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: Bay Terrace Rehab and Healthcare Center **DATE SURVEY COMPLETED:** February 19, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Annual and Complaint Survey was conducted at this facility from February 11, 2025, through February 19, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was seventy-six. The investigative sample totaled eighteen residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed February 19, 2025: E0006, F550, F568, F583, F623, F644, F655, F656, F657, F677, F684, F688, F690, F695, F697, F756, F758, F791, and F812.		

Provider's Signature Diane M Stadel Title Administrator Date 3/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085019	A. BUILDING _____ B. WING _____	C 02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAY TERRACE REHABILITATION AND HEALTH CENTER	889 SOUTH LITTLE CREEK ROAD DOVER, DE 19901

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced emergency preparedness survey was conducted at this facility from February 11, 2025 through February 19, 2025. The facility census was 76 on the first day of the survey. In accordance with 42 CFR 483.73, an Emergency Preparedness survey was also conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility during the same time period. Based on observations, interviews, and document review, Emergency Preparedness deficiencies were identified.	E 000		
E 006 SS=E	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) §403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment.	E 006		4/10/25

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

Electronically Signed | 03/14/2025

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

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E 006	Continued From page 1 * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients.	E 006		

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E 006	Continued From page 2 (2) Include strategies for addressing emergency events identified by the risk assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, it was determined that the facility failed to ensure the Emergency Preparedness Plan was updated utilizing a community-based and facility-based all hazards approach risk assessment that included missing residents as a potential hazard. 2/19/25 10:43 AM - A review of facility documents revealed that the facility's Emergency Operations Plan Appendix 3 Hazard Vulnerability Analysis, Section 2.0 labeled Facility specific hazards, only listed Tornados, Winter Storm, Coastal Storm, Pandemic, and Hazardous Materials Release as potential concerns. Missing residents were not addressed in the facility's Emergency Operations Plan. 2/19/25 11:29 AM - The facility provided a policy that addressed elopments and wandering residents, but it was separate from the facility's Emergency Operations Plan. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA), and E2 (DON).	E 006	A. Deficiency cannot be retroactively corrected. B. There is a facility policy and procedure in place which addresses the potential hazard of a missing resident, however it was not included in the Emergency Preparedness Plan. No residents were potentially affected by this deficient practice, as policy and procedure addresses needed strategies for a missing resident. C. The root cause was that the NHA/safety committee members did not realize that "missing residents" needs to be included in the Emergency Preparedness Plan. All Safety Committee members will be educated on this regulation. D. The Emergency Preparedness Plan will be updated to include facility-based all hazards approach risk assessment to include missing residents as a potential hazard and needed strategies for addressing emergency events identified.	
F 000	INITIAL COMMENTS An unannounced annual and complaint Survey was conducted at this facility from February 11, 2025 through February 19, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical	F 000		

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F 000	Continued From page 3	F 000		

records and other facility documentation as indicated. The facility census on the first day of the survey was seventy-six. The investigative sample totaled eighteen residents.

Abbreviations/definitions used in this report are as follows:

ADON - Assistant Director of Nursing;
BOM - Business Office Manager;
CNA - Certified Nurse's Aide;
DON - Director of Nursing;
FSS - Food Services Supervisor;
LPN - Licensed Practical Nurse;
NP - Nurse Practitioner;
RCC - Regional Clinical Consultant;
RN - Registered Nurse;
SW - Social worker;

Alzheimer's Disease - degenerative disorder that attacks the brain's nerve cells resulting in loss of memory, thinking and language;
Anti-anxiety Medication - medication used to treat any of several disorders that cause nervousness, fear, apprehension and worrying;
Antibiotic - medication used to treat bacterial infections;
Arterial duplex scan - a painless exam that uses high-frequency sound waves (ultrasound) to capture internal images of the major arteries in the arms, legs and neck;
BIMS - (Brief Interview for Mental Status) - assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best;
Braden Scale - tool used to determine risk for development of pressure ulcers;
chorea - a neurological disorder characterized by involuntary, brief, and irregular movements;

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F 000	Continued From page 4 Cognitively Impaired - abnormal mental processes; thinking OR mental decline including losing the ability to understand, the ability to talk or write, resulting in the inability to live independently Cognitively Intact - able to make own decisions Debridement - removal of necrotic (dead) tissues so that healthy tissue can regenerate OR surgical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue OR the process of removing nonliving tissue from pressure ulcers Deep Tissue Injury (DTI) - Purple or maroon localized area of discolored intact skin. May be preceded by tissue that is painful, mushy, firm, boggy (wet, spongy feeling), warmer or cooler than adjacent tissue; Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation OR loss of mental functions such as memory and reasoning that is severe enough to interfere with a person's daily functioning Diabetes mellitus: More commonly referred to as "diabetes" -- a chronic disease associated with abnormally high levels of the sugar glucose in the blood EMR - (Electronic Medical Record) - a systematized collection of patient and population electronically stored health information in a digital format. Eschar - dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed OR dead tissue forming a hard scab; usually black in color Frequently Incontinent - 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period Incontinence - loss of control of bladder &/or	F 000		

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F 000	Continued From page 5	F 000		

bowel function
Kardex - instructions for care provided to the residents by the CNA;
MDS assessment- federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs;
MG/DL - Milligrams per deciliter, a unit of measure that shows the concentration of a substance in a specific amount of fluid
Moderate cognitive impairment - decisions poor; cues and supervision required;
Nasal cannula - a tube placed into the nostrils to deliver oxygen;
Necrosis / Necrotic - tissue death, usually due to interruption of blood supply or injury OR dead; non-viable tissue
Non-Alzheimer's Dementia- Dementia from another cause other than Alzheimer's, such as vascular or brain damage caused by multiple strokes;
Offloading - removal of pressure from an area;
Oxycodone - an opioid pain medication sometimes called a narcotic; used to treat moderate to severe pain;
Pain Scale - 1-10. The most common scale for pain. The patient to identify their pain between one to ten, with ten being the worst pain imaginable and one being no pain at all;
Pixus - System for storage of emergency stock and back up medications.
Pressure Ulcer (PU) - sore area of skin that develops when the blood supply to it is cut off due to pressure;
ROM - Range of motion - exercises to asssit with movement.
Scheduled (or timed) toileting program - fixed time interval toileting assistance for resident's

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F 000	Continued From page 6 with urinary incontinence; Serosanguineous - drainage containing serum and blood; Skin prep - a liquid film-forming dressing that, upon application to intact skin, forms a protective film; SpO2 or oxygen saturation - a measurement of the percentage of oxygen in the blood; TAR - Treatment Administration Record; Unit - a type of measurement; Unstageable - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed).	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and	F 550		4/10/25

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F 550	Continued From page 7 practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for two (R43 and R63) out of eighteen (18) residents in the investigative sample, the facility failed to ensure residents were treated with respect and dignity. Findings include: 1. Review of R43's clinical record revealed: 4/8/24 - R43 was admitted to the facility. 4/12/24 - An admission MDS documented R43 as cognitively intact with a BIMS score of 14. 2/11/25 10:31 AM - An observation of E20 (LPN) entering R43's room revealed that staff did not knock or request to enter.	F 550	A. Deficiency cannot be retroactively corrected for R43 and R63. E20 and E12 will be educated regarding knocking before entering the room. B. All active residents could be potentially affected. All Nursing staff will be educated regarding knocking before entering residents' rooms. C. The root cause was determined to be due to lack of understanding of the importance of knocking before entering to respect resident□s rights	

