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: KUTZ Rehabilitation and Nursing

DATE SURVEY COMPLETED: March 26, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	POST IDR **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 March 6, 2025, through March 26, 2025. The deficiencies contained in this report are based on interviews, observations, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was seventy-five (75). The survey sample was thirty-five (35). Abbreviations/definitions used in this report are as follows: Aphasia – impairment in a person's ability to comprehend or formulate language because of damage to specific area in the brain; CEO – Chief Executive Officer; CNA – Certified Nurse's Assistant; DON – Director of Nursing; ICP – Infection Control Preventionist; LNHA – Licensed Nursing Home Administrator; SD – Staff Development.		
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**		

Provider's Signature Title NHA, CEO Date 5/9/25

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	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 March 26, 2025: F557, F558, F580, F600, F607, F609, F610, F656, F684, F688, F689, F693, F695, F700, F711, F726, F755, F756, F757, F760, F761, F842, F867, F880, F881, F919 and F940.		
3201.7.0	**Plant, Equipment and Physical Environment.**		
3201.7.5	**Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** **Delaware Food Code** **6-2 DESIGN, CONSTRUCTION, AND INSTALLATION** **6-202 Functionality** **6-202.15 Outer Openings, Protected.** **(A) Except as specified in (B), (C), and (E) and under (D) of this section, outer openings of a FOOD ESTABLISHMENT shall be protected against the entry of insects and rodents by:** **(1) Filling or closing holes and other gaps along floors, walls, and ceilings;** **(2) Closed, tight-fitting windows; and** **(3) Solid, self-closing, tight-fitting doors.** **B) Paragraph (A) of this section does not apply if a FOOD ESTABLISHMENT opens into a larger structure, such as a mall, airport, or**	1. Unable to correct in the past. Dumpster door was immediately remediated on 3/11/2025 to cover gap where rodents could enter the building. 2. All Exterior doors have potential to be affected. The maintenance director or designee will audit exterior doors for gaps large enough for rodents to enter the facility By May 5, 2025. 3. RCA: Monitoring of outside doors for gaps large enough for rodents to enter was not on the Maintenance Directors Monthly checklist, so it was missed. The Maintenance Director, or designee, will enter the task of checking outside doors for gaps large	04/30/2025

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	office building, or into an attached structure, such as a porch, and the outer openings from the larger or attached structure are protected against the entry of insects and rodents This requirement was not met as evidenced by: Based on the observation, interview and record review, the facility failed to provide a safe working environment for food service staff and a vermin proof environment for food storage and preparation. Findings include: 3/11/25 at 2:13 PM – During the kitchen tour with E36 (Maintenance Director), the Surveyorfound a gap underthe outermost double door that leads to the outside trash docking platform, where two dumpsters were located. This outermost double door is in close proximity to the kitchen entrance door. The door gap was large enough that a rodent could crawl through. Due to the nature of kitchen waste transport through the doors and the hallway, the kitchen and food storage room are accessible to the vermin that can successfully come inside the building. The finding was confirmed with E36. 3/11/25 3:25 PM - Finding was reviewed with E1 (CEO/LNHA).	enough for rodents to enter the facility, into the TELS Workorder system to be completed monthly. The task will be assigned by the Lead Maintenance technician to a Maintenance technician monthly to complete and document in the TELS system. The Maintenance Director will educate the maintenance staff on the new process and size of gap that will require repairs. 4. Maintenance Director (or designee) will conduct audits of exterior doors weekly x 3 to ensure they do not have gaps large enough for rodents to enter the building, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
3201.9.0	**Records and Reports**		
3201.9.5	**Incident Reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the**	1. Unable to correct in the past. 2. Unable to correct in the past. 3. RCA: Reporting staff unaware of requirement to report all staff names as per policy.	05/10/2025

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	nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate. This requirement was not met as evidenced by: Based on interview and record review, it was determined that for one (R63) out of eight residents reviewed for falls, the facility failed to have an incident report for an unwitnessed fall. Findings include: 1. Review of R63's clinical record revealed: 9/19/24 - R63 was admitted to the facility with diagnoses that included, but were not limited to, dementia, expressive aphasia and history of falls. a. 10/1/24 4:42 PM - A nurse's note documented, "Late Entry: Resident found on the floor sitting on his bottom on top of his floor mat between his chair and his bed at 1600 [4 PM]. Resident was assessed no signs of bruises or trauma." 3/18/25 1:15 PM – Surveyor provided a written request to E1 (CEO/LNHA) for R63's fall incident reports with complete investigation. No incident report/investigation was provided to the Surveyor for R63's unwitnessed fall on 10/1/24. b. 12/4/24 3:51 PM – The facility's incident report documented, "Resident was sitting in his wheelchair and then rolled on to the floor from his wheelchair... Was the incident witnessed: N [NO]...".	The Staff Development nurse (or designee) will educate staff on policy for incident reporting and the inclusion of the names of all staff, if available, so as not to delay timely reporting. 4. DON (or designee) will conduct audits of State Reportables daily x 3 to ensure inclusion of the names of all staff, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

Provider's Signature Tricia L. Hall Title NHA, CEO Date

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	12/5/24 10:43 AM – The facility reported R63's witnessed fall to the State Agency as follows: "The CNA was in the process of pushing the resident in his wheelchair, and then the resident leaned forward and rolled onto the floor...". The facility failed to list E25, the CNA's name, on the facility incident report and include E25's name in the initial report to the State Agency on 12/5/24 in the section for Witnesses. 3/21/25 12:21 PM – Finding was reviewed with E1 (CEO/LNHA) and E2 (DON). 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1, E2, E3 (SD/ICP) and nine department managers/representatives.		
3201.9.8	**Reportable incidents are as follows:**		
3201.9.8.4	**Significant Injuries**		
3201.9.8.4.2	**Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.**		
3201.9.8.4.4	**Significant error or omission in medication/treatment, including drug diversion, which causes the resident discomfort, jeopardizes the resident's health and safety or requires periodic monitoring for up to 48 hours.** These requirements were not met as evidenced by:		

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	Based on interview and review of clinical records and other documentation as indicated, it was determined that for one (R63) out of eight residents reviewed for falls and four (R4, R47, R52 and R84) out of 14 residents reviewed for medication errors, the facility failed to report each incident to the State Agency within the required eight hours of the incident. Findings include: 1. Review of R63's clinical record and other documentation revealed: 1/3/25 11:05 AM - The facility's incident report documented that E20 (CNA) "was assisting resident with transfer from bed to wheelchair where he obtained a laceration to right lower extremity. Resident unable to give description...". 1/3/25 11:49 AM - E20's written statement as part of the facility's investigation documented, "... was transferring patient from bed to chair and leg was up against the leg rest connector... blood running down patient leg, along with a (sic) open area... Were you being assisted by anyone... no assistant (sic) from anyone...". 1/3/25 1:19 PM - The hospital record documented, "... suffered a laceration of... right leg while transferring from his bed into... wheelchair... Wound was thoroughly irrigated... and then repaired with... sutures and then Steri-Strips were placed over top of the area...". Review of the State Agency's reporting system revealed that the facility failed to report R63's 1/3/25 incident as required.	1. Unable to correct in the past. 2. All residents with injury from patient care requiring transfer to the Emergency Room could be affected. The DON audited all April Emergency Room visits r/t injury during resident care on 5/5/25 to ensure they were reported to the SA and found all were reported. No correction was needed. 3. RCA: Knowledge deficit by employee who did not know a report was required if resident transferred to ER by family, not EMS. Facility will attempt to modify the EMR Risk Management report "Injuries" tab to include a question asking: "Did injury require transfer by any means to the ER for eval and treatment?" If the answer is yes, it will trigger the question: "Was State Agency Reportable completed timely?" They are attempting to make this field a mandatory field in the EMR. Staff Development nurse, or designee, will educate all professional	05/10/2025

Provider's Signature [signature] Title NHA, CEO Date [redacted]

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	3/21/25 12:21 PM – Finding was reviewed and confirmed with E1 (CEO/LNHA) and E2 (DON).	nursing staff on new policy on incident reporting, and requirement for SA reporting for any injury requiring an ER transfer regardless of mode of transport to the ER. If able to alter internal Risk Management report, the Staff D will educate all professional nursing staff on completing the new question(s). 4. DON (or designee) will conduct audits of resident transferred to the Emergency Room for an injury that occurred during resident care daily x 3 to ensure State Reportables are completed when necessary, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
	2. Review of the facility's individual incident reports for each resident (R4, R47, R52 and R84) documented that multiple medications were not administered to each resident on 10/3/24 day shift. Review of the State Agency's reporting intakes revealed that the facility reported the omission in medications for all four residents on 10/28/24 at 2:10 PM, twenty-five days later. The facility failed to report the omission of medications for four residents within the eight-hour timeframe to the State Agency as required.	1. Unable to correct in the past. 2. Unable to correct in the past. 3. RCA: Initially, the medication error was not thought to need to be reported as there was no injury to the residents and no extra monitoring was required. However, the policy at Kutz was updated to report all medication errors, unless otherwise instructed by the NHA, after a deficiency for not reporting a medication error was received at Lodge	05/10/2025

