at least five minutes between different types of eye drops and to wipe with a tissue from inner eye to outer eye to prevent any dripping. He had not been taught about putting any pressure on the tear duct. During an interview on 04/17/25 at 5:32 PM, the Staffing Coordinator stated staff were to apply a little pressure at the corner of the eye after	F 759	administration. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. 1. R64 still resides in the facility and was not negatively impacted by this deficient practice. 2. All residents who reside in the facility and have physician orders for insulin administration via pen have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A facility wide sweep of all residents residing in the facility and have physicians orders for insulin to be administered via pen was completed and no other residents were affected by this deficient practice.	

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F 759	Continued From page 51 administering the eye drop medication. During an interview on 04/18/25 at 11:07 AM, Director of Nursing (DON) 1 reviewed the "Eye Drop Administration" policy and stated she expected staff to follow it and to instruct or assist residents to close their eyes slowly to allow for even distribution over the surface of the eye and use one finger to compress the tear duct in the inner corner of the eye for 1-2 minutes. 2. Review of the "Admelog Solostar Pen Instructions for Use," dated November 2019, accessed at https://products.sanofi.us/admelog/Admelog_Solostar_Pen_IFU.pdf on 04/16/25, revealed " ... Step 1: check your pen ...1B Pull off the pen cap ...1C check that the insulin is clear ... 1D wipe the rubber seal with an alcohol swab ... Step 2: Attach a new needle ... Step 3: Do a safety test ... 3A Select 2 units by turning the dose selector until the dose pointer is at the 2 mark. 3B press the injection button all the way in. when insulin comes out of the needle tip, your pen is working correctly ..." Review of R64's undated "Admission Record" located in the EMR under the "Profile" tab, revealed R64 was admitted to the facility on 04/20/24 with a diagnosis of type 1 diabetes mellitus (DM) with hyperglycemia. Review of R64's "Physician Orders," dated 01/21/25, located in the EMR under the "Orders" tab, revealed an order for "Admelog SoloStar (a rapid acting insulin) 100 unit/milliliters (ML) solution pen-injector inject 10 units subcutaneously before meals for DM."	F 759	A root cause analysis was conducted, and it was determined that the licensed nursing staff failed to administer the insulin via pen accurately. The Staff Developer/designee will educate the licensed nursing staff on priming the insulin pen with 2 units prior to administration. 4. The Staff Developer/designee will audit five random residents with physician orders for insulin via pen to ensure it is primed prior to administration. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 759	Continued From page 52 During an observation on 04/15/25 at 12:46 PM, Registered Nurse (RN) 6 retrieved R64's insulin pen (a pen contains the vial of insulin inside the pen and has a mechanism where the dose to be administered is set on a dial at the top of the pen, and only that amount can then be injected) from the medication cart, wiped the top with an alcohol wipe, attached a needle to the pen then dialed the dose to 10 units. RN6 carried the pen to R64's room. RN6 washed her hands, applied gloves, observed R64's left side of the abdomen, cleansed her abdomen with an alcohol wipe, gently inserted the pen needle into the flesh, injected the dose, then removed the needle after ten seconds. Next, RN6 carried the pen to the medication cart, disposed of the needle, and performed hand hygiene. During an interview on 04/15/25 at 12:51 PM, RN6 confirmed she did not prime the pen with two units to ensure the needle was working. RN6 stated she did not prime the insulin pens and was not trained to do so. During an interview on 04/18/25 at 10:07 AM, the Staffing Coordinator stated she reviewed insulin pen administration on day 3 of orientation and the nurses completed the competency afterwards. The Staffing Coordinator also stated she would make medication administration observations on a schedule but did not know the schedule yet since she began employment on 04/01/25. The Staffing Coordinator indicated that after the needle was applied to the insulin pen, it should be dialed to two units and then push the plunger to ensure that it worked. During an interview on 04/17/25 at 6:49 PM, DON1 stated she expected the nursing staff to	F 759		

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F 759	Continued From page 53 administer insulin via the manufacturer's directions and the insulin pen should be primed with two units after attaching the needle to ensure it worked.	F 759		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure there was not more than a 14-hour gap between the evening meal (dinner) and breakfast the following day for 118 out of 158 residents (40 residents received nutrition via tube feedings). The planned meal gap between dinner and breakfast the following day was 15 hours. The resident group had not approved the 15-hour gap between dinner and	F 809	1. The residents who were cited were not negatively impacted by this deficient practice. 2. All residents who reside in the facility and have physicians' orders for oral intake have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by	6/2/25