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F 550	Continued From page 8 2/13/25 11:01 AM - An observation of E12 (CNA) entering R43's room revealed that staff did not knock or request to enter. 2/13/25 11:10 AM - An interview with E12 confirmed that she entered R43's room without knocking or requesting to enter. 2. Review of R63's clinical record revealed: 9/23/24 - R63 was admitted to the facility. 9/27/24 - An admission MDS documented R63 as cognitively intact with a BIMS score of 15. 2/11/25 10:24 AM - An observation of E20 (LPN) entering R63's room revealed that staff did not knock or request to enter. 2/11/25 10:27 AM - An interview with E20 confirmed that she entered R63's room and did not knock or request to enter. 2/13/25 11:10 AM - An interview with E12 confirmed that she entered R43's room without knocking or requesting to enter. The facility failed to ensure that R43 and R63 were treated with respect and dignity. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA), and E2 (DON).	F 550	Staff Development/Designee will re-educate all nursing staff on the importance of knocking before entering the resident's room. D. Daily audit by ADON/Designee will be conducted to ensure staff are knocking before entering rooms x 5 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	
F 568 SS=D	Accounting and Records of Personal Funds CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a	F 568		4/10/25

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F 568	Continued From page 9 system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R43) out of one resident reviewed for personal funds, the facility failed to ensure that the resident received their quarterly personal funds statement. Findings include: The facility policy entitled; "Transactions Involving Residents Funds" last updated November 2024 indicated, "Quarterly statements will be provided in writing to the resident or the resident's representative, at the end of the quarter and upon request." Review of R43's clinical record revealed: 4/8/24 - R43 was admitted to facility. 12/30/24 - A quarterly MDS assessment documented that R43 was cognitively intact. 6/24/24 - 9/30/24 - A review of R43's electronic record revealed that the quarterly statement was not provided. 2/11/25 10:34 AM - During an interview, R43 reported the facility manages R43's money and	F 568	A. R43 was provided with a copy of their quarterly statements. B. BOM mailed or hand-delivered copies of quarterly statements to all active residents in house with a Resident Trust account. C. Root Cause was that Business Manager had no tracking system to account for quarterly statements being provided. NHA or designee will provide education to the BOM regarding the resident rights to receive quarterly statements and the need to have tracking system. Residents will be educated via Resident Council on their right to receive a statement of their Resident trust account quarterly or upon request. D. The BOM will audit all resident trust account statements at the end of each quarter and compare the list of residents who have a trust account. The NHA will reconcile the statements delivered via mail or in person to current accounts	

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F 568	Continued From page 10 the resident has not received quarterly statements. 2/18/25 9:12 AM - During an interview E1 (NHA) confirmed R43 did not receive quarterly statements. 2/18/25 9:14 AM - During an interview E10 (Business Office Manager) confirmed R43 was not provided with quarterly statements. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1 and E2 (DON).	F 568	managed by the facility to assure 100% compliance. A random audit of ten residents will be conducted by NHA or designee to validate that they did receive their quarterly statement and are aware that that can request statements on a PRN basis as well. Audit will be done after quarter ending 3/31/25 and then quarterly x2 to assure 100% compliance is maintained. Results will be reviewed at QA meeting.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		4/10/25

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F 583	Continued From page 11 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview,it was determined that for one (R43) out of eighteen sampled residents, the facility failed to protect personal privacy. Findings include: Review of R43's clinical record revealed: 4/8/24 - R43 was admitted to the facility. 4/12/24 - An admission MDS documented R43 as cognitively intact with a BIMS score of 14. 2/11/25 10:33 AM - An interview with R43 revealed that R43 felt she was unable to have a private phone call in the facility due to not having a phone available to use in her room. R43 stated when she makes phone calls she uses the phone in the facility lobby. R43 stated that when she asked the facility advised her she could get a cell phone for personal use. 2/17/25 1:26 PM - An interview with E22 (Corporate Maintenance) confirmed that all resident rooms currently do not have phone access and the facility is running the phone lines today so the residents will have personal phones	F 583	A. Resident (R43) was informed immediately of the location of the cordless phone and that it is available to all residents to use for private phone calls. B. All residents were notified that a cordless telephone was available for private conversations. C. Root Cause was lack of awareness by staff and residents of cordless phones location and availability to residents for personal phone calls. Staff and residents will be informed via signage. D. The activities/guest services staff or designee will conduct random resident interviews of availability of communication devices weekly x4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. Results will be reviewed at the QA Committee to maintain and sustain compliance.	

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F 583	Continued From page 12 available to use in each room. 2/17/25 01:45 PM - An interview with E2 (DON) revealed that the facility has portable phones available for use that the residents can take back to the rooms and utilize. E2 also stated that the nursing supervisor has a phone that family members are given the number to call. 2/18/25 2:43 PM - An interview with R43 revealed that R43 was unaware of a portable phone to use for personal calls and staff had not offered the use of it to maintain privacy. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA) and E2 (DON).	F 583		
F 623 SS=D	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	F 623		4/10/25

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F 623	Continued From page 13 (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 (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;	F 623		

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F 623	Continued From page 14 (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. 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 record review and interview, it was determined that for one (R60) out of two residents reviewed for hospitalization the facility	F 623	A. R60 was added to the September 2024 log and log was resubmitted	

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F 623	Continued From page 15 failed to notify the Ombudsman of the residents transfer to the hospital. Findings include: The facility policy on Transfer and Discharge last updated September 2024, indicated "Emergency Transfers/Discharges - The Social Services Director, or designee, will provide copies of the notices for emergency transfers to the Ombudsman, but the may be sent when practicable, such as in a list of residents on a monthly basis." Review of R60's clinical record revealed: 9/17/24 - R60 was transferred from the facility to the hospital emergently. 2/17/25 1:36 PM - E1 (NHA) provided the September 2024 Ombudsman Notification List of residents transferred out of the facility. A review of the list lacked evidence of notice of R60's transfer. 2/17/25 1:35 PM - E1 confirmed the findings. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1 and E2 (DON).	F 623	B. Last one months of transfer logs have been reviewed for discrepancies. Logs have been updated and resubmitted as necessary to Ombudsman. C. Root Cause was no audit process established to cross check the information of transfers with log submitted to Ombudsman. Education will be conducted to Admissions/ Licensed Nursing and Social service staff to assure understanding of requirements of monthly ombudsman reporting as it pertains to F623. D. A monthly log will be updated with daily transfers and Business Manager, or designee will audit weekly X4 then monthly x3 to assure ongoing compliance. NHA or designee will audit log submission monthly x3 to assure compliance. Results will be reviewed at the QA Committee to maintain and sustain compliance.	
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		4/10/25

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F 644	Continued From page 16 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for two (R19 and R31) out of three residents reviewed for PASARR, the facility failed to ensure that a referral for PASARR screening was completed. Findings include: 1. Review of R19's clinical record revealed: 3/7/18 - R19 was admitted to the facility with the diagnoses including non-Alzheimer's dementia. 4/16/18 - A PASARR level I was submitted to the state PASARR authority and had no evidence of any serious mental illness noted. 12/23/24 - A quarterly MDS assessment documented that R19 had the following diagnoses: non Alzheimer's dementia and psychotic disorder. 2/17/25 3:21 PM - A phone interview with E23 (SW) confirmed that a PASARR update had not been submitted since March of 2021. E23 also confirmed that the PASARR system had an issue with the system having previous employee information in system and resulting in the facility	F 644	A. The PASRR has been updated and submitted for R 19 and R 31 B. An audit of residents in-house with newly identified mental health disorder in the last 30 days will be conducted to confirm that the a referral for PASRR was submitted C. Root Cause determined lack of understanding of the need of a referral for PASRR screening for newly identified mental health condition. Education will be provided to DSS to ensure understanding of regulation. D. SSD or designee will conduct random audits weekly x4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% achieved and sustained. Audit findings will be reported to QA committee monthly x 3 months.	