Provider's Signature Trisha E. Hall Title NH A. CEO Date

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	3/18/24 12:18 PM – During a combined interview with E1 (CEO/LNHA) and E2 (DON), E2 confirmed that the medication error for four residents was reported late to the State Agency. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1, E2, E3 (SD/ICP) and nine department managers/representatives.	Lane in November 2024. Despite the Medication error at Kutz occurring prior to the policy update at both Kutz and Lodge, the NHA and DON decided to report this medication error as a consequence of the new policy, even though they knew it would be considered reported late, rather than the errors not being reported altogether. Education on the new policy was provided in November when the policy was updated, and is provided to all new professional nurse hires at New Employee Orientation. In addition, the education is provided again at Mandatory Review Education Days for Professional nurses. The facility will continue to report medication errors as stated in the policy. No re-education is required. 4. DON (or designee) will conduct audits of medication errors daily x 3 to ensure State Reportables were completed, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

Provider's Signature Trisha L. Hall Title NHA, CEO Date _____

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. BUILDING _____ B. WING _____	C 03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

(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 date March 6, 2025 through March 26, 2025. The facility census was seventy-five (75) 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, no Emergency Preparedness deficiencies were identified.	E 000		
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from March 6, 2025 through March 26, 2025. The deficiencies contained in this report are based on interviews, observations, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 75. The survey sample was 35. Abbreviations/definitions used in this report are as follows: ADLs - activities of daily living/tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; aFib - Atrial Fibrillation/irregular heart rhythm; angina - severe, often choking, chest pain; Antiviral - a drug or a treatment effective against viruses; Aphasia - neurological condition in which	F 000		

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

Electronically Signed | 05/06/2025

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F 000	Continued From page 1	F 000		

language function is defective or absent;
B&B - bowel and bladder;
Bair hugger - a convective temperature management medical device that is used in hospitals to maintian a patient's core body temperature;
BIMS - Basic Inventory of Mental Status, a structured assessment tool aimed at evaluating cognition int he elderly. BIMS score of 0-7 is reflective of severe cognition deficit, 8-12 reflects moderate cognition deficit and 13-15 score is reflective of normal cognition;
BMP - basic metabolic panel, a lab study that measures the electrolytes and kidney function;
BP - blood pressure;
bpm - beats per minute;
bradycardia - slow heart rate; fewer than 60 times per minute;
bs - blood sugar;
cannula - a thin tubing utlized to deliver supplemental oxygen to a patient;
CBC - complete blood count, a lab study that measure the red blood cells, white blood cells and platelets;
CEO - Chief Executive Officer;
cerebral palsy - disorder that affects muscle tone, movement and motor skills;
cfu/ml - colony-forming units per milliliter; a unit of measurement for growth of microorganisms;
CMP - complete metabolic panel, a lab study that measures the electrolytes, liver enzymes and kidney function;
c/o - complaint of;
Congestive heart failure - heart unable to pump enough blood to meet the body's needs;
Contracture - joint with fixed resistance to passive stretch of a muscle and cannot straighten;
Conversion of Celsius to Fahrenheit: F= (C X 9/5) +32 www.metric-conversions.org

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F 000	Continued From page 2 COPD - Chronic Obstructive Lung Disease - a lung condition that results in limited airflow in and out of lungs; CNA - Certified Nurse's Assistant; CXR - chest X-ray; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation OR loss of mental functions such as memory and reasoning that interferes with a person's daily functioning; DON - Director of Nursing; DOR - Director of Rehabilitation; DVT - deep vein thrombosis; a clot in a vein typically in the lower legs; dyspnea - shortness of breath; dysuria - pain on urination; EBP - Enhanced Barrier Preecautions, an infection control intervention designed to reduce the transmission of multidrug-resistant organisms that employs targets gown and gloves use during high contact resident care activities; ED - emergency department; eMAR - electronic Medication Administration Record/list of daily medications to be administered; emphysema - lung disease; EMR - electronic medical record; EMTs - emergency medical teechnicians; enablers - devices added to the bed that faciliate movement and may reduce oressure ulcer development; ER - emergency room; ESRD - end stage renal disease; F - Fahrenheit; Failure to Thrive - chronic condition with decline of function (i.e., weight loss, poor appetite/nutrition); gait - posture when walking; gm - grams;	F 000		

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habitus - physical characteristics of a person;
hyponatremia - low blood concentration of sodium, below 135 mmol/L;
hypopituitarism - a deficit or shortage of one or more of the pituitary hormones;
hypothermia - dangerous drop in body temperature/occurs when body temperature falls below 95 degree Fahrenheit/35 degree Celsius;
hypothyroid - a condition resulting from a decreased production of thyroid hormones;
hypoxia - low levels of oxygen in the patient's body tissues;
HIV - Human Immunodeficiency Virus, a virus that attacks the body's immune system;
hypoxia - low oxygen concentration in the blood;
ICP - Infection Control Preventionist;
Incontinence - loss of control of bladder and/or bowel function;
immobilizer - device used to prevent patient movement;
Immune - having a high degree of resistance;
infiltrate - an abnormal collection of fluid or cells seen on CXR;
IVSS - intravenous soluset solution, a method of infusing medication that is mixed in sterile fluid over a designated time period;
L - liters;
leukocytes - white blood cells;
LNHA - Licensed Nursing Home Administrator;
LPN - Licensed Practical Nurse;
LSW - Licensed Social Worker;
MAR - Medication Administration Record, the eleectronic record where staff document when medications were given;
MD - Medical Doctor;
MDROs - multidrug-resistant organisms;
MDS - Minimum Data Set; a federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid

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nursing homes that evaluates functional capabilities and health needs;
Milligram (mg) - metric unit of weight, 1 mg equals 0.0035 ounce;
ml - milliliters;
mmol/L - millimole per Liter;
n/a - not available
Nebulizer Treatment- inhaling medication mist directly into lungs;
neurogenic bladder - a lack of bladder control due to a brain, spinal cord, or nerve condition;
neuropathy - disease or dysfunction of one or more peripheral nerves, typically causing numbness or weakness or pain;
neutrophilia - a condition when the body produces too many neutrophils, a type of white blood cell that fights off infection, typically > 7,700;
NNO - no new orders;
O2 - oxygen;
obstructive uropathy - conditiona where a blockage hinders urine flow in the urinary system;
osteomyelitis - an infection of the bone that is typically treated with several weeks of IV antibiotics infusions;
osteoporosis - weakened bones with increased risk of breaking;
OT - Occupational Therapy;
p - pulse;
Parkinson's disease - a disorder of the brain that leads to shaking (tremors) and difficulty with walking, movement, and coordination;
PCC - Point Click Care, the electronic platform used by the facility for record keeping;
palm guard - a protective splint that safeguards the palm of the hand from injury from contracted fingers;
PEG - percutaneous gastrostomy tube; an indwelling medical device thatallows direct feeding of the stomach via a tube;

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F 000	Continued From page 5 perineal - area between the anus and genitals; POA - Power of Attorney; psychiatry - medical specialty focused on diagnosis and treatment of mental disorders; Pulmonary embolism - sudden blockage in a lung artery by a blood clot; Q - every; r/t - related to; RA - room air; RN - Registered Nurse; RNAC - Registered Nurse Assessment Coordinator; rr - respirations; SD - Staff Development; seizure disorder - abnormal electrical activity in the brain causing repetitive muscle jerking; SPO2 - a measurement of the percentage of oxygen in the blood; s/s - signs and symptoms; T - temperature; TSh - Tyhroid stimulating hormone, a lab study that measures thyroid function; ug/ml - microgram perr milliliter, a lab measure of density; UM - unit manager; VS - vital signs; vascular dementia - problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to your brain.	F 000		
F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal	F 557		5/10/25

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F 557	Continued From page 6 possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for one (R26) out of thirty-five sampled residents, the facility failed to treat R26 with dignity. Findings include: R26's clinical record revealed: 9/3/20 - R26 was admitted to the facility. 2/28/25 - R26's quarterly MDS documented that R26 was totally dependent for the functional ability to shower or bathe self. 3/13/25 10:32 AM - The surveyor observed R26, who was wearing only a hospital gown, being wheeled through the hallway on a shower transport stretcher by E17 (RN/UM) and E18 (CNA) to the shower room (about 500 yards) with R26's legs and feet exposed. 3/13/25 10:35 AM - During an interview, E18 confirmed that R26 did not have a blanket covering her legs and feet during transport. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.	F 557	1. Unable to correct in the past. 2. Unable to correct in the past. 3. RCA: Knowledge deficit by employee who was helping the CNA by taking the resident to the shower and left the resident's legs and feet uncovered. Resident had her own comforter on the bed so a bed sheet or bath blanket was not available to cover the resident. A new process will be instituted to provide Laundry with a list of those needing showers each day by shift. The Laundry will prepare linen packs for all residents with scheduled showers that shift/day to include a washcloth, towel and top sheet or bath blanket. The Shower/Linen packs will be given to the Nursing Supervisor each shift to be distributed to the staff providing showers that day/shift. The "Resident-Showers-Policy" will be updated to include the Shower/Linen packs and distribution process. The DON, or designee, will educate all nursing staff on the Resident Dignity portion of Residents Rights, to cover all residents during transport to and from the shower room unless the resident refuses, and the update to the	

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F 557	Continued From page 7	F 557	"Resident-Showers-Policy" with the new shower/linen packs. 4. DON (or designee) will conduct audits of 10% of the residents being transferred to the shower room each audit day daily x 3 to ensure all residents' legs and feet are covered on the way to the shower room, unless resident refuses, until 100% compliance is achieved. Audits will continue weekly x 3 until 100% compliance is achieved, and then monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that for one (R23) out of thirty-five residents sampled, the facility failed to provide a special need for a larger bed. R23 rolled out of the bed on to the floor during incontinence care and was transported to the emergency room for evaluation and treatment. Findings include: Cross Refer F689, example 2	F 558	1. Unable to correct in the past. R23 was moved into a larger (bariatric) bed on 5/6/25. 2. All residents over 300 pounds have potential to be affected. There are no other residents weighing over 300 pounds at facility. 3. RCA: R23 does not meet the criteria for	5/10/25