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F 809	Continued From page 54 breakfast. This created the potential for residents to experience hunger while waiting for breakfast. Findings include: Review of the undated "Mealtimes" document provided by the facility revealed breakfast was scheduled to be served at 8:00 AM to Limestone, 8:10 AM to Millcreek Low, 8:20 AM to Millcreek High, 8:30 AM to Delcastle Low, 8:40 AM to Delcastle High, 8:50 AM to White Clay High, and 9:00 AM to White Clay Low. Dinner was scheduled to be served at 5:00 PM in Limestone, 5:10 PM in Millcreek Low, 5:20 PM in Millcreek High, 5:30 PM in Delcastle Low, 5:40 PM in Delcastle High, 5:50 PM in White Clay High, and 6:00 PM in White Clay Low. There was a 15-hour span for each location from dinner until breakfast the following day. Meal observations revealed breakfast was served late on 04/18/25 with the breakfast meal cart being served to residents in rooms Delcastle High at 09:18 AM. Staff were serving breakfast trays to residents with 12 trays remaining on the cart at this time. According to the scheduled mealtimes, Delcastle High meals were to be served at 8:40 AM. During an interview with the Resident Group on 04/16/25 at 2:00 PM with six residents (R38, R58, R34, R143, R19, and R36). The group stated the 15-hour gap between dinner and breakfast the next day was too long. All six residents confirmed the 15-hour gap between dinner and breakfast had not been approved by resident council. 1. Review of R38's quarterly "Minimum Data Set (MDS)" with an assessment reference date	F 809	measures outlined in section 3. 3. The facility offers/provides evening snacks every night to all residents who receive meals. A root cause analysis was conducted, and it was determined that the facility failed to meet with Resident Council to explain that HS snacks are offered and available each night between dinner and breakfast and to gain their acknowledgement and approval. The Nursing Home Administrator and the Activities Director will meet with Resident Council members and document in the minutes. 4. The Director of Nursing/designee will audit five random residents treatment administration records to ensure that HS snacks are offered and documented on. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 809	Continued From page 55 (ARD) of 01/29/25 and located in the electronic medical record (EMR) under the "MDS" tab revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated the resident was cognitively intact. 2. Review of R58's quarterly "MDS" with an ARD of 01/09/25 and located in the EMR under the "MDS" tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. 3. Review of R34's quarterly "MDS" with an ARD of 01/09/25 and located in the EMR under the "MDS" tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. 4. Review of R143's admission "MDS" with an ARD of 02/03/25 and located in the EMR under the "MDS" tab revealed the facility assessed the resident to have a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. 5. Review of R19's quarterly "MDS" with an ARD of 01/30/25 and located in the EMR under the "MDS" tab revealed the facility assessed the resident to have a BIMS score of 11 out of 15 which indicated the resident was moderately cognitively impaired. 6. Review of R36's quarterly "MDS" with an ARD of 02/12/25 and located in the EMR under the "MDS" tab revealed the facility assessed the resident to have a BIMS score of 14 out of 15	F 809		

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	085054	A. BUILDING _____ B. WING _____	C 04/18/2025

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F 809	Continued From page 56 which indicated the resident was cognitively intact. During an interview on 04/14/25 at 9:34 AM, the Dietary Manager (DM) stated mealtimes were 8:00 AM for breakfast, 12:00 PM for lunch, and 5:00 PM for dinner. During an interview on 04/15/25 at 8:26 AM, the DM stated she was invited to and attended resident council meetings, adding she had been employed for approximately five months in her position as DM. The DM stated she was not aware of the 15-hour gap, and it had not been brought up in resident council when she had attended. During an interview on 04/17/25 at 4:57 PM, Registered Dietician (RD) 2 stated the time span between dinner and breakfast the next day should be 14 hours or less, unless the resident council approved of a longer period. During an interview on 04/18/25 at 9:46 AM, Activity Aide (AA) 1 stated she had been employed about a year and a half and attended the resident council meetings. She stated she did not remember any conversation about a gap of more than 14 hours between dinner and breakfast or the gap being discussed and/or approved of by the resident council. AA1 stated there were complaints about the consistency of mealtimes; however, the AA did not indicate if she acted on these complaints. During an interview on 04/18/25 at 9:53 AM, the DM stated she had not calculated the gap between dinner and breakfast, but confirmed it was 15 hours. She stated she was aware of the	F 809		