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F 644	Continued From page 17 being unable to submit updates. 2. Review of R31's clinical record revealed: 2/13/19 - R31 was admitted to the facility with diagnoses including psychotic disorder with behavioral disturbances and altered mental status. 4/21/21 - A review of R31's diagnoses list revealed a new diagnosis of major depressive disorder and delusional disorder were added. 9/16/21 - A psychology progress note documented that R19 had the following new diagnoses: mood disorder and delusional disorder. 10/1/22 - A review of R31's diagnoses list revealed a new diagnosis of unspecified dementia with other behavioral disturbances. 1/7/25 - A quarterly MDS assessment documented R19 had a diagnoses of a psychotic disorder, depression, mood disorder, and non Alzheimer's dementia. 2/17/25 3:21 PM - A phone interview with E23 (SW) confirmed that a PASARR update had not been submitted since March of 2021. E23 also confirmed that the PASARR system had an issue with the system having previous employee information in system and resulting in the facility being unable to submit updates. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA) and E2 (DON).	F 644		
F 655 SS=D	Baseline Care Plan	F 655		4/10/25

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F 655	Continued From page 18 CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and	F 655		

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F 655	Continued From page 19 dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R69) out of one reviewed for new admission, the facility failed to ensure that a baseline care plan was completed. Findings include: Record review for R69 revealed: 11/29/24 - R69 was admitted to the facility. 12/4/24 - A review of R69's clinical record revealed a lack of evidence of a baseline care plan. 2/17/25 12:57 PM - E1 (NHA) confirmed that there was no evidence that R69 had a base line care plan developed and that a summary of the plan was provided to the resident/ resident representative. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1and E2 (DON).	F 655	A. R69 has been provided a copy of baseline care plan and was invited to attend care conference with the IDT team. B. New admissions from the last 7 days will be reviewed to ensure the baseline care plan was reviewed with appropriate parties and signature sheet completed as indicated. C. The root cause was determined to be due to lack of understanding by the IDT team on expectations during baseline care plan reviews. Regional Operational Support Consultant/ Staff Development/Designee will in-service IDT team on expectations related to baseline care plan summaries with appropriate parties. D. Daily in morning meeting, baseline care plan UDA will be reviewed to ensure appropriate documentation is in place. Daily audit by NHA/Designee to ensure proof of documentation of baseline care plan discussion of new admissions is in place x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit until a 100% compliance is achieved x4, then monthly x	

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F 655	Continued From page 20	F 655	3 months with a goal of 100% compliance. Audit findings will be reported to QA committee monthly x 3 months.	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		4/10/25

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F 656	Continued From page 21 future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that for one (R63) out of eighteen residents in the investigative sample the facility failed to develop and implement a comprehensive resident centered care plan for an identified care area. Findings include: Cross refer F690 Review of R63's clinical record revealed: 9/23/24 - R63 was admitted to the facility. 9/23/24 - A care plan (last updated 1/6/25) was initiated for R63 and documented R63 had a self care defecit related to limited mobility with interventions including R63 was completely dependent on staff for toileting use and to encourage R63 to participate to the fullest extent possible with care. 9/27/24 - An admission MDS assessment documented R63 was dependent on staff for toileting. The MDS also documented R63 was	F 656	A. Comprehensive Care plan for bladder incontinence has been initiated for R63. B. Active residents with change in bladder incontinence in the last 14 days will be reviewed to assure that a comprehensive plan of care was initiated. C. The root cause was determined to be due to lack of consistent oversight to ensure residents with bladder incontinence has an appropriate plan of care. D. Daily audit by ADON/Designee will be conducted to ensure new admissions and readmissions with bladder incontinence to assure an appropriate plan of care is in place x 5 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where	

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F 656	Continued From page 22 always incontinent of bowel and bladder and was not on a toileting program. 12/27/24 - A quaterly MDS assessment documented R63 was dependent on staff for toileting. The MDS also documented R63 was always incontinent of bowel and frequently incontinent bladder and was not on a toileting program. The facility failed to develop and implement a comprehensive resident centered care plan related to R63's incontinence. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA) and E2 (DON).	F 656	compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	
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	F 657		4/10/25

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F 657	Continued From page 23 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined for two (R22 and R63) out of eighteen residents in the investigative sample the facility failed to review and revise the care plan. Findings include: 1. Review of R22's clinical record revealed: 12/14/18 - R22 was admitted to the facility. 12/14/18 - A care plan documented that R22 had a self care deficit related to impaired mobility and cognitive defect with the following interventions: provide total assist with personal hygiene and dressing, provide a bed bath per RP (responsible party) and risk for falls in shower chair due to severe chorea. 2/19/25 10:30 AM - An interview with E3 (ADON) confirmed that R22 was unsafe to use shower chair or stretcher related to falls and that care plan was not updated to accurately reflect R22's current plan of care. 2. Review of R63's clinical record revealed: 9/23/24 - R63 was admitted to the facility. 9/25/24 - A care plan for R63 was initiated for	F 657	A. R22's care plan for self-care deficit related to showers was revised. R63's plan of care for pain was revised to include an acceptable level of pain and non-pharmacological interventions in the plan of care. B. Active residents care plan for self-care (showers) will be reviewed to ensure it accurately reflect current plan of care for the resident. Active residents' care plan for pain will be reviewed to reflect an acceptable level of pain and non-pharmacological interventions. C. The root cause was determined to be lack of consistent oversight in reviewing care plans appropriate for the resident. Staff Development/Designee will educate Licensed nursing staff, Social service/RNAC staff on the importance of updating the plan of care to reflect resident's self-care needs r/t showers and acceptable level of pain with non-pharmacological interventions. New admissions/Readmissions will be	

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F 657	Continued From page 24 pain related to chronic pain with the following interventions: administer analgesia per orders, monitor and document side effects from pain medication, monitor/record/report to nurse any signs and symptoms of pain to the nurse, and notify the physician if interventions are unsuccessful or if current complaint is a significant change from resident's experience of pain. 2/14/25 12:31 PM - An interview with E2 (DON) and E19 (Corporate) confirmed that R63's care plan lacked an acceptable level of pain and updated interventions related to non-pharmacological interventions. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA) and E2 (DON).	F 657	reviewed to determine acceptable level of pain and reflect in the residents plan of care. Daily audit by ADON/Designee will be conducted to ensure quarterly review of plan of care during comprehensive care plan meetings for self-care needs is current for the resident x 5 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. Daily audit by ADON/Designee will be conducted to ensure new admissions and readmissions acceptable level of pain is reflected in their plan of care x 5 days until 100% compliance is achieved and sustained. Following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for three (R19, R22 and R55) out of five residents reviewed for ADL's, the facility failed to ensure ADL care was provided to dependent residents. Findings include: 1. Review of R55's clinical record revealed: 1/2/25 - R55 was admitted to the facility with multiple diagnoses including legal blindness. 1/3/25 - A baseline care plan documented that R55 had visual impairment and needed substantial maximum assistance with hygiene. 1/9/25 - An admission MDS assessment documented that R55's vision was severely impaired, and that the resident required partial moderate assistance to complete hygiene related ADL's such as shaving. 2/11/25 9:08 AM - During an interview R55 stated, "I have a brand new razor and they have used it once. I can't see and need help to shave." R55 was observed with significant unkempt facial hair that he confirmed was not his preference. 2/14/25 10:48 AM - R55 was observed with unkempt facial hair. 2/14/25 1:11 PM - The surveyor accompanied	F 677	A. R55 was assisted with shaving. R19's and R22's hair was washed during showers. E28 was educated on assuring that ADL care is provided to residents B. Current male residents will be reviewed to assess the need for assistance with shaving. Dependent residents are potentially affected. Staff education will be completed to remind staff to provide ADL care which includes washing hair during showers. C. The root cause was determined to be due to lack of consistent oversight to ensure residents are assisted and shaved as needed. The root cause was determined to be due to lack of understanding related to shower completion includes washing of hair for dependent residents. Staff Development will re-educate staff regarding assistance and shaving residents as needed. Staff Development/Designee will	4/10/25