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F 558	Continued From page 8 A review of R23's clinical record revealed: 8/24/23 - R23 was admitted to the facility with the following diagnoses including, but were not limited to, large body habitus, anxiety, compressed lower back nerves, muscle weakness, nerve pain and osteoporosis. 12/22/24 3:55 AM - A facility incident report documented R23 had a fall that a (CNA) did not assure positioning safety prior to attempting to provide care therefore contributing to the resident's fall onto floor. Resident taken to the ER (sic) for evaluation for complaints of pain returned in 24 hours with no acute findings. 12/22/24 - A facility statement for E40 documented, "I was giving [R23] care this morning at 4AM she went to turn to her left side and continued forward out of the bed she had little to no room to actually move well from side to side when asked about a bigger bed for her I was told she was unable to get a bigger bed." 3/19/25 - Review of R23's quarterly MDS assessment for 12/4/24 and 3/5/25 revealed the resident was cognitively intact. 3/20/25 11:53 AM - Review of R23's ADL (activities of daily living) care plan interventions created on 9/23/23 documented... 1. "Bed mobility the resident requires by (sic) x1 staff to turn and reposition in bed and as necessary." Further review of R23's care plan revealed an intervention created on 3/18/25 to "turn and reposition: 2 person assist with all turns and repositioning for safety." The intervention was added to R23's care plan 3 months after the	F 558	a bariatric bed according to her weight. The facility did not have a process to evaluate if residents weighing over 300 pounds, but less than 350 pounds, need a larger bed to ensure proper bed mobility. An order will be placed in the facility□s EMR, and a paper referral form will be completed and given to the Therapy Department for Occupational Therapy to evaluate all residents with a new admission weight greater than 300 pounds for the resident□s ability to safely turn and reposition in the standard size beds at Kutz Rehabilitation and Nursing. Therapy turn-around time for the referral will be no longer than 3 business days. If therapy determines a larger bed is needed, they will notify the DON, or designee to obtain an order for a larger bed so that it can be obtained. The Staff Development nurse, or designee, will educate all nursing staff , and Therapists on the new process for residents with a new admission weight greater than 300 pounds. 4. DON (or designee) will conduct audits of admission residents weighing over 300 pounds daily x 3 to ensure that Therapy determines if they need a larger bed, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure	

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F 558	Continued From page 9 residents fall on 12/22/24. 3/20/25 2:05 PM - During an interview, R23 was observed lying in a standard sized bed on her back with a fall mat on the right and left side of the bed. [R23] stated, "I slipped out of the bed I was turning over and I fell out of the bed, the bed is not wide enough for me if I turn over, I am right here on the edge." R23 also stated, "I'm afraid when I am being turned in the bed, I'm always on the edge of the bed no matter what, when I fell off the bed, I was right on the edge the aide could not grab me and then after that they put down mats, but I am still afraid of falling." 3/21/25 11:00 AM - During an interview, E2 (DON) stated, "[R23] is not bariatric weight we moved her room to give her more space in her room. E2 also confirmed "all residents in the building have enablers that are attached on their bed." When E2 was asked about approaches to assist with preventing another fall for R23, E2 stated, "I think the CNA was educated on proper turning and repositioning and to be careful when providing care for R23 when in the bed." 3/21/25 1:10 PM - During an interview with E16 (DOR), it was revealed that the current therapy department arrived in "October 2024" and that all the beds in the facility had enablers on them. E16, stated and confirmed, "[R23] had enablers on the bed in October 2024." Additionally, E16 stated, "she is in a standard bed and because she is a large lady it is a tight fit she is afraid when turning in the bed, and nursing said that she does not meet the classification for a larger bed." The facility failed to accommodate R23 a resident that would be more comfortable in a larger bed.	F 558	compliance is obtained and maintained.	

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F 558	Continued From page 10 3/24/25 10:30 AM - Findings were reviewed and confirmed with E1 (CEO/LNHA) and E3 (SD). 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1, E2 (DON), E3 and nine department managers/representatives.	F 558		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 580		5/10/25

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F 580	Continued From page 11 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and review of clinical record and other documentation as indicated, it was determined that for one (R7) out of thirty-five sampled residents, the facility failed to consult the provider of the significant change in R7's physical status with her heart rate (HR) running in the 40's. Findings include: Cross refer F684, F726, F755 and F760 R7's clinical record revealed: 1/10/20 - R7 was admitted to the facility with diagnoses including, but were not limited to, seizure disorder and hypopituitarism. 10/16/24 12:22 AM - E24 (RN/shift supervisor) documented in R7's EMR progress note, "Fall	F 580	1. Unable to correct in the past. 2. All residents with new onset bradycardia have potential to be affected. All residents were audited on 4/20/2025, and no instances of new onset bradycardia were identified. 3. RCA: Vital Signs Policy did not state what to do when vital signs were abnormal. Cross Ref F864, F726, F755, F760 The facility updated their "Vital Signs" Policy to include directions to notify provider when the resident has new onset bradycardia.	

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F 580	Continued From page 12 details: Date/Time of fall: 10/15/24 11:50 PM fall was not witnessed... Provider: [E4, contracted Physician] Time notified 10/16/24 Notified of: fall... Resident found sitting on the floor legs facing the head board of the bed... Resident stated she was self transferring from wheelchair to the bed, when she fell. VS (vital signs) 154/66 (blood pressure), p (pulse) 43, 97.6 T (temperature), 18 rr (respiratory rate), bs (blood sugar) 89...". 10/16/24 1:13 AM - R7's heart rate was documented in the EMR as "43 bpm (beats per minute) (irregular- new onset)". 10/16/24 3:36 AM - R7's heart rate was documented in the EMR as "43 bpm". 10/16/24 6:45 AM - E10 (LPN) documented in R7's EMR progress note, "Resident rang at 2350h [11:50 PM hour], employee went into the room and found the resident sitting on her buttocks on the floor... VS were obtained BP (blood pressure) 154/66, HR 43...". 10/16/24 10:45 PM - R7's heart rate was documented in the EMR as 41 bpm. Review of R7's documented heart rate from 8/26/24 to 10/16/24 revealed R7's baseline heart rate range was 50 to 96 bpm, with no documented heart rates in the 40's. 10/18/24 3:39 AM - C1 (hospital emergency room MD) documented in R7's hospital admission history and physical, "Upon arrival to the ED (emergency department), vital were remarkable for hypothermia to 33.8 (degrees Celsius) and bradycardia to 42...".	F 580	The Staff Development nurse, or designee, will educate licensed nurses on the update and new process. 4. DON (or designee) will conduct audits of residents with new onset bradycardia daily x 3 to ensure the provider is notified, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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F 580	Continued From page 13 3/24/25 3:54 PM - During a telephone interview, E4 (contracted MD) stated that she was not notified that R7's heart was in the 40's on 10/15/24 and 10/16/24. E4 also stated that due to the fall occurring on night shift, the covering service would have been notified about the fall as they provide call coverage from 5 PM to 8 AM daily. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.	F 580		
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, it was determined that for two (R19 and R82) out of fourteen residents reviewed for abuse/neglect, the facility failed to ensure that	F 600	1. Unable to correct in the past. 2. Unable to correct in the past.	5/10/25

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F 600	Continued From page 14 each resident remained free from abuse or neglect from staff. For R82, the facility failed to ensure the resident was free from neglect. For R19, the facility failed to ensure the resident was free from verbal and emotional abuse from a staff member. Findings include: A facility policy titled "Resident Abuse Policies and Procedures", revised 12/2023, stated, "The facility will prohibit, prevent and not tolerate residents to be subject to abuse, violence, neglect, mistreatment, or misappropriation of property by anyone, including: staff members, other residents, family members, resident representatives, friends, volunteers, consultants, visitors, or any other individuals...". 1. Cross Refer F677, example 2 A review of R82's clinical record revealed: 12/9/24 - R82 was admitted to the facility with the following diagnoses left knee fracture, muscle weakness and osteoporosis. 12/9/24 11:00 PM - A physician's order for R82 documented, "immobilizer to left leg at all times do not bend left knee every shift." 12/16/24 - A review of R82's MDS five day admission assessment documented R82 was cognitively intact and required partial moderate assist for transfers. 12/23/24 2:40 PM - A facility reported incident documented, "[R82] reported to E21 (LSW) that on 12/22/24 on 3-11 shift [R82] asked her assigned CNA to assist with transferring out of the bed. Further review of the incident report	F 600	3a. RCA: CNA stated that she did provide the care, however she was not in the room long enough. This occurred despite the CNA receiving education on abuse and neglect via web educations and on Mandatory review day in 2024, and discussion at all staff meetings. CNA was terminated per policy. 3b. RCA: During the interview process, E22 told the ADON that E23 spoke to the resident rudely but did not think it was abuse. Therefore, it was determined the CNA needed more training in customer service and responses to residents so the residents would not misunderstand what the CAN was saying/asking. This was a customer service issue, not abuse. The CNA received education on abuse and neglect, and customer service. KRN will continue to provide education on Abuse and Neglect prior to all employees□ first day in the building via web educations, during their New Employee orientation (NEO), at Mandatory Review days (MRD), and at Critical Skills on a yearly basis. All employees will also receive customer service training at NEO, MRD and Critical Skills. Staff Development nurse, or designee, will continue to provide abuse and neglect, and customer service, training to all staff annually. 4.a. & b. DON (or designee) will conduct audits of 10% of CNA to resident	