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F 809	Continued From page 57 requirement for no more than 14 hours between dinner and breakfast. The DM stated the current mealtimes had been in place when she started in her position. The DM confirmed that a discussion with the resident council to approve the 15-hour gap had not occurred since she had been in her position. During an interview on 04/18/25 at 12:47 PM, the Administrator stated she was not aware the facility's planned mealtimes exceeded the 14-hour requirement from dinner to breakfast the next day. The Administrator stated she was not aware of the requirement that a time span of over 14 hours from dinner to breakfast required both an approval from the resident council and a substantial evening snack be provided.	F 809		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		6/2/25

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F 812	Continued From page 58 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to ensure the kitchen was maintained in a sanitary manner. Specifically, the dish room was in a state of disrepair, the floors lacked regular cleaning, dishware was not clean, there was no garbage can in the handwashing sink area that prevented contamination of one's hands, wiping rag sanitizer solutions were not at the proper concentration, and food was not properly labeled. These failures placed 118 out of 158 residents (40 residents received nutrition via tube feedings) at risk for foodborne illness. Findings include: Review of the facility's policy titled, "Storage of Food and Supply," dated 01/03/25 revealed, "Food storage areas shall be maintained in a clean, safe, and sanitary manner ...Prepared foods with potentially hazardous ingredients must be labeled with a 'use-by date' not to exceed (3) days if held below 41 degrees F [Fahrenheit] ...This standard also applies to containers of commercially processed foods once opened. Such food will be tightly sealed with plastic wrap, foil or a lid and labeled ..." Review of the facility's policy titled, "Handwashing Hygiene for Food Handlers" dated 01/03/25 revealed, "Food service personnel shall wash hands: ...As often as required to remove soil and contamination; After working with unclean equipment, work surfaces, clothing, wash cloths, etc ..."	F 812	1. The residents who were cited were not negatively impacted by this deficient practice. 2. All residents who reside in the facility have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A thorough inspection of the kitchen was conducted, and it was determined that extensive repairs are necessary as well as a detailed cleaning. a. Trash can, by the handwashing sink, was replaced with foot pedal to open the lid. b. A contractor was identified and a work quote/order signed, to commence work after hours to repair walls and floors. c. The floor in the kitchen was power washed immediately and a weekly power washing schedule implemented. d. Back splash handwashing sink repaired by Maintenance Director. e. Hole in wall in food cart storage area will be repaired by contractor at the same time the wall and floor work in completed in the dishwasher area. f. All kitchen staff to be educated by the Food Service Director about proper cleaning solutions and appropriate concentration. g. All kitchen staff are to be educated by the Food Service Director to label and date food accordingly and to discard after 3 days.	

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F 812	Continued From page 59 1. During the initial kitchen observation on 04/14/25 from 9:34 AM to 10:22 AM, the following observations were made with the Dietary Manager (DM): a. Observation at the handwashing sink revealed there was no garbage can in the area in which paper towels from handwashing could be disposed of without contaminating one's hands by removing the soiled garbage can lid of a 55-gallon garbage can. b. The dish washing room was observed with deteriorating tile where the tile back splash met the tile floor. This extended the length of the wall beneath where the dish machine and counters were located. Several of the tiles were broken or partially affixed to the wall. There was an area several feet in length and approximately a foot wide where a covering was taped over a hole in the wall/tile. The tape was peeling off and the area was not sealed. There was a significant amount of food scraps/particles on the floor in this area, which was located below the dirty side of the counter and dishwasher. The DM confirmed these observations. c. The flooring surrounding a floor drain behind the fryer, ovens, and steamer was covered with a thick congealed layer of grease and numerous food particles/spills, and there was a black substance extending about a foot in each direction from the floor drains. There was also a large pool of congealed grease on the floor located below the grill. The DM verified the floor was dirty and needed to be cleaned. She stated the dietary staff power washed the floor on a weekly basis.	F 812	h. All kitchen staff to be educated by the Food Service Director on clean and dirty areas of the dish room and to place/store dishes accordingly. i. All kitchen staff are to be educated by the Food Service Director to label and date food accordingly and to discard after 3 days. 4. The Food Service Director/designee will audit cleaning solutions and concentrations to ensure proper concentrations, food storage to ensure they are labeled and dated and discarded after 3 days, and the clean and dirty areas of the dish room to ensure dishes are placed accordingly. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings. 1. The residents who were cited were not negatively impacted by this deficient practice. 2. All residents who reside in the facility	