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F 677	Continued From page 26 E11 (CNA) to R55's room where R55 remained with unkempt facial hair. E11 confirmed that that she was aware of R55's visual impairment and did not offer to assist R55 with shaving/hygiene because "This is a rehab floor so I assume they can all do that themselves." February 2025 - Review of the CNA task completion documented that hygiene, which includes shaving, was documented as completed and was inconsistent with observation of R55's unkempt facial hair. 2. Review of R19's clinical record revealed: 3/7/18 - R19 was admitted to the facility. 3/7/18 - A care plan documented that R19 had a self care defect for related to impaired mobility and cognitive defect with the following interventions: provide total assist with with personal hygiene and dressing, provide tub bath/shower two times a week, and provide tub bath/ shower with total dependence. 12/27/24 - A quarterly assessment documented that R19 was dependent with one staff member for ADL's including showering and bathing. 1/2025 - A review of the January CNA documentation record revealed that R19 was receiving two showers a week on Sunday and Thursday. 2/2025 - A review of the February CNA documentation record revealed that R19 was receiving two showers a week on Sunday and Thursday.	F 677	re-educate nursing staff regarding shower completion which includes washing of hair for dependent residents. D. Daily audit by ADON/Designee will be conducted to ensure residents has no facial hair and hair is washed and clean x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	

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F 677	Continued From page 27 2/13/25 11:34 AM - An observation of R19 with uncombed, unmanaged, greasy hair. 2/14/25 1:50 PM - An observation of R19 with uncombed, unmanaged, greasy hair. 2/17/25 9:35 AM - An observation of R19 with uncombed, unmanaged, greasy hair. 2/18/25 9:54 AM - An observation of R19 with uncombed, unmanaged, greasy hair. 2/19/25 9:30 AM - An observation of R19 with uncombed, unmanaged, greasy hair. 2/19/25 9:50 AM - An interview with E28 (CNA) confirmed that R19's shower's were signed off and confirmed the R19's hair did not appear clean. E28 stated that typically the floor has limited staff and it is difficult to complete twelve residents per CNA, especially on shower days. E28 stated a CNA can be scheduled to come in and assist with showers but they have not been in since previous week. 2/19/25 10:30 AM - An interview with E3 (ADON) confirmed that a CNA responsible for showers was not present on unit today and will review acuity for the unit to see if they can get more staff to assist the unit. The facility failed to assist a dependent resident with ADL care. 3. Review of R22's clinical record revealed: 12/14/18 - R22 was admitted to the facility. 12/14/18 - A care plan documented that R22 had	F 677		

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F 677	Continued From page 28 a self care defect for related to impaired mobility and cognitive defect with the following interventions: provide total assist with with personal hygiene and dressing, provide a bed bath per RP (responsible party) and risk for falls in shower chair due to severe chorea. 1/3/25 - A CNA task for R19 was revised for bed baths on Tuesday's 3 to 11 and Friday's 7 to 3 and bed bath for all other days unless specified. 2/13/25 11:44 AM - An observation of R22 with uncombed, unmanaged, greasy hair. 2/14/25 1:40 PM - An observation of R22 with uncombed, unmanaged, greasy hair. 2/17/25 9:55 AM - An observation of R22 with uncombed, unmanaged, greasy hair. 2/18/25 10:07 AM - An observation of R22 with uncombed, unmanaged, greasy hair. 2/19/25 9:30 AM - An observation of R22 with uncombed, unmanaged, greasy hair. 2/19/25 9:50 AM - An interview with E28 (CNA) confirmed that R22's bath's were signed off and confirmed the R22's hair did not appear clean. E28 stated that typically the floor has limited staff and it is difficult to complete twelve residents per CNA, especially on shower days. E28 stated a CNA can be scheduled to come in and assist with showers but they have not been in since previous week. 2/19/25 10:30 AM - An interview with E3 (ADON) confirmed that a CNA responsible for showers was not present on unit today and will review	F 677		

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F 677	Continued From page 29 acuity for the unit to see if they can get more staff to assist the unit. The facility failed to assist a dependent resident with ADL care. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA), and E2 (DON).	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for two (R43 and R63) out of two residents reviewed for general care and services, the facility failed to ensure treatment and care in accordance with professional standards of practice and physician orders. Findings include: 1. Review of R43's clinical record revealed: 4/8/24 - R43 was admitted to the facility with diagnoses including but not limited to constipation. 12/30/24 - A quarterly MDS assessment documented that R43 has a diagnosis of constipation unspecified.	F 684	A. R43's bowel regimen protocol had been reviewed and revised. Resident had a bowel movement as per protocol. R63's wound treatment order was clarified and revised. E20 was educated on following prescribed physician orders for wound care B. Active resident's bowel protocol order will be reviewed and revised as per policy Licensed nursing Staff will be educated regarding the steps to complete when a verbal order is received. C. The root cause was determined to be	4/10/25

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F 684	Continued From page 30 1/2/25 - A review of physician's orders revealed the following orders: -Milk of Magnesia (MOM) give 30 mL every seventy two hours as needed for constipation if no bowel movement (BM) after three days. -Bisacodyl suppository 10 mg insert one suppository rectally as needed for constipation daily if no results from MOM. -Fleet enema insert one dose rectally every twenty four hours as needed if no BM in three days. 1/21/25 to 2/10/25 - Review of the CNA documentation sheet revealed that the facility failed to ensure that physician's orders were implemented when R43 failed to have bowel activity for nine (9) shifts on the following dates: - 2/10/25 ending on 7 AM to 3 PM shift - total of 12 shifts. 2/18/25 12:40 PM - An interview with E16 (LPN) revealed that the bowel protocol is initiated by the 7 AM to 3 PM shift after review of the facilities BM report and the supervisor will notify nurses who is on the list to have protocol initiated. 7 AM to 3 PM will document medication in the electronic medical record (EMR) and verbally notify the next shift regarding results of protocol. E16 confirmed that R43 had 12 shifts with no BM and protocol was initiated. 2. Review of R63's clinical record: 9/23/24 - R63 was admitted to the facility with the following diagnoses but not limited to venous insufficiency and local infection of the skin and subcutaneous tissue.	F 684	an oversight to ensure the facility bowel protocol is consistent with the physician's order. The root cause was determined to be due to the staff's lack of understanding of the importance of documenting a verbal order in a timely manner. D. Daily audit by ADON/Designee will be conducted to ensure bowel protocol is followed as per physician's order x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. Random Observation of wound care by ADON/Designee will be conducted to ensure physician order is followed daily x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance.	