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F 600	Continued From page 15 revealed the CNA told [R82] she could transfer herself and that R82 did not need the CNA's help." Additionally, on 12/31/24 the facility's follow up report documented "[R82] reported to E21 (LSW) E38 (CNA) replied to R82's request for help stating, "You don't need me, you can do it yourself, you don't need my help and that E38 was nasty when speaking to R82 which caused the resident distress." 3/20/25 12:30 PM - A review of a facility's discipline report titled "Performance Conduct Title" for E38 dated 10/27/23 documented... 1. "Misconduct based on failure to assist a resident for the remainder of the shift and confirmed with video surveillance. In addition, on 12/27/24 E38's facility discipline documented... 2. "Termination for misconduct allegation of abuse." 3/21/25 11:00 AM - During an interview E2 (DON) confirmed, "review of the video footage of the shift in question revealed E38 did not provide the care that was documented in R82's record." "Timeline of video camera footage E38 entered R82's room 3:42:44 PM, E38 exiting at 3:42:59 15 seconds after entering R82's room, E38 entered R82's room 3:15:12 PM E38 exited at 3:52:15 PM 2 minutes and 3 seconds after entering R82's room, E38 entered R82's room 5:02:23 PM and exited at 5:02:46 PM 23 seconds after entering the room. E38 spent a total of 2 minutes and 41 seconds providing care to this resident in a 8 hour shift. [E38] documented in R82's chart for toileting times 3:40 PM, 5:41 PM, 7:30 PM, 8:00 PM, and 9:30 PM. [E38] documented repositioning [R82] at 2:56 PM, 4:41 PM, 6:22 PM, 8:22 PM and 10:00 PM. These times are not shown to have occurred on the video footage." R82 had a left	F 600	interactions daily x 3 to ensure the CNA does not abuse or neglect the resident and/or does not provide poor customer service to the resident, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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F 600	Continued From page 16	F 600		

knee fracture and required partial moderate assistance for toileting, bed mobility and transfers. Despite the documentation that E38 was in the room 2 minutes would not have been enough time to provide care for R82.

3/21/25 1:28 PM - An interview with E21 revealed [R82] was in a brace that immobilized her leg to extend out and she needed help with transfers. E21 stated, "[E38] told [R82] she needed to transfer herself." E21 also stated, "[R82] was very upset."

2. A review of R19's clinical record revealed:

3/3/22 - R19 was admitted to the facility with diagnoses including a stroke which affected his right dominant side, cerebral palsy, and muscle weakness.

1/5/25 - R19's most recent quarterly MDS documented a BIMS' score of 10, which indicated a mild cognitive impairment, and R19 required substantial assistance with toileting.

1/15/25 - A facility's reported incident submitted to the Division documented, that R19 reported to E21 (LSW) at approximately 2:30 PM he asked E22 (CNA) to use the toilet. E22 entered his room and asked, "What do you want?" R19 stated that he needed to use the bathroom, and E22 replied, "Its's too late, you should have asked to go to the bathroom at 2:00 PM." R19 described E22 as yelling at him and being "Really mad." R19 also reported that after E23 assisted him onto the toilet, E22 returned and scolded him for attempting to wipe himself.

1/15/25 - During an interview, E23 (CNA) stated,

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F 600	Continued From page 17 "I was coming to duty and I heard E22 talking to the resident [R19] very rudely. I saw that he (sic) very upset, I talked to him to calm him down." 3/13/25 - During an interview, R19 stated, "I felt like I was being punished and yelled at by E22 when I asked If I could use the bathroom". 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of	F 607		5/10/25

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	085043	A. BUILDING _____ B. WING _____	C 03/26/2025

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F 607	Continued From page 18 employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Resident Abuse Policies and Procedures, last revised 12/2023, it was determined that the facility failed to develop a written policy and procedure that clearly addressed sections under Identification and Reporting. Findings include: Review of the facility's Resident Abuse Policies and Procedures included, but was not limited to, the following: "POLICY... Any allegation of abuse, neglect, mistreatment, injury of unknown origin, suspected commission of a crime, misappropriation of resident property or financial exploitation will be thoroughly investigated and reported..". While the facility policy under the separate section for Definitions listed the different types of abuse, neglect, exploitation of residents, the section for Identification lacked evidence that the facility addressed in the written procedures how staff can identify different types of abuse by resident outcomes, such as an unwitnessed injury that was suspicious or multiple injuries over time or unexplained changes in resident behaviors or activities. Under the section for Reporting, the facility failed to clearly delineate the reporting times for abuse, neglect, mistreatment under the Federal and	F 607	1. Unable to correct in the past. 2. Unable to correct in the past. 3. RCA: The SOD alleges the Resident Policies and Procedures did not address in the written procedures how staff can identify different types of abuse by resident outcomes such as unwitnessed injury that was suspicious, or multiple injuries over time or unexplained changes in resident behaviors or activities. And under the section for Reporting, it did not clearly delineate the reporting times for abuse, neglect, mistreatment. The information is located within the policy, but not as clearly as the surveyors felt it should be. Additionally, there is an "Incident Reporting" policy that provides more in-depth information about what needs to be reported and when, with examples for clarity, so the NHA felt this information was sufficient. The two policies will be combined into one policy to ensure clarity. The Staff Development nurse, or designee, will educate all employees and contractors (Staffing Agency personnel) on the revised Resident Policies and	

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F 607	Continued From page 19 State regulations, whichever is more stringent with the reporting timeframe. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.	F 607	Procedures Policy and explain that the information previously residing in the "Incident Reporting" policy will now be located in the Resident Policies and Procedures Policy. The Incident Reporting policy will be retired. 4. DON (or designee) will conduct audits of resident complaints of abuse and/or neglect daily x 3 to ensure all incidents are reported accurately and timely, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
F 609 SS=E	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609		5/10/25

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F 609	Continued From page 20 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for four (R5, R13, R19 and R65) out of fourteen residents reviewed for abuse, the facility failed to report the allegations of neglect/abuse and injury of unknown source to the State Agency within the required timeframe. Findings include: The facility's "Resident Abuse Policies and Procedures... Identification- under Delaware State Law, any employee who has reasonable cause to believe that a resident has been abused, mistreated, neglected, or has been subject to misappropriation of funds MUST file a report immediately... If there is reasonable suspicion of a crime, and the events that cause the reasonable suspicion result in serious injury, the report must be made immediately after forming the suspicion as follows: Serious bodily injury- within 2 hours, All others- within 24 hours...". Revised 12/2023 1. Review of R5's clinical record revealed: 1/17/18 - R5 was admitted to the facility with	F 609	1. Unable to correct in the past. 2. Unable to correct in the past. 3a. RCA: The incident was initially reported as a skin tear, and was not initially thought to be suspicious. Upon investigation of the skin tear, it was determined that the CNA providing care caused the injury during incontinence care, but did not report the injury. As soon as this new information was discovered, the incident was reported as alleged abuse to the SA within 2 hours. Although there was no deficiency in reporting timely, the DON (or designee) will educate all staff they must report any injury that occurs during patient care to Supervisor/Unit Manager immediately so it can be determined if the injury needs to be reported to the SA timely with 2 hours. 3b. & c. RCA: This deficiency was included in the plan of correction for 2024.	

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F 609	Continued From page 21 diagnosis including, but was not limited to, stroke with left-sided weakness. 11/27/24 - R5's MDS documented that R5 was not able to complete the BIMS cognitive assessment. 1/16/25 Approximately 9:30 AM - E18 (CNA) noted a mark on R5's face and reported it to E15 (LPN). 1/16/25 6:14 PM - E9 (RN) documented in R5's EMR progress notes, "During AM care, CNA [E18] noticed a skin tear to mid forehead and notify (sic) nurse. Neuro check completed and within normal limits, MD made aware and treatment order in place, POA also made aware." 1/17/25 10:15 PM - E28 (RN/ADON) reported the incident of alleged injury of unknown source during care to the State Agency. The report of the alleged injury of unknown source was submitted thirty-five hours after this injury of during care was first noted. 3/13/25 2:20 PM - During an interview, R1 (R5's roommate) reported that on 1/16/25 in the early morning when the CNA [E42 (agency CNA)] was turning R5 to perform incontinence care with R5, R5's head struck the enabler bar on the bed. R5 then said, "Well, do I have to wear a helmet to get changed?" R1 stated that he did not see any other staff in the room until E18 (CNA) came in on day shift and noted the facial skin tear. 2. Review of R13's clinical record revealed: 9/15/22 - R13 was admitted to the facility with	F 609	These two incidents were identified while still monitoring for the 2024 PoC. The PoC was updated at that time, additional education was provided and auditing completed. These two incidents were addressed as a part of the PoC for 2024. The complaints were expressed at the Resident Counsil meeting. They were not recognized by the activities staff member as possible abuse. The Activities staff member was re-educated, and the process was changed to include a review of Resident council issues immediately after all Resident Council meetings with the DON/ADON and/or SW. The PoC was updated, and the new process was thoroughly audited. No additional incidents have occurred since the revised process was instituted and audited for completion. All of the documentation was given to the surveyors at the time of exit from the current survey. As these incidents were already covered under the F609 PoC for 2024, and no new incidents have occurred since those audits were completed, there is no new education or monitoring required. 3d. RCA: The old electronic system for reporting incidents to the SA was taken off-line while the SA was instituting a new electronic reporting system (Wellsky). During this downtime, the SA requested all incident reporting, including the 5-day follow-up, be completed via paper and sent via fax until 1/14/25. On 1/15/25 the Wellsky system was still inoperable, so it was submitted via fax. The incident was	