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F 812	Continued From page 60 d. On the wall beneath the handwashing sink, the back splash was coming away from the wall. e. In the food cart storage area adjacent to the kitchen, there was a large hole in the sheet rock, approximately three feet by four inches above the tile trim. d. Two buckets of wiping rag sanitizer solution, which were set up and in use, were tested by the DM for concentration of sanitizer. Both buckets read zero parts per million (PPM) of lactic acid concentration. The DM stated the product was called "Sink and Surface Cleaner" and review of the label for the test strips and confirmation by the DM revealed the concentration should be between 272 - 700 PPM. The DM disposed of the buckets with the solutions stating the buckets did not have any sanitizer. The DM verified the solutions were used to wipe up spills and to clean kitchen surfaces. e. There were two steamtable pans with leftovers in the walk-in refrigerator. The first pan was labeled "Potato" with "Friday" documented. The second pan was labeled "Chili" with "Wednesday" documented. It was unclear which Friday and Wednesday applied and the DM stated it had been more than three days for the pan of chili with "Wednesday" so it should be discarded. f. There were three plastic cereal/soup bowls stored on a tray as clean that were soiled with food residue/particles adhered to the inside surface of the bowls. The DM verified the bowls were not clean and she removed them, placing them on the dirty side of the dish counter to be washed.	F 812	have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A thorough inspection of the kitchen was conducted, and it was determined that extensive repairs are necessary as well as a detailed cleaning. a. Trash can, by the handwashing sink, was replaced with foot pedal to open the lid. b. All kitchen staff to be educated by the Food Service Director on clean and dirty areas of the dish room and to place/store dishes accordingly. c. A contractor was identified and a work quote/order signed, to commence work after hours to repair walls and floors. 4. The Food Service Director/designee will audit the clean and dirty areas of the dish room to ensure dishes are placed accordingly. The audit process will be conducted three times weekly until compliance is consistently reached 100% of the time during three consecutive audits. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 812	Continued From page 61 g. There were two pans of sliced meat, one ham and one chicken, in the cook's reach in refrigerator. Neither had a label with the name of the food or date. The DM stated they should be labeled. 2. A follow-up observation was made on 04/15/25 at 10:43 AM. The following concerns were noted: a. Observation at the handwashing sink revealed there was no garbage can in the area in which used paper towels from handwashing could be disposed of without soiling one's hands by removing the soiled garbage can lid of a 55-gallon garbage can. The DM stated they used to have a garbage can located by the handwashing sink that was foot operated and could be operated without soiling one's hands, but she did not know where it was. The DM verified one's hands were potentially contaminated by removing the garbage can lid with clean hands. The garbage cans lid was visibly soiled with food residue. b. There was a plastic cereal/soup bowl stored as clean that had large food pieces adhered to the inside surface. The DM verified it was not clean and removed it. c. The areas noted on 04/14/25 in need of repair (floor, tiles, walls) remained in the same condition as noted during the initial inspection. 3. During an interview on 04/15/25 08:26 AM the DM stated she had been in her position for about five months. She stated she had been focusing on decluttering and cleaning and getting work orders for repairs. The DM indicated the dish room had been in disrepair for a while.	F 812	1. The residents who were cited were not negatively impacted by this deficient practice. 2. All residents who reside in the facility have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by measures outlined in section 3. 3. A thorough inspection of the kitchen was conducted, and it was determined that extensive repairs are necessary as well as a detailed cleaning. The Food Service Director will educate all kitchen staff on their cleaning tasks and assignments each day. A daily sign-off sheet system will be implemented to ensure accountability of completion. 4. The Food Service Director/designee will conduct kitchen sanitation audits daily Monday through Friday to ensure the kitchen is in compliance 100% for three consecutive weeks. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 812	Continued From page 62 During an interview on 04/17/25 at 5:22 PM, the Maintenance Director (MD) verified the kitchen was not kept clean enough. The MD stated he had been in his position about five months and was not sure how long the kitchen dish room had needed repair of the tile, flooring, and walls. He stated they were waiting for an additional estimate for repair. During an interview on 04/18/25 at 9:53 AM, the DM stated there were cleaning assignments for staff; however, there were no sign off sheets to show the work was completed. She stated the assignments were built into the position assignments. The DM stated the kitchen did not have a power washer for the floors and staff had to borrow one from maintenance. During an interview on 04/18/25 at 4:45 PM, the MD stated he observed the floor in the kitchen on 04/14/25 was soiled with built up food.	F 812		
F 925 SS=E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the pest control contract, pest control service records, and work orders, the facility failed to ensure the kitchen and adjacent cart storage area were free from pests including fruit flies and ants. The facility failed to keep the kitchen clean and to make needed repairs to deter pests as recommended by their pest control provider. This	F 925	1. The residents who were cited were not negatively impacted by this deficient practice. 2. All residents who reside in the facility have the potential to be impacted by this deficient practice. Further residents will be protected from this deficient practice by	6/2/25