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F 684	Continued From page 31 12/17/24 - A physician's order documented acetic acid irrigation solution use one application every day shift for open areas to R63's left lower leg: cleanse left lower leg with acetic acid and apply bacitracin and abdominal pad daily and as needed. Order was discontinued 1/20/25. 1/17/25 - A physician's order documented to R63's left leg dressing apply bacitracin (antibiotic ointment) then non-adherent dressing, wrap with ACE bandage. 2/11/25 - A physician's order documented to cleanse R63's left leg with soap and water then apply dermaseptin infused kling and wrap legs daily and as needed. 2/13/25 11:25 AM - An observation of wound care to R63's lower extremities revealed that E20 (LPN) administered acetic acid irrigation solution to R63's lower left leg and applied bacitracin ointment to open areas post irrigation solution. 2/13/25 2:37 PM - An interview with E20 confirmed that the current physician's order in the system was not the same as the treatment administered at 11:25 AM. E20 stated she was given a verbal order by E9 (Physician) this morning and to change the treatment. Facility documentation did not reflect this change in treatment orders. 2/14/25 12:31 PM - An interview with E9 confirmed that the treatment order in the EMR was not the current order for R63's current plan of care. The facility failed to follow a physician's order.	F 684	Audit findings will be reported to QA committee monthly x 3 months.	

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F 684	Continued From page 32 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA), and E2 (DON).	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R31) out of two residents reviewed for positioning and mobility, the facility failed to apply an ordered splint device. Findings include: Review of R31's clinical record revealed: 2/13/19 - R31 was admitted to the facility with diagonoses to including hemipleglia and hemiparesis following a cerebral vascular accident.	F 688	A. The facility is not able to retroactively correct the issue. R31 splint was reapplied as per physician order B. Active residents with splint orders will be reviewed to ensure splints are applied as ordered. C. The root cause was determined to be due to lack of oversight to ensure staff are applying splints as ordered.	4/10/25

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F 688	Continued From page 33 2/13/19 - A care plan was initiated for R31 documented actual contractures related to decreased mobility with the following interventions: left and right hand/wrist orthotic on each shift, maintain joints and body in a neutral body position at all times, and passive range of motion as tolerated. 6/26/24 - A physician's order for R31 documented apply right hand/wrist orthortic on every shift and remove for range of motion (ROM), hygiene, and routine skin checks every two hours. 12/12/24 - A physician's order for R31 documented apply left hand soft resting hand splint to be on in morning and remove in evening. 1/7/25 - A quarterly MDS assessment documented that R31 had impairments bilaterally to upper extremities and dependent of one staff for ADL's. 2/13/25 9:02 AM - An observation of R31 with bilateral contractures to bilateral upper extremities and no splints noted in place. 2/13/25 11:00 AM - An observation of R31 with bilateral splints noted but not in proper placement for intended function. 2/18/25 9:40 AM - An observation of R31 with bilateral contractures to bilateral upper extremities and no splints noted in place. 2/18/25 11:40 AM - An observation of R31 with bilateral contractures to bilateral upper extremities and no splints noted in place.	F 688	DON/Designee will be educating nursing staff regarding schedule for splints application and location of the order. D. Daily audit by ADON/Designee will be conducted to ensure that splints are applied as ordered x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	

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F 688	Continued From page 34 2/18/25 11:41 AM - An interview with E12 (CNA) confirmed that R31 wears bilateral hand splints and stated they are applied in the morning and removed in the evening. E12 confirmed that the CNA is responsible to check for placement of the splint during the day and adjust if moved out of place. E12 confirmed that R31's bilateral hand splints were not placed properly at time of observation. 2/19/25 9:27 AM - An observation of R31 with bilateral contractures to bilateral upper extremities and no splints noted in place. 2/19/25 10:45 AM - An interview with E26 (CNA) confirmed that R31 did not have splints on and stated that another staff member told her R31's bilateral splint order was discontinued. 2/19/25 10:52 AM - An interview with E27 (COTA) confirmed that R31's bilateral splint order was not discontinued. 2/19/25 10:59 AM - An interview with E16 (LPN) confirmed that R31 still had an active order in the EMR (electronic medical record) for bilateral splints and stated that she will ensure they get placed on R31. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA), and E2 (DON).	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to	F 690		4/10/25

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F 690	Continued From page 35 maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that for two (R53 and R63) out of two residents reviewed for bowel and bladder, the facility failed to provide services to maintain or restore bowel and bladder continence. Findings include:	F 690	A. R53 had been on an individualized toileting program since January 2024. A Bowel and Bladder re-evaluation was completed to determine voiding pattern. R63 will have bowel and bladder re-evaluation completed. Toileting program will be initiated as indicated.	

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F 690	Continued From page 36 1. Review of R53's clinical record revealed: 4/5/24 - R53 was admitted to the facility. 4/5/24 - A care plan was initiated for bladder incontinence related to occasionally incontinent with the following interventions: apply barrier cream with each incontinent episode, change clothing with each incontinent episode, and check resident every two hours for incontinence and provide care. 10/9/24 - A quarterly MDS assessment documented that R53 required supervision of one for toileting. The MDS also documented that R53 had a BIMS score of 5 indicating cognitive decline and was occasionally incontinent of bladder, always continent of bowel, and was not indicated for a toileting program. 10/2024 - A review of the October CNA documentation record revealed that R53 was incontinent of urine 14 times out of 95 opportunities and incontinent of bowel 14 out of 96 opportunities. 11/4/24 - A bowel and bladder assessment documented R53 was incontinent of urine and continent of bowel. The assessment also documented that R53 was aware of urges for toileting and required assistance of one for toileting. 11/2024 - A review of the November CNA documentation record revealed that R53 was incontinent of urine 40 out of 93 opportunities and incontinent of bowel seven times out of 91 opportunities.	F 690	B. Residents with bladder incontinence will be reviewed and toileting program initiated as indicated C. The root cause was determined to be due to lack of consistent oversight related to bowel and bladder re-evaluation and initiation of toileting program as indicated. The DON or designee will educate all nursing supervisors on bowel and bladder evaluation/re-evaluations and initiation of a toileting program as indicated to meet the resident needs. D. Daily audit by ADON/Designee will be conducted to ensure new admission/readmissions and quarterly, Bowel and Bladder evaluation is completed and toileting program initiated as indicated x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	

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F 690	Continued From page 37 11/15/24 - A significant change MDS assessment documented that R53 required supervision of one for toileting. The MDS also documented that R53 was frequently incontinent of bladder, occasionally incontinent of bowel, and was not indicated for a toileting program. 12/2024 - A review of the December CNA documentation record revealed that R53 was incontinent of urine 62 times out of 101 opportunities and incontinent of bowel 11 times out of 96 opportunities. 1/2025 - A review of the January CNA documentation record revealed that R53 was incontinent of urine 79 times out of 102 opportunities and incontinent of bowel 13 times out of 98 opportunities. 2/2025 - A review of the February CNA documentation record revealed that R53 was incontinent of urine 42 out of 49 opportunities and incontinent of bowel four times out of 55 opportunities. 2/8/25 12:45 PM - An interview with E25 (CNA) confirmed that R53 was an assist of one staff for toileting and that R53 can tell staff that she has to use the bathroom. E25 stated that she does not recall resident being on a toileting program. The facility lacked evidence that they attempted to restore bowel and bladder function for R53. 2. Review of R63's clinical record revealed: 9/23/24 - R63 was admitted to the facility. 9/27/24 - An admission MDS assessment	F 690		