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F 609	Continued From page 22 diagnoses including, but was not limited to, heart failure and dementia. 3/12/25 11:35 AM - Review of a facility grievance revealed that during a resident led meeting on 4/17/24, R13 reported that on 4/14/24 her CNA [E43 (agency CNA)] stated, "You are not coming out of the bathroom until you brush your teeth." R13 explained that she preferred to eat her breakfast and then brush her teeth. Per R13, E43 blocked her from exiting the bathroom and "would not listen." 5/2/24 5:55 PM - E21 (LSW) reported the incident to the State Agency documenting that the incident of alleged "mistreatment" occurred on 4/14/24 at 9 AM. The report of the alleged "mistreatment" was submitted eighteen days after the alleged incident and fifteen days after the facility became aware of the allegation. 3. Review of R65's clinical record revealed: 10/6/23 - R65 was admitted to the facility, with diagnoses including, but were not limited to, heart failure and breast cancer. 3/12/25 11:40 AM - Review of a facility grievance revealed that during a resident led meeting on 4/17/24, R65 reported that on 4/12/24 another resident (R16) was throwing up so she (R65) went to the nurses' station to report it. R65 reported that there were four employees at the nurses' station and one stated that R16's assigned CNA was on dinner break and that the assigned CNA would check on R16 when she returned from her dinner break.	F 609	re-reported on the new Wellsky system once the system was fully up and running at DHCQ. There is a note in the reportable under the Additional Information - Is there anything else you would like us to know? section of the form, explaining the incident had already been reported on paper due to the computer downtime and why it was reported late electronically. As there was no delay in reporting, no education or monitoring is required. 4a. DON (or designee) will conduct audits of resident injuries during resident care to determine if abuse or neglect occurred and was reported to the SA within 2 hours daily x 3 to ensure all incidents are reported accurately and timely, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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F 609	Continued From page 23 5/2/24 5:03 PM - E21 (LSW) reported the incident of alleged "neglect" to the State Agency. The report of the alleged "neglect" was submitted twenty days after the incident and fifteen days after the facility was aware of the allegation. 4. Review of R19's clinical record revealed: 1/15/25 - R19 reported to facility administration including E21 (LSW) that he alleged that E22 (CNA) verbally abused him during an interaction related to his request for assistance to use the toilet. 1/21/25 - The facility reported the incident of verbal abuse to the State Agency. The facility failed to report R19's allegation of verbal and emotional abuse to the State Agency in the required time of 2 hours. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		5/10/25

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F 610	Continued From page 24 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R26) out of fourteen residents reviewed for abuse, the facility failed to report their investigation results to the State Agency within 5 working days of the incident. Findings include: The facility's "Resident Abuse Policies and Procedures:... Investigation... Within five days, a follow-up State Incident Report is completed indicating the results of the investigation and sent to the Division of Long Term Care Residents Protection electronically...". Revised 12/2023 Review of R26's clinical record revealed: 9/3/20 - R26 was admitted to the facility with diagnoses including, but were not limited to, Parkinson's disease and dementia. 2/19/25 4:10 PM - E21 (LSW) reported an alleged incident of "neglect" to the State Agency. The report stated that on 2/18/25 at approximately 1 PM, R26 had to wait for an hour to be changed by her assigned CNA on 7-3 PM shift. F3 (R26's POA) reported this incident to the facility on 2/19/25 at 3:23 PM.	F 610	1. Unable to correct in the past. 2. Unable to correct in the past. 3. RCA: ADON who was handling the follow-up left employment on 2/13/25. The facility failed to have a back-up for completing the follow-ups within the timeframe. The facility instituted a weekly High Risk meeting in which all Reportables are discussed. The team includes the RNAC (leader of the team), the DON, the ADON, the Staff D/IPCO, LSW, Therapy Director, and NHA. This will ensure that the team is aware of all Reportables and due dates for 5-day follow-up. The RNAC will educate the High-Risk interdisciplinary team on the need to ensure Reportables are reported timely and followed up within 5 days. If an incident has not been reported, the RNAC will assign the reporting duties to a member of the team to report, or to the DON/ADON/Staff D-IPCO if the 5-day	

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F 610	Continued From page 25 The five day follow up report to the State Agency was due on 2/26/25. 3/14/25 1:54 PM - E21 filed the five day follow up report with the State Agency eighteen days late. 3/21/25 10:30 AM - E1 (CEO/LNHA) confirmed the incident was reported to the facility on 2/19/25 at 3:23 PM and the five day follow up was entered on the State Agency website on 3/14/25. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1, E2 (DON), E3 (SD/ICP) and nine department managers/representatives.	F 610	follow-up report needs to be filed to ensure reports are timely. 4. DON (or designee) will conduct audits of SA Reportables daily x 3 to ensure completion of the 5-day follow-up, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
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	F 656		5/10/25

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F 656	Continued From page 26 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 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 observation, interview and record review, it was determined that for two (R17 and R23) out of thirty-five residents sampled, the facility failed to develop and implement a comprehensive person-centered care plan for R17 that included specific directions for taking vital signs on a resident with a dialysis fistula. For R23, the facility failed to include bed enablers as an intervention on the care plan. Findings include: 1. Review of R17's clinical record revealed:	F 656	1a. R17's care plan was updated on 03/24/2025 by NHA. 1b. R23's care plan was updated by the RNAC on 3/11/2025. 2a. All residents on dialysis with fistula precautions have potential to be affected. There are no other residents on dialysis in the facility. 2b. All residents with enablers have	

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F 656	Continued From page 27 11/13/23 - R17 was admitted to the facility with diagnosis including, but was not limited to, end stage renal (kidney) disease with a dialysis fistula on his left arm. R17's most current orders included dialysis three times a week, on Mondays, Wednesdays, and Fridays, check vital signs pre- and post-dialysis on these days on both the day and evening shifts. And monthly vital signs on the first three days of each month during the evening shift. R17's most recent care plan included, "Monitor vital signs as ordered." R17's dialysis care plan failed to include that the blood pressure should not be taken on the left arm to prevent injury to the fistula. 3/12/25 11:30 AM - Interview with E8 (LPN) stated that she knew to take the blood pressure on residents right arm due to it being in the orders, but there was no documentation of orders in the residents electronic chart. 2. Cross Refer F689, example 2 and F700, example 4 Review of R23's clinical record revealed: 8/24/23 - R23 was admitted to the facility with the following diagnoses including, but were not limited to, large body habitus, anxiety, compressed lower back nerves, muscle weakness, nerve pain and osteoporosis. 12/22/24 - R23 had a fall and was sent to the hospital for evaluation after the fall.	F 656	potential to be affected. The RNAC will audit residents with enablers for care plans and make corrections by 5/10/2025. 3a. RCA: The facility did not have a process for creating precaution orders for residents with dialysis fistulas which would trigger the RNAC to care plan their use. The facility updated the Care of Dialysis Policy to include a physician order for dialysis fistula precautions, including not to take blood pressures or perform venipunctures on the extremity where there is a shunt placed. The facility created an order set for dialysis residents including an order template for dialysis fistulas that will give specific direction for where to obtain vital signs on a resident with a dialysis fistula (no blood pressures or venipunctures on the same extremity with a dialysis shunt). The RNAC will develop and implement a comprehensive patient-centered care plan that includes the fistula precautions based on the order as an intervention. The Staff Development nurse (or designee) will educate licensed nursing staff on the updated policy, order and care plan. 3b. RCA: Knowledge Deficit. The facility did not recognize that the enablers they have utilized for years fell into the category of bedrails. They did not have a process for creating orders for residents using enablers, which would trigger the RNAC to care plan their use. The facility created a policy for enablers	

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F 656	Continued From page 28 12/23/24 - Review of R23's care plan for an actual fall on 12/22/24 interventions documented... 1. "Bed mobility evaluation and education on rolling/self-positioning in bed... 2. Continue interventions on at risk program." R23's care plan lacked evidence of the intervention "bed enabler bars added for additional repositioning assistance." 12/31/24 - A review of a facility follow up incident report documented, "Bed enabler bars added for additional repositioning assistance." 3/21/25 11:00 AM - During an interview, E2 (DON) stated, "[R23's] care plan had not been revised to include enablers after the fall." 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.	F 656	called: "Enablers Policy" The facility created an order template for the use of enablers. The RNAC will care plan the enablers based on the order. The Staff Development nurse (or designee) will educate licensed nursing staff on the new process and policy. 4a. RNAC (or designee) will conduct audits of residents with new dialysis fistulas daily x 3 to ensure that the dialysis fistulas are care planned, including not to take blood pressures or venipunctures on the extremity where the dialysis shunt is placed, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 4b. RNAC (or designee) will conduct audits of residents with new enablers daily x 3 to ensure that the enablers are care planned, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 1a. R17's care plan was updated on 03/24/2025 by NHA.	

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F 656	Continued From page 29	F 656	1b. R23's care plan was updated by the RNAC on 3/11/2025. 2a. All residents on dialysis with fistula precautions have potential to be affected. There are no other residents on dialysis in the facility. 2b. All residents with enablers have potential to be affected. The RNAC will audit residents with enablers for care plans and make corrections by 5/10/2025. 3a. RCA: The facility did not have a process for creating precaution orders for residents with dialysis fistulas which would trigger the RNAC to care plan their use. The facility updated the Care of Dialysis Policy to include a physician order for dialysis fistula precautions, including not to take blood pressures or perform venipunctures on the extremity where there is a shunt placed. The facility created an order set for dialysis residents including an order template for dialysis fistulas that will give specific direction for where to obtain vital signs on a resident with a dialysis fistula (no blood pressures or venipunctures on the same extremity with a dialysis shunt). The RNAC will develop and implement a comprehensive patient-centered care plan that includes the fistula precautions based on the order as an intervention. The Staff Development nurse (or designee) will educate licensed nursing staff on the updated policy, order and care plan.	