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F 925	Continued From page 63 created the potential for the harborage of insects and vermin. Findings include: 1. During the initial kitchen observation on 04/14/25 from 9:34 AM to 10:22 AM, the following observations were made with the Dietary Manager (DM): a. The dish washing room was observed with deteriorating tile where the tile back splash met the tile floor. This extended the length of the wall beneath where the dish machine and counters were located. Several of the tiles were broken or partially affixed to the wall. There was an area several feet in length and approximately a foot wide where a covering was taped over a hole in the wall/tile. The tape was peeling off; the area was not sealed. There was a significant amount of food scraps/food particles on the floor in this area, which was located below the dirty side of the counter and dishwasher. There were approximately 15 small black flying insects flying around the dish machine. The DM observed and identified the insects as "fruit flies." There were a couple of ants crawling on the floor in the same area. The DM confirmed these observations. b. There were approximately ten fruit flies observed flying around in the janitor closet and surrounding area confirmed by the DM. c. There were a few fruit flies observed flying around in the cook's preparation area confirmed by the DM. d. The flooring surrounding a floor drain and the floor drain, behind the fryer, ovens, and steamer,	F 925	measures outlined in section 3. 3. A thorough inspection of the kitchen was conducted, and it was determined that extensive repairs are necessary as well as a detailed cleaning. It was also identified that more effective pest control management needs to be implemented to manage pest control. The primary source of fruit flies was determined to be the floor drain as well as the sanitation. A contractor has been retained to complete the necessary repairs on the walls and floor and Eco labs will be contracted to provide drain treatments to remedy the fruit flies (and will continue pest management monthly and as needed). A plan is in place to complete a detailed/thorough cleaning of the kitchen upon completion of the construction/repairs. The Food Service Director will educate all kitchen staff on their cleaning tasks and assignments each day. A daily sign-off sheet system will be implemented to ensure accountability of completion. 4. The Food Service Director/designee will conduct kitchen sanitation audits daily Monday through Friday to ensure the kitchen is in compliance 100% for three consecutive weeks. This will be followed by audits performed once a week until compliance is consistently achieved over three consecutive weeks. Finally, a monthly audit will be conducted to determine on-going compliance. If compliance is not achieved, reassessment of ongoing issues and	

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F 925	Continued From page 64 was covered with a thick congealed layer of grease and numerous food particles/spills, and there was a black substance extending about a foot in each direction from the floor drains. The DM verified the floor was dirty and needed to be cleaned. There were several fruit flies flying around in this area. e. In the food cart storage area adjacent to the kitchen, there was a large hole in the sheet rock, approximately three feet by four inches above the tile trim. The DM stated the facility planned to repair all the areas identified on the inspection. 2. Review of the "Pest Management Maintenance Agreement" dated 12/16/24 and provided by the facility, revealed that food residue on and under the kitchen equipment should be cleaned on a more consistent basis. The "Pest Management Maintenance Agreement" read, "Small fly and large fly issues primarily in the kitchen area...Fly control programs are greatly enhanced when proper cleaning is performed frequently and consistently." 3. Review of the pest control "Summary of Service" records provided by the facility revealed: a. The "Summary of Service" dated 01/21/25 revealed, "Kitchen - Cracks or damage to floor allowing pest access. Please repair to prevent pest entry ... Treated the kitchen for flies ..." b. The "Summary of Service" dated 02/11/25 revealed, "Kitchen - Grease build-up noted in drain. Please clean drain to prevent unsanitary conditions and attraction by pests ...Kitchen - Cracks or damage to floor allowing pest access. Please repair to prevent pest entry ...I found one	F 925	corrective action will be taken. If compliance is achieved, corrective measures will be noted as successful. All results will be brought through the QAPI meetings.	