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F 690	Continued From page 38 documented R63 is dependent on staff for toileting. The MDS also documented R63 was always incontinent of bowel and bladder and was not on a toileting program. 11/2024 - A review of the November CNA documentation record revealed that R63 was continent of urine four times out of 96 opportunities and continent of bowel six times out of 96 opportunities. 12/2024 - A review of the December CNA documentation record revealed that R63 was continent of urine two times out of 105 opportunities and continent of bowel two times out of 98 opportunities. 12/27/24 - An quaterly MDS assessment documented R63 is dependent on staff for toileting. The MDS also documented R63 was always incontinent of bowel and and frequently incontinent bladder and was not on a toileting program. 12/30/24 - A bowel and bladder assessment documented R63 was total incontinence of urine and total incontinence of bowel. The assessment also documented that R63 was unaware of urges for toileting and required complete dependence of one for toileting. 1/2025 - A review of the January CNA documentation record revealed that R63 was continent of urine zero times out of 101 opportunities and continent of bowel zero times out of 98 opportunities. 2/11/25 10:20 AM - An interview with R63 revealed that R63 was using a bed pan prior to	F 690		

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F 690	Continued From page 39 admission to the facility and R63 stated she requested to use one and has not received one. 2/18/25 11:30 AM - An interview with E12 (CNA) confirmed that R63 is dependent for care and R63 is able to verbalize when she needs to use the bathroom. E12 stated that R63 does not use a bed pan and has not been on a toileting program that she can recall. The facility lacked evidence that they attempted to restore bowel and bladder function for R63. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA), and E2 (DON).	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R375) out of one resident reviewed for respiratory care, the facility failed to provide professional standards of of practice by ensuring the oxygen tubing was changed weekly and nasal cannula was stored in a bag when not in use. Findings include: Review of R375's clinical record revealed:	F 695	A. R375's oxygen tubing was changed immediately. Staff will be educated regarding oxygen tubing change process and storage of tubing when not utilized . B. Residents with oxygen orders will be reviewed to ensure oxygen tubing are changed weekly and tubing stored	4/10/25

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F 695	Continued From page 40 12/12/24 - R375 was admitted to the facility. 12/12/24 - A physician order was written to administer oxygen at 2 liters/minute via nasal cannula, may titrate to maintain SpO2 90% or greater. 12/13/24 - A physician order was written to change oxygen tubing weekly and PRN (as needed) and to label tubing, date time and initial. Nasal cannula to be stored in a bag when not in use. 12/16/24 - An admission MDS indicated R375 had a BIMS score of 3 (severe impairment) and diagnoses of COPD, asthma and respiratory failure. 2/11/25 10:29 AM - An observation of R375's oxygen tubing revealed a label dated 1/30/25, no time or initial. Oxygen tubing was on the floor beside R375's bed. 2/11/25 11;12 AM - During an interview, E15 (LPN) confirmed that the tubing was labeled 1/30/25, no time or initial and the oxygen tubing was on the floor. 2/12/25 1:20 PM - An observation revealed R375 was in bed with nasal cannula applied, tubing was still labeled 1/30/25. 2/12/25 approximately 1: 40 PM - During an interview, E21 (Regional Corporate Consultant) confirmed the oxygen tubing needed to be changed and stated "I'll take care of it." 2/19/25 1:41 PM - Findings were reviewed during	F 695	appropriately when not in use. C. The root cause was determined to be due to the staff's lack of thorough understanding of the importance of changing oxygen tubing as indicated and maintaining tubing appropriately when not in use. DON/Designee will in-service licensed nurse to ensure oxygen tubing is changed and dated weekly. Nursing staff will be educated on importance of proper storage of oxygen tubing when not in use. A. Daily audit by ADON/Designee will be conducted to ensure oxygen tubing are changed and dated every week x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. Daily observational audit by ADON/designee of proper storage of oxygen tubing when not in use every week x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal,	

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F 695	Continued From page 41 the exit conference with E1(NHA), and E2 (DON).	F 695	the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance Audit findings will be reported to QA committee monthly x 3 months.	
F 697 SS=E	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that for three (R63, R53, and R59) out of three residents reviewed for pain, the facility failed to ensure that that adequate pain management was provided and pain assessments were not conducted with a consistent scale for pre and post pain assessments. Findings include: April 2002 - The pain management standards by the American Geriatrics Society included: appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management.	F 697	A. R63's pain medication was re-evaluated and changed as per resident's preference for pain during wound care. Every shift pain monitoring was initiated for R53. PRN Tylenol's numerical effectiveness result auto populates in the medication administration note which is reflected in the progress note. It is a mandatory task to indicate when a PRN pain medication is administered. Every shift pain monitoring was initiated for R59. PRN Tylenol's numerical effectiveness result auto populates in the medication administration note which is reflected in the progress note. It is a mandatory task to indicate when a PRN pain medication is	4/10/25

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F 697	Continued From page 42 November 2009 - The American Academy of Pain Medicine, "Pharmacological Management of Persistent Pain in Older persons, stated to refer to the previous American Geriatrics Society for specific recommendations for pain assessment in older persons that remain relevant." 1. Review of R63's clinical record revealed: 9/23/24 - R63 was admitted to the facility with the diagnoses including chronic pain, venous insufficiency, and cellulitis. 9/25/24 - A care plan for R63 was initiated for pain related to chronic pain with the following interventions: administer analgesia per orders, monitor and document side effects from pain medication, monitor/record/report to nurse any signs and symptoms of pain to the nurse, and notify the physician if interventions are unsucessful or if current complaint is a significant change from resident's experience of pain. 9/27/24 - An admission MDS documented R63 was receiving scheduled pain medication, as needed pain medication, pain frequency is occasional, and level of 3/10 as highest pain level in the last 5 days. 11/12/24 - A physician's order for R63 documented Tramadol 50 mg give one tablet by mouth every six hours for moderate and severe pain as needed and give thirty minutes prior to wound care. 11/2024 - A review of the November MAR revealed that R63 received Tramadol one time out of the 18 ordered opportunities to be given.	F 697	administered. E20 was educated on following physician orders for pain medication B. Residents with significant wounds will be reviewed and appropriate pain medication will be initiated as applicable. Active residents will be reviewed, and every shift pain monitoring will be initiated as indicated. The numeral effectiveness result is already reflected in the progress notes. C. The root cause was determined to be due to lack of thorough understanding by the licensed nurse regarding pain management in relation to dressing changes. DON/Designee will educate licensed nurse the importance of administering pain medication prior to dressing changes. The root cause was determined to be due to an oversight to ensure every shift pain monitoring is in place. DON/Designee will educate licensed nurses to ensure every shift pain monitoring is in place for new admissions/readmissions. The root cause was determined to be dure to the EMAR does not reflect the numerical number, although it is reflected in the progress note.	