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F 656	Continued From page 30	F 656	3b. RCA: Knowledge Deficit. The facility did not recognize that the enablers they have utilized for years fell into the category of bedrails. They did not have a process for creating orders for residents using enablers, which would trigger the RNAC to care plan their use. The facility created a policy for enablers called: "Enablers Policy" The facility created an order template for the use of enablers. The RNAC will care plan the enablers based on the order. The Staff Development nurse (or designee) will educate licensed nursing staff on the new process and policy. 4a. RNAC (or designee) will conduct audits of residents with new dialysis fistulas daily x 3 to ensure that the dialysis fistulas are care planned, including not to take blood pressures or venipunctures on the extremity where the dialysis shunt is placed, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 4b. RNAC (or designee) will conduct audits of residents with new enablers daily x 3 to ensure that the enablers are care planned, until 100% compliance is achieved. Audits will continue weekly x 3,	

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F 656	Continued From page 31	F 656	until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
F 684 SS=G	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 record review and interview, it was determined that for seven (R7, R11, R18, R24, R54, R63, R80) out of fifteen residents reviewed for quality of care, the facility failed to provide the residents' care in accordance with the professional standards of practice. For R7, the facility failed to monitor R7's vital signs after noting a change in physical status on 10/16/24; failed to ensure the Provider ordered lab work to check R7's phenytoin levels and serum sodium orders were completed. The facility failed to identify and notify the Provider about the low heart rate, which resulted in a delay in care of R7 obtaining the appropriate level of care. The failure to monitor R7's phenytoin level resulted in in a harm as R7 was admitted to the hospital on 10/17/24 for lethargy and change in mental status with a critically high phenytoin level of 38.5 mg/L.	F 684	1.1. A physician□s telephone order was placed by the Staff Development nurse on 4/23/25 for phenytoin labs every 6 months for R7. 1.2. Unable to correct in the past. 1.3 & 1.4. & 1.5. Unable to correct in the past. Hospice agencies were contacted and medications reconciled for medications being received in the facility for R11, R18, and R54 on 5/9/25 by DON (or designee). 1.6. Unable to correct in the past. R24's skin was assessed and the skin discoloration identified on a Bi-Weekly Skin Assessment form on 3/12/25 by RN	5/6/25

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F 684	Continued From page 32 For R63, the facility failed to monitor timely and accurately document the resident's vitals signs after an unwitnessed fall. For R11 and R54, the facility failed to ensure that each residents' most recent hospice plan of care included the services furnished by the facility. For R24, the facility failed to ensure the resident's skin discoloration was identified and assessed. Findings include: 1. Review of R7's clinical record revealed: Cross refer F580, F726, F755 and F760 Desmopressin: "The major adverse effect of desmopressin for which to monitor is hyponatremia... Hyponatremia is an absolute contraindication to the administration of desmopressin ...". The National Library of Medicine, 2025. www.ncbi.nlm.nih.gov Phenytoin, a seizure disorder drug, has a narrow therapeutic range. Therapeutic range is defined as between 10-20 mg/L. Routine monitoring of serum phenytoin levels is not recommended. However, in clinical suspicion of drug toxicity, serum phenytoin levels should be measured. Clinical signs of phenytoin toxicity include: nystagmus, slurred speech, lethargy and confusion among other symptoms ... National Library of Medicine, Phenytoin Toxicity 2022 Nov 11:15 (11): e253250. Temperature - may vary with the time of day and method used (axillary slightly lower) 98.6 F (37 C) is considered normal oral temperature, but range is 96.4 F (35.8C) to 99.1 F (37.3C). Pulse - Normal adult pulse (heart rate) is 60 to 80 beats/minute; regular in rhythm. Lippincott Manual of Nursing Practice 11th edition, 2019.	F 684	supervisor. 2.1. All residents on phenytoin have potential to be affected. DON (or designee) will audit residents on phenytoin for labs every 6 months and make corrections by 5/6/2025. R7 is the ONLY resident on this medication. 2.2. All residents with bradycardia have potential to be affected. NHA audited all residents on 4/20/25 with bradycardia to ensure vital signs were monitored. There were no instances of bradycardia identified. 2.2. Unable to correct in the past. All residents with falls have the potential to be affected 2.3. & 2.4. & 2.5. All residents on hospice service have potential to be affected. Residents on Hospice will be audited by DON by 5/9/25 to ensure Hospice care plan r/t medications is correct. 2.6. All residents at risk of bleeding r/t aspirin have potential to be affected. DON will audit residents at risk for bleeding r/t aspirin for skin discoloration to ensure documentation appears on the UDA Bi-weekly Skin Assessment by 4/30/2025. 3.1. RCA: A thorough review of R7□s EMR revealed R7 had her labs monitored by the neurologist. R□7□s sister had to cancel and reschedule several of the neurology follow up appointments which	

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F 684	Continued From page 33 1/10/20 - R7 was admitted to the facility with diagnoses including but were not limited to, seizure disorder, diabetes insipidus and hypopituitarism. 11/16/23 - E4 (contracted MD) ordered in R7's EMR, "Dilantin oral capsule 100 mg (phenytoin sodium extended)- give 100 mg by mouth three times a day for seizure disorder." 2023 - R7 had phenytoin levels drawn on 1/24/23, 4/11/23 and 8/3/23. 2/5/24 - E4 ordered in R7's EMR, "CBC with diff, phenytoin free blood level, Vitamin D25-OH, total blood level. Fax results to Neurology ...". The facility failed to provide evidence that these labs were obtained. 8/24/24 - E4 ordered in R7's EMR, "Phenytoin (anti-seizure medication) oral capsule 100 mg- give 1 capsule by mouth three times a day for seizures." 8/25/24 - E4 ordered in R7's EMR, "Desmopressin Acetate oral tablet 0.1 mg- give 0.5 mg tablet by mouth in the morning for diabetes insipidus." 8/26/24 - The quarterly Minimum Data Set (MDS) documented R7's BIMS (basic Inventory of Mental Status) score as 15, which reflected normal cognition. 9/11/24 - E4 ordered in R7's EMR, "BMP, TSH, free T4 one time for hyponatremia, hypothyroid."	F 684	resulted in R7□s phenytoin lab work and levels to be delayed. The facilities attending physician failed to follow up by ordering phenytoin lab work and levels after the several missed neurology appointments. A template order in the EMR for phenytoin labs monitoring has been created. All residents on phenytoin will have labs ordered every 6 months via this template. The Staff Development nurse, or designee, will educate licensed nurses on the new order process. 3.2. RCA: " Vital Signs Policy did not state what to do when vital signs are abnormal. Cross Ref F580 o The facility updated their "Vital Signs" Policy to include directions to notify the provider when the resident has new onset bradycardia. o The Staff Developer, or designee, will educate licensed nurses on the new order process. " The facility process for alert charting is an order instructing the licensed staff to write a progress note r/t the alerted condition. The alert charting order for R63 did not include monitoring vital signs or force the nurse to write a progress note. o The facility created a new UDA named "Alert Monitoring - Abnormal Vital Signs" that will include real time insertion of the vital signs in the UDA and forces a progress note to be written.	

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F 684	Continued From page 34 9/19/24 12:52 PM - The facility laboratory reported R7's serum sodium level as 132 mmol/L. The normal serum sodium level is 135 to 145 mmol/L. 10/16/24 12:22 AM - E24 (RN/Shift supervisor) documented in R7's EMR progress note, "Fall details: Date/Time of fall: 10/15/24 11:50 PM fall was not witnessed ...Provider: [E4] Time notified 10/16/24 Notified of: fall ... Resident found sitting on the floor legs facing the head board of the bed ...Resident stated she was self transferring from wheelchair to the bed, when she fell. VS (vital signs) 154/66, p (pulse) 43, 97.6 T (temperature), 18 rr (respirations), bs (blood sugar) 89 ...". 10/16/24 1:13 AM - R7's heart rate was documented in the EMR as 43 bpm (beats per minute) (irregular- new onset) and temperature of 97.6 F (Fahrenheit). 10/16/24 3:36 AM - R7's heart rate was documented in the EMR as 43 bpm and temperature 97.7 F. The facility failed to identify that R7's heart rate was low and notify the provider of this change. 10/16/24 6:45 AM - E10 (LPN) documented in R7's EMR progress note, "Resident rang at 2350h (11:50 PM hour), employee went into the room and found the resident sitting on her buttocks on the floor ... VS were obtained BP (blood pressure) 154/66, HR 43 SPO2 97%, ...". 10/16/24 10:45 PM - R7's heart rate was documented in the EMR as 41 bpm and temperature 97.2 F.	F 684	o The Staff Development nurse, or designee, will educate the professional nursing staff on the new UDA, and how to properly complete it and the progress note. " The EMR provider changed the fall assessment to a Nursing Advantage assessment that vital signs do not correctly pull into. o The facility created a new Post Fall Follow-up UDA that has vital signs required to be entered, rather than pulling in the last set of documented vitals. o The Staff Development nurse, or designee, will educate the professional nursing staff on the new UDA and how to properly complete it and the progress note. 3.3. & 3.4. & 3.5. RCA: Hospice providers only update their care plans every two weeks. Hospice nurses from each provider have varied methods of communicating with the facility physician and staff, which could lead to confusion of the medication reconciliation process. The process for the physician notification of the Hospice provider of changes was inconsistent. The Hospice Policy was updated to reflect the following changes: The facility has requested that the hospice providers provide the new plan of care for medications every two weeks. A new process for acknowledging and confirming changes between the physician and Hospice was implemented. Paper	