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F 925	Continued From page 65 drain with heavy food debris on it and around it ..." c. The "Summary of Service" dated 02/25/25 revealed, "Kitchen - Employee sanitation practices need improvement ... Kitchen - Grease build-up noted in drain. Please clean drain to prevent unsanitary conditions and attraction by pests ...Cracks or damage to floor allowing pest access. Please repair to prevent pest entry." d. The "Summary of Service" dated 03/11/25 revealed, "Kitchen - Employee sanitation practices need improvement ...Grease build up noted in drain. Please clean drain to prevent unsanitary conditions and attraction by pests ...Cracks or damage to floor allowing pest access. Please repair to prevent pest entry ...The table that stores the onions and potatoes has quite a lot of activity. I highly recommend storing onions and potatoes in clear plastic containers with closed lids. Fruit flies can transmit bacteria such as E coli, salmonella, and listeria. Fruit flies transmit such diseases thru [sic] coming in contact with food or clean surfaces. Fruit flies tend to lay eggs on food." e. The "Summary of Service" dated 03/25/25 revealed, "Kitchen - Employee sanitation practices need improvement ...There is still drain fly activity. I found some food debris left in the sinks in the dishwasher room ...Food debris on the floor under kitchen equipment ...containing onions and potatoes in bins with lids as the drain flies are drawn to them. The kitchen dustpans are in need of a good scrubbing ... Accumulation of food product from damaged goods noted ...Employee sanitation practices need improvement ...Grease build up noted in drain	F 925		

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F 925	Continued From page 66 ...Cracks or damage to floor that allows pest access ..." f. The "Summary of Service" dated 04/08/25 revealed, "Kitchen - Employee sanitation practices need improvement ...An accumulation of food product from damaged good noted ...Cracks or damage to floor allowing pest access ...Sanitation continues to be an issue. Potatoes and onions are still in containers without lids. They really need to have lids. The kitchen had food all over the floor. The drains need to be cleaned more often ..." 4. Review of a "Work Order" created by the DM on 03/19/25 and provided by the facility revealed a request for repair of a "large hole in back hallway by door across from cook's entrance where wall and flooring meet." The "Work Order" was coded as being in progress. It had not been completed. Review of a "Work Order" created by the DM on 03/19/25 and provided by the facility revealed, "loose tiles along wall and under dish machine, walls are not sturdy and have openings where the wall and flooring meet." The "Work Order" was documented as being in progress. It had not been completed. 5. During an interview on 04/15/25 at 10:43 AM, the Maintenance Director (MD) stated he had been in his position since mid-December. He stated he was not sure how long the dish room and adjacent areas had been in disrepair. The MD stated the covering taped on the wall under the dish machine was there to cover holes in the wall. The MD stated he was waiting for a second estimate for the repairs and had one bid so far,	F 925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085054	A. BUILDING _____ B. WING _____	C 04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 925	Continued From page 67 but it did not cover everything. The MD stated he was waiting for an additional bid before a decision was made regarding the repairs. The DM stated there were a lot of fruit flies in the kitchen on 04/14/25 and it needed better cleaning. During an interview on 04/17/25 at 5:22 PM, the MD stated he was aware of the pest control provider's recommendations for the kitchen to be repaired and cleaned more thoroughly. The DM stated the ants, and the fruit flies were a result of the kitchen not being clean. During an interview on 04/18/25 at 9:53 AM, the DM stated none of the pest control service provider's recommendations regarding improving cleanliness in the kitchen had been shared with her by the pest control provider or by maintenance staff. The DM stated she was not aware of ongoing kitchen recommendations made by the pest control provider. During an interview on 04/18/25 at 11:52 AM, the District Manager of Housekeeping stated food was an attraction for ants and it was important to keep the entrance and areas clean. During an interview on 04/18/25 at 12:47 PM, the Administrator stated they had a quote for the kitchen repairs; however, she was not sure what the current status of getting the repairs was.	F 925		