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F 697	Continued From page 43 12/2024 - A review of the December MAR revealed that R63 received Tramadol one time out of the 31 ordered opportunities to be given. 1/2025 - A review of the January MAR revealed that R63 received Tramadol zero times out of the 31 ordered opportunities to be given. 2/11/25 10:15 AM - An interview with R63 revealed that R63 was having bilateral lower leg pain at a score of 7-8 out of 10. R63 stated she had received Tylenol for pain and it was ineffective and she had told the doctor previously that Tylenol does not help her pain. 2/13/25 11:11 AM - An observation of R63's wound care treatment revealed that R63 stated she had pain of 5/10 prior to administration of the treatment. R63 confirmed she was a 10/10 during treatment and 10/10 after treatment. An observation of resident yelling out every time E20 (LPN) would touch an area on R63's left lower extremity. R63's bilateral lower extremities were covered in crusted scab like areas and when touched the crusted area would come off and revealed reddened tissue underneath. R63 stated that the liquid (acetic acid) that E20 was applying to her legs was burning and stinging when applied. 2/13/25 11:25 AM - An interview with E20 revealed that she administered Tylenol 650 mg to R63 despite the order in the EMR stated to give Tramadol (pain medication) 50 mg 30 minutes prior to wound care. 2/13/25 2:37 PM - An interview with E20 confirmed she only administers the Tramadol	F 697	D.Daily audit by ADON/Designee will be conducted to ensure pain medication is administered per physician order along with appropriate pain monitoring is in place every week x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance	

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F 697	Continued From page 44 when R63 complains of moderate or severe pain. E20 confirmed that she usually gives R63 Tylenol prior to wound care and today she did because resident complained of 5/10 pain. 2/14/25 12:31 PM - An interview with E9 (MD) confirmed that the Tramadol was to be administered 30 minutes prior to R63 receiving wound care to control pain. E9 was unaware staff was not administering the Tramadol per order. 2/14/25 1:00 PM - An interview with R63 confirmed she received Tramadol per order and her legs are less painful today. 2/2025 - A review of the February MAR revealed that R63 received Tramadol four times out of the 13 opportunities to be given. The facility failed to administer pain medication prior to wound care treatment per physician's order. 2. Review of R53's clinical record revealed: 4/5/24 - R53 was admitted to the facility. 4/5/24 - A care plan was initiated and documented that R53 had pain related to generalized pain, diagnosis of pain in joints, right shoulder pain, and hemrorroid pain. Interventions included notify physician if interventions are unsuccessful and observe and report any changes in usual routine, sleep pattern, or if current pain complaint is a significant change from baseline. 4/18/24 - An admission MDS documented that R53 was on a scheduled pain regimen and had	F 697		

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F 697	Continued From page 45 constant pain. 12/2024 - A review of R53's December MAR revealed that R53's pain was not being monitored every shift and PRN (as needed) medications were being administered with a numerical pre pain score and post score documented as "ineffective, effective, and unchanged." R53 received four doses of Tylenol out of 30 potential opportunities with the incorrect pain scale used pre and post administration. 1/2025 - A review of R53's January MAR revealed that R53's pain was not being monitored every shift and PRN (as needed) medications were being administered with a numerical pre pain score and post score documented as "ineffective, effective, and unchanged." R53 received four doses of Tylenol out of 30 potential opportunities with the incorrect pain scale used pre and post administration. 2/2025 - A review of R53's February MAR revealed that R53's pain was not being monitored every shift and PRN (as needed) medications were being administered with a numerical pre pain score and post score documented as "ineffective, effective, and unchanged." R53 received one dose of Tylenol out of 30 potential opportunities with the incorrect pain scale used pre and post administration. 2/11/25 9:42 AM - An interview with R53 revealed that she is having left knee pain and Tylenol is not effective. 2/14/25 12:31 PM - An interview with E2 (DON) and E19 (Corporate) confirmed that R53's pain was not being monitored and the pain scale did	F 697		

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F 697	Continued From page 46 not match pre and post assessment. The review of R53's medical record revealed that the facility failed to monitor pain with a consistent scale. 3. Review of R59's clinical record revealed: 12/23/23 - R59 was admitted to the facility. 1/8/24 - A review of the care plan lacked evidence of a pain care plan. 1/19/24 - An admission MDS documented that R59 was on a scheduled pain medication and did not have pain currently. 12/2024 - A review of R59's December MAR revealed that R59's pain was not being monitored every shift and PRN (as needed) medications were being administered with a numerical pre pain score and post score documented as "ineffective, effective, and unchanged." R59 received four doses of Tylenol out of 30 potential opportunities with the incorrect pain scale used pre and post administration. 1/2025 - A review of R59's January MAR revealed that R59's pain was not being monitored every shift and PRN (as needed) medications were being administered with a numerical pre pain score and post score documented as "ineffective, effective, and unchanged." R59 received one dose of Voltaten (topical pain cream) out of 30 potential opportunities with the incorrect pain scale used pre and post administration. 2/2025 - A review of R59's February MAR revealed that R59's pain was not being monitored	F 697		

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F 697	Continued From page 47 every shift and PRN (as needed) medications were being administered with a numerical pre pain score and post score documented as "ineffective, effective, and unchanged." R59 received two doses of Tylenol and five doses of Voltaren out of 30 potential opportunities with the incorrect pain scale used pre and post administration. 2/18/25 09:30 AM - An interview with R59 revealed she is having bilateral knee pain and Tylenol is not effective. 2/14/25 12:31 PM - An interview with E2 (DON) and E19 (Corporate) confirmed that R59's pain was not being monitored and the pain scale did not match pre and post assessment. The review of R59's medical record revealed that the facility failed to monitor pain with a consistent scale. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA), and E2 (DON).	F 697		
F 756 SS=C	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing,	F 756		4/10/25

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F 756	Continued From page 48 and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to develop policies and procedures for the monthly MRR (Medication Regimen Reviews) that included time frames for different steps in the MRR process. Findings include: 1/2025 - Review of the facilities undated policy titled, "Medication Regimen Review," lacked information regarding the time frames for a pharmacist response for urgent	F 756	A. The facility's Medication Regimen Review policy was reviewed and revised to indicate time frame for a pharmacist response for urgent recommendations. No adverse effect related to the citation. B. New admissions from the last 14 days will be reviewed to ensure pharmacist response for urgent recommendations are within established timeframes	

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F 756	Continued From page 49 recommendations. 2/14/25 9:55 AM - An interview with E2 (DON) and E19 (Corporate) confirmed the policy was current. The facilities policy did not meet expected requirements to address timeframes for urgent recommendations. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA), and E2 (DON).	F 756	C. The root cause was determined to be due to an oversight during policy review to ensure timeframe for urgent recommendations is specified. Pharmacist/Designee will educate DON/NHA regarding timeframe for urgent recommendations. D.Annually, DON/Designee will review Medication Regimen Review policy to ensure it is in compliance with federal regulation. Daily audit by ADON/Designee will be conducted to ensure DRR is conducted within timeframes for new admissions/readmissions every week x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3 months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:	F 758		4/10/25

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F 758	Continued From page 50 (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or	F 758		

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F 758	Continued From page 51 prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that for two (R31 and R53) out of five residents reviewed for unnecessary medications, the physician failed to ensure that an appropriate diagnosis was reflected in the resident's chart while antipsychotic medications were being administered. Additionally, the facility failed to ensure that a fourteen day stop date was implemented for an as needed antipsychotic medication. Findings include: 1. Review of R31's clinical record included: 2/13/19 - R31 was admitted to the facility with the following diagnosis, but not limited to, psychotic disorder with delusions. 1/24/25 - A physician's order for R31 documented risperidone (antipsychotic) tablet 0.5 mg: give one tablet by mouth at bedtime for delusional disorder. 1/2025 - A review of the monthly medication review (MRR) documented a recommendation to evaluate use of risperidone for delusional disorder. 2/1/25 - A physician's order for R31 documented risperidone tablet 0.5 mg: give one tablet by mouth at bedtime for delusional disorder. 2/14/25 9:55 AM - An interview with E2 (DON) confirmed that antipsychotropic medications were not being prescribed or written with appropriate diagnosis related to use. E2 confirmed that the	F 758	A. R31's diagnosis for anti-psychotic medication uses had been clarified. R53's PRN anti-anxiety medication had been clarified to reflect a stop date. B. Active residents receiving anti-psychotic medications will be reviewed to ensure an appropriate diagnosis is in place. Active residents receiving PRN anti-anxiety will be reviewed to ensure there is a 14 day stop date or justification for extended use. C. The root cause was determined to be due to inconsistent provider follow through regarding anti-psychotic medication diagnosis and prn anti-anxiety 14-day limitation. DON/Designee will educate licensed nurses regarding coordination with provider to ensure appropriate diagnosis is in place for anti-psychotic medication use and prn anti-anxiety use with a 14 day stop date or justification for extended use. D. Daily audit by ADON/Designee will be conducted to ensure appropriate diagnosis for anti-psychotic use is in place, 14 days stop date for prn anti-anxiety or justification for extended use x 5 days until 100% compliance is achieved and sustained. The following will be a weekly audit x 4 until a 100% compliance is achieved, then monthly x 3	