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F 684	Continued From page 35 There were no documented vital signs after 10/16/24 10:45 PM until 10/17/24 1:20 PM, which was thirty-six hours later, despite R7's heart rate being documented as bradycardic at 41 bpm. It should also be noted that the vital signs documented in the hospital transfer note did not include a temperature, respirations, and pulse oximetry. Additionally, the facility failed to monitor R7 with a full set of vital signs including temperature, pulse ox and blood pressure after R7 was documented as having a low heart rate. 10/17/24 1:20 PM - E17 (RN/UM) documented in R7's EMR progress note, "resident had a sudden change in mental status. 148/43 BP, 44 HR and extremely lethargic. MD was called, new order to send to ED (emergency department) for evaluation ... Resident left the facility at 1320 (1:20 PM) on a stretcher with 2 EMTS (emergency medical technicians) ...". R7 was transferred to the hospital thirty-six hours after being documented as bradycardic with a heart rate in the 40's. 10/17/24 to 10/28/24 - For eleven days, R7 was hospitalized for mental status change and visual changes. R7's hospital admission diagnoses included: hyponatremia (low serum sodium level) and phenytoin toxicity. R7 presented to the hospital on 10/17/24 with a phenytoin level of 38.5 mg/L (milligram/Liter) (normal phenytoin range is 10-20 mg/L) and a serum sodium level of 130 (normal sodium range is 135-145). 10/17/24 2:09 PM - C4 (hospital emergency room MD) documented in R7's ED Physician Record, "	F 684	progress notes will be utilized in the resident Hospice binder for all proposed order changes. There will be a section for the physician and the Hospice Representative notification date and time in each binder. When both the physician and the Hospice agree to the order, the licensed nurse will input the order and write a progress note "Facility/Hospice communication" in the EMR. This will serve as evidence that the Hospice knew and agreed to the medication change between their nursing visits and Order updates in the Hospice binder. The Staff Development nurse will educate all professional nursing staff, the providers, and Hospice agencies on the new Hospice process for the nurses and physicians. 3.6. RCA: Staff did not report the skin discolorations as they thought the changes were normal for the resident. The Staff Development Nurse, or designee, will educate licensed staff that all skin discolorations must be documented on the bi-weekly skin assessment. 4.1. DON (or designee) will conduct audits of new medication orders for phenytoin daily x 3 to ensure labs are ordered every 6 months, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings	

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F 684	Continued From page 36 ...History of Present Illness: 64 year old female ...Patient 's sister notes that the patient has been lethargic over the past 2 weeks ...". 10/17/24 2:18 PM - The hospital laboratory reported R7's serum sodium level as 130 mmol/L, with the normal range being 135 to 145 mmol/L. The facility's failure to monitor R7's vital signs and appropriately respond to her bradycardic heart rate resulted in a delay of obtaining the next level of care for R7. 10/18/24 2:46 AM - The hospital laboratory reported R7's phenytoin level as 38.5 mg/L, which is nearly double the therapeutic range. Review of R7's physician orders for 2024 to date revealed no other order for a phenytoin level until 10/31/24, which was after R7's eleven-day hospitalization from 10/17/24 to 10/28/24 during which R7 was discovered to have phenytoin toxicity. The facility's failure to monitor R7's phenytoin level resulted in R7 experiencing phenytoin toxicity. 10/18/24 3:39 AM - C1 (hospital emergency room MD) documented in R7's hospital admission history and physical, "Upon arrival to the ED (emergency department), vital were remarkable for hypothermia to 33.8 (degrees Celsius) and bradycardia to 42 ... she did ultimately require 4 L nasal cannula, however does not require oxygen at home ...". The documented temperature of 33.8 C was the equivalent of 92.8 F. R7's most recent	F 684	of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 4.2. " DON (or designee) will conduct audits of resident with new onset bradycardia daily x 3 to ensure the provider is notified, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. " DON (or designee) will conduct audits of resident with new onset bradycardia daily x 3 to ensure continued monitoring of vital signs, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. " DON (or designee) will conduct audits of falls daily x 3 to ensure continued monitoring of vital signs, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure	

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F 684	Continued From page 37 documented temperature prior to this hypothermic temperature obtained 10/18/24 3:39 AM in the hospital ED was on 10/16/24 at 10:45 PM. The facility failed to obtain a temperature as part of her vital signs when R7 was noted to have a mental status change on 10/17/24 at 1:20 PM. 10/24/24 12:23 PM - C1 (Hospital emergency room MD) documented in R7's discharge summary, " ...Hypothermia - Patient initially hypothermic with temp (temperature) 33.1 (91.6 F), thought to be secondary to phenytoin toxicity versus adrenal crisis. She (R7) was treated with Bair Hugger (a convective temperature management medical device used in hospitals to maintain a patient's core body temperature) and had symptomatic improvement. 3/24/25 3:54 PM - During a telephone interview, E4 (contracted MD) stated that she was not notified that R7's heart rate was in the 40's in October 2024. She stated that her practice's on-call coverage starts at 5 PM to 8 AM and that she does not typically receive a sign-out of any issues overnight so unless the staff told he or wrote in the doctor's book that R7 was bradycardic in the 40's, there would be no way for her to know. E4 did confirm that R7 was evaluated by a provider on 10/17/24 (the same day that R7 was transferred to the hospital) for nasal congestion but no vital signs were documented in that progress note. The constellation of failing to monitor vital signs, failing to identify and notify a provider about a low heart rate led to a significant time delay in obtaining the appropriate level of care that R7	F 684	compliance is obtained and maintained. 4.3. & 4.4. & 4.5. DON (or designee) will conduct audits of changes made to facility resident care plans daily x 3 to ensure the hospice acknowledge changes between biweekly hospice care plan updates, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 4.6. DON (or designee) will conduct audits of residents at risk for bleeding r/t aspirin daily x 3 to ensure the skin check matches any skin discolorations, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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	085043	A. BUILDING _____ B. WING _____	C 03/26/2025

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F 684	Continued From page 38 required during this health crisis. The failure to monitor R7's serum phenytoin levels led to a critically phenytoin level that was diagnosed during R7's 10/17/24 hospitalization. 2. The facility's policy entitled Fall Prevention Program, last reviewed/revised 2/2025, stated, "... 9. In the event of a resident fall, the RN is to assess the resident and document the incident per the following instructions: a. An incident Report is to be completed... b. The "72 hour Fall Risk Assessment" is to be completed in [name of electronic medical record system]... i. Document all assessments and actions...". It should be noted that although the facility's policy stated that a "72 hour Fall Risk Assessment" was to be completed in [electronic medical record system], the actual document nursing staff are currently using to monitor a resident after a fall on every shift for 72 hours was the "Post Fall Evaluation" (PFE). Review of R63's clinical record revealed: 9/19/24 - R63 was admitted to the facility with diagnoses that included, but were not limited to, dementia, aphasia and history of falls. 10/1/24 at 4:42 PM - A nurse's note documented, "Late Entry: Resident found on the floor sitting on his bottom on top of his floor mat between his chair and his bed at 1600 [4 PM]. Resident was assessed no signs of bruises or trauma." There was no evidence of R63's initial vital signs and assessment was obtained and documented in the RN's initial assessment immediately after R63's unwitnessed fall during the evening shift of	F 684		

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F 684	Continued From page 39 10/1/24. 10/2/24 at 1:33 AM - A Post Fall Evaluation by E10 (LPN) documented the following vital signs (VS): - "Temperature: [blank]... - Blood Pressure: 125/72 Date: 10/3/2024 01:34 [1:34 AM]... - Pulse: 79 Date: 10/3/2024 01:34... - Respiration: 20 Date: 10/3/2024 01:34... - O2 sats: 98% Date: 10/3/2024 01:34... - Pain Level: 0 Date: 9/29/2024 07:36...". 10/2/24 8:35 AM - A Post Fall Evaluation by E10 (LPN) documented the following VS: - "Temperature: [blank]... - Blood Pressure: 125/72 Date: 10/3/2024 01:36 [1:36 AM]... - Pulse: 79 Date: 10/3/2024 01:36... - Respiration: 20 Date: 10/3/2024 01:36... - O2 sats: 98% Date: 10/3/2024 01:36... - Pain Level: 0 Date: 9/29/2024 07:36...". It should be noted that E10 documented the same vitals signs on both 10/2/24 PFEs timed 1:33 AM and 8:35 AM. 10/2/24 8:37 PM - A Post Fall Evaluation by E10 (LPN) documented the following VS: - "Temperature: 98 Date: 10/3/2024 01:38 [1:38 AM]... - Blood Pressure: 119/68 Date: 10/3/2024 01:38... - Pulse: 73 Date: 10/3/2024 01:38... - Respiration: 20 Date: 10/3/2024 01:38... - O2 sats: 98% Date: 10/3/2024 01:38... - Pain Level: 0 Date: 9/28/2024 07:36 [7:38 AM]...". 10/3/24 1:40 AM - A Post Fall Evaluation by E10	F 684		