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F 758	Continued From page 52 provider no longer worked at the facility and the provider documenting the proper indication of use was an ongoing concern. 2. Review of R53's clinical record revealed: 4/5/24 - R53 was admitted to the facility with the following diagnosis, but not limited to, unspecified dementia with agitation. 2/6/25 - A physician's order for R53 documented lorazepam (anti-anxiety medication) 0.5 mg: give one tablet by mouth every six hours as needed for anxiety for 90 days. 2/14/25 10:45 AM - An interview with E2 and E19 (Corporate) confirmed that the aforementioned physician's order did not include a stop date of 14 days and the facility could not provide documentation of rationale from provider for extending order longer than 14 days. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA), and E2 (DON).	F 758	months with a goal of 100% is achieved and sustained. In an event where compliance is consistently below the goal, the Interdisciplinary Team (IDT) will meet with the QA Committee to review the process, and revision will be made to maintain and sustain compliance. Audit findings will be reported to QA committee monthly x 3 months.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident:	F 791		4/10/25

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F 791	Continued From page 53 (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for two (R59 and R63) out of two sampled residents for dental services, the facility failed to assist the residents in obtaining routine dental services. Findings include:	F 791	A. R59 and R63 were scheduled to have dental visit. R 59 was seen by dental provider and R63 refused dental services at the time of the consult. B. Root Cause determined to be lack of a tracking process to offer and consult for	

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F 791	Continued From page 54 1. Review of R59's clinical record: 1/8/24 - R59 was admitted to facility. 4/4/24 - A review of R59's care plan documented R59 has a risk for an alteration in nutrition/hydration secondary to dementia, type II diabetes, and hypertension. The interventions included the following but not limited to explain and reinforce the importance of maintaining diet ordered and educate on refusals and risks. The care plan lacked evidence of a care plan relating to dental concerns. 12/17/24 - An annual MDS documented R59 had no natural teeth, no broken or loosely fitting dentures/partials, and no mouth or tooth pain. 2/11/25 9:37 AM - An interview with R59 revealed that R59 did not have dentures and complained of difficulty chewing due to not having dentures. R59 stated she wanted to see a dentist and had not been offered to see one. 2/18/25 2:53 PM - An interview with E1 (NHA) and E24 (Corporate) confirmed R59 had not seen the dentist or had been offered dental services. 2. Review of R63's clinical record revealed: 9/23/24 - R63 was admitted to the facility. 9/25/24 - A review of R63's care plan documented R63 had a potential for ADL self care deficit related to limited mobility. Interventions included assistance of one staff member for personal hygiene and oral care. The care plan lacked evidence of a care plan relating to dental concerns.	F 791	dental services. C. All residents/ representatives will be provided information on the process for receiving dental services. DON or designee will educate all nursing staff and SSD on residents' right to receive routine and emergency dental care and how to coordinate services. D. SSD/designee will audit weekly x 4, and monthly x3 with goal of 100% compliance to assure residents have been offered dental services and are aware of process to request consult. Audit findings will be reported to QA committee monthly x 3 months.	

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F 791	Continued From page 55 12/23/24 - A quarterly MDS assessment documented that R63 did not have broken or loosely fitting dentures and R63 had no mouth or facial discomfort. 2/11/25 10:25 AM - An interview with R63 revealed that she had not seen a dentist since admission and R63 would like to receive dental services. 2/18/25 2:53 PM - An interview with E1 (NHA) and E24 (Corporate) confirmed R63 had not seen the dentist or had been offered dental services. The facility failed to offer dental services to R53 and R63. 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA), and E2 (DON).	F 791		
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.	F 812		4/10/25

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F 812	Continued From page 56 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 1. 2/11/25 8:39 AM - During the initial tour of the kitchen the surveyor observed the following: - The hair on the front of E5's (FSS) head was unsecured by a hair net. - The hand washing sink located in the dish area was obstructed by a fan and the paper towel dispenser was empty. - The small refrigerator for milk storage contained an opened gallon of milk with an expiration date of 2/5/25. 2. 2/17/25 10:06 AM - During a tour of the kitchen, food particles were splattered on the top and sides of the cooktop and oven. Food debris and other litter was on the kitchen floor, under the shelving, prep trables and oven. 2/17/25 11:05 AM - The underside of all of the shelves on the plastice shelving units in the walk-in refrigerator had numerous areas of small black circular staining, which appeared to be mold or mildew creating the potential for contamination of food items stored there. 2/17/25 11:40 AM - During a tour of the kitchen, the walk-in refrigerator contained a pan of	F 812	FTAG812-Food Procurement A. 1.The regional dining consultant completed a sanitation audit on 2/11/25, after the initial tour of the kitchen, to ensure the dietary staff were properly wearing hair nets. The paper towel dispenser in the dish room was filled with paper towels on 2/11/25, and the fan blocking dispenser was relocated on 2/11/25. The expired milk was removed and discarded from the refrigerator on 2/11/25 during walk through. 2. The food debris and litter that was noted during the walk through on 2/17/25 was swept up and discarded. The food splatter that was found on the sides and top of the oven was cleaned. The container of sausage patties was discarded immediately and the racks in the walk-in refrigerator were removed and cleaned. B. 1.The regional dining consultant completed a walk through the kitchen on 2/11/25 to ensure food items were properly stored, staff were wearing hairnets appropriately, and the paper towel dispenser was filled. 2. The regional dining consultant and food service director completed a food safety and sanitation audit, on 2/18/25 to ensure	

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F 812	Continued From page 57 sausage patties, which was not completely covered exposing it to contamination from dust and other debri 2/19/25 1:41 PM - Findings were reviewed during the exit conference with E1(NHA), and E2 (DON).	F 812	all food storage areas were cleaned and sanitized and food items were properly wrapped and labeled. C. 1. The root cause analysis determined that staff failed to follow policy and procedure for food safety & sanitation, as evidence by improper usage of hair nets, food debris on floors and equipment, failure to discard expired food items, and the lack of paper towels in the handwashing area. This staff also failed to properly clean and sanitize food storage areas and follow the weekly cleaning assignment sheet. All dietary staff received additional education, on the food safety and sanitation policy, on 2/19/25 by the food service director and regional dining consultant. The dietary staff also received additional education on cleaning and following the weekly cleaning schedule on 2/19/25. D. The food service director, or designee, will conduct audits to ensure that the food safety and sanitation policy is being followed. The audits will be completed daily, or once 100% compliance is achieved, for three consecutive days. The audits will continue to occur 3x a week for 3 consecutive weeks, or until 100% compliance is achieved. Audits will continue monthly until 100% compliance is achieved for 3 consecutive months. Once 100% compliance is sustained the deficient practice will be considered resolved.	

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F 812	Continued From page 58	F 812	Audit findings will be reported to QA committee monthly x 3 months.	