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F 684	Continued From page 40 (LPN) documented the following VS: - "Temperature: 98 Date: 10/3/2024 01:41 [1:41 AM]... - Blood Pressure: 119/68 Date: 10/3/2024 01:38 [1:38 AM]... - Pulse: 73 Date: 10/3/2024 01:38... - Respiration: 20 Date: 10/3/2024 01:38... - O2 sats: 98% Date: 10/3/2024 01:38... - Pain Level: 0 Date: 9/28/2024 07:36 [7:38 AM]...". It should be noted that E10 documented the same vitals signs on both 10/2/24 and 10/3/24 PFEs respectively timed 8:37 PM and 1:40 AM. The facility failed to ensure that vital signs were being accurately captured, monitored and documented every shift for 72 hours by nursing for R63, a dependent, non-verbal resident who had an unwitnessed fall on 10/1/24. 3/20/25 8:10 AM - During an interview, E9 (RN) explained the facility's procedure after a resident falls. When an incident report is started, a Fall Risk Assessment and Post-Fall Evaluation (PFE) forms are automatically triggered and are to be completed by a nurse. E9 stated that Charge Nurses are to complete PFEs every shift for nine (9) shifts [72 hours]. E9 explained that the PFE included entering vital signs, pain level, bruising, confusion, change of condition. E9 explained and showed the Surveyor that the PFE captured the date that it was opened, then the nurse has the ability to select box "Finish Later" or "Complete". "Complete" button can only be selected if all the information was entered otherwise it remains shaded out and unable to be selected. When the PFE was completed and the nurse clicks the "Complete" button, then the nurse will check the	F 684		

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F 684	Continued From page 41 box to sign, date and exit the form. The PFE form then locks. 3/21/25 at 12:21 PM - Finding was reviewed with E1 (CEO/LNHA) and E2 (DON). Surveyor reviewed the vital signs that were entered on R63's PFEs by E10 (LPN) that were timed on four back-to-back shifts: 10/1/24 - 10/2/24 night shift; 10/2/24 day shift; 10/2/24 evening shift; and 10/2/24 - 10/3/24 night shift. When asked if E10 (LPN) worked four 8-hour shifts back-to-back, E2 (DON) nodded her head "no". 3. A review of R11's clinical record revealed: 3/24/21 - R11 was admitted to the facility. 11/16/24 - R11 was admitted to hospice care. 3/12/25 - A review of the medications on the 2/26/25 hospice plan of care document in the electronic medical record (EMR) compared to the medications that the facility had profiled for R11 in the facility EMR revealed the following discrepancies: -Ativan 0.5 mg by mouth every four hours as needed for agitation that was ordered by hospice on 11/16/24 was on the hospice medication list but not on the current facility medication list. -Miralax 17 grams, 1 scoop daily by mouth for constipation, was ordered by the facility on 11/1/24 was on the facility medication profile, but not on the hospice list of medications. -Omeprazole 40 mg, 1 capsule daily for reflux, was ordered by hospice on 11/16/24 was on the hospice medication list, but not on the current	F 684		

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F 684	Continued From page 42 facility medication list. 3/11/25 1:50 pm - During an interview, E17 (RN/UM) confirmed that the hospice medications on R11's 2/26/25 hospice plan of care did not match the current medications that the facility was administering to R11. 4. A review of R18's clinical record revealed: 2/1/23 - R18 was admitted to the facility. 1/4/24 - R18 was admitted to hospice care. 3/12/25 - A review of the medications on the 2/26/25 hospice plan of care document in the R18's chart compared to the medications that the facility had profiled in R18's EMR revealed the following discrepancies: -Sertaline 50 mg, give by mouth daily, was ordered by the facility on 2/2/23, but it was not on the 2/26/25 hospice plan of care medication list. Sertaline is a medication to help mood disorders. -Trazodone 50 mg, give 100 mg by mouth daily at bedtime, was ordered by the facility on 12/12/24, but the dosage was different, it was listed on the 2/26/25 medication list as Trazodone 150mg by mouth daily at bedtime. Trazodone treats sleeping problems and depression. 3/14/25 9:20 AM - During an interview, E2 (DON) confirmed that the hospice medications on the R18's 2/26/25 hospice plan of care did not match the current medications that the facility was administering to R18. 5. A review of R54's clinical record revealed:	F 684		

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F 684	Continued From page 43 12/16/24 - R54 was admitted to the facility, already under the care of hospice. 3/12/25 - A review of the medications on the hospice plan of care document in the R54's chart compared to the medications that the facility had profiled in R54's EMR revealed the following discrepancies: - Trazodone 50 mg ½ tab by mouth daily, ordered by the facility on 12/17/24, was not on the hospice medication list. 3/14/25 9:25 AM - During an interview, E2 (DON) confirmed that the hospice medications on R54's hospice plan of care in the chart did not match the current medications that the facility was administering to R54. The facility failed to ensure that the most recent hospice plan of care included the services furnished by the facility. The most recent hospice care plan medication list for R11, R18 and R54 did not match the medications that R11, R18 and R54 were receiving from the facility.The medication discrepancies between the facility and hospice medications as described above could lead to a delay in symptom treatment for R11, R18 and R54. The facility and the hospice medications should match so that the end-of-life care is seamless and without potential care delays. 6. A review of R24's clinical record revealed: 6/27/18 - R24 was admitted to the facility with diagnoses including, but were not limited to paralysis of one side of the body due to a stroke,	F 684		

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F 684	Continued From page 44 and blood clots. R24's current physician's orders included Aspirin 81mg, daily, and showers and skin checks on Tuesdays and Fridays on the 3-11 shifts. R24's current ADLs (activities of daily living) records revealed that her baths/showers on were scheduled on Mondays and Thursdays on the 7-3 shift. R24's current care plan documented, "... At risk for bleeding related to use of aspirin...". The interventions included, "Monitor for any signs or symptoms of bleeding, as well as to notify the doctor with any concerns or changes." 3/3/25 - R24's clinical records lacked evidence that a skin check was completed. 3/6/25 11:05 AM - R24 was observed with purple and black discoloration on her left forearm, around the elbow area. 3/6/25 3:46 PM - R24's clinical records documented that a skin assessment was completed but failed to include the purple and black discoloration on the left forearm. 3/11/25 6:52 PM - R24's skin assessment was documented but failed to include the purple and black discoloration on the left forearm. 3/12/25 10:00 AM - During an interview, E2 (DON) stated that R24 had discoloration on the left elbow area, and it should be documented during bi-weekly skin assessments. 3/26/25 11:45 AM - Findings were reviewed	F 684		

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F 684	Continued From page 45 during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.	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 record review and interview, it was determined that for one (R11) out of four residents sampled for range of motion, the facility failed to provide R11 with a right-hand palm guard that was ordered on 5/2/24. Findings include: A review of R11's clinical record revealed: 3/24/21 - R11 was admitted to the facility. 5/2/24 - An order was written in the EMR for R11 to have a right palm guard, to put the palm guard	F 688	1. R11's order for a right-hand palm guard was discontinued by the Medical Director on 3/11/25 related to resident refusals to comply. 2. All residents with orthotics have potential to be affected. DON, or designee, will audit residents with orthotics for proper order entry By May 6, 2025. 3. RCA: Upon readmission, the order was	5/10/25

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F 688	Continued From page 46 on after morning care, and to take the palm guard off before bedtime. 3/7/25 10:10 AM - During an observation, R11 was not wearing a right-hand palm guard. R11's right hand was contracted, with his fingers pressing into the palm of his hand. The following document review, observation and interviews occurred on 3/10/25: -A review of R11's care plan revealed that R11 was at risk for pain because of... and multiple contractures and decreased mobility. R11 had a diagnosis of a right hand contracture listed on the care plan. -9:30 AM - During an observation, R11 was not wearing a right-hand palm guard. R11's right hand was contracted with his fingers pressing into the palm of his hand. 3/10/25 9:35 AM - During an interview, E50 (CNA) stated that R11 had never worn a right-hand palm guard that she knew of. -A review of the medication and treatment administration record revealed that R11's palm guard did not show as a nursing task to be completed daily. -A review of the CNA Task List revealed that a right-hand palm guard application and removal was not a task for the CNA to do for R11. -10:00 AM - During an interview, E26 (LPN) confirmed that the application and removal of a right-hand palm guard for R11 was not present on the Medication Administration Record (MAR) or	F 688	not put in correctly by therapy and the system allowed the therapist to confirm their own orders. Nursing did not correct the order or initiate the task when they did the 24-hour chart check. The facility changed the therapy access so that they cannot confirm their own orders. The Staff Development nurse, or designee, will educate licensed nurses to thoroughly review each order to ensure they are entered properly, and tasks are initiated, when completing the 24- hour chart check. 4. DON (or designee) will conduct audits of residents□ orders created by therapy daily x 3 to ensure the orders are entered properly and tasks are initiated, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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F 688	Continued From page 47 the Treatment Administration Record (TAR) as a nursing task to complete. -11:30 AM - During an interview, E9 (RN) confirmed that the 5/2/24 order for a right-hand palm guard was present as an active order for R11, but the reason that the order was not showing on nursing tasks lists was because the 5/2/24 order was entered incorrectly into the EMR. The frequency for the palm guard application and removal was not entered as part of the order entry, which caused it to not show on any nursing task lists. 3/14/25 9:20 AM - During an interview, E2 (DON) stated that the process to verify the accuracy of all new orders entered into the EMR is through a daily 24-hour chart check process. The 11-7 overnight nursing staff completes the chart check process and verifies the accuracy of any new order entered the EMR that day. After a review of R11's May 2024 TAR, E2 confirmed that a 24-hour chart check had been completed for R11 5/2/24 new orders. The facility's nursing staff failed to provide R11 with a right-hand palm guard as ordered from 5/2/24, for more than 10 months, or to be aware that there was an active order for R11 to have a right-hand palm guard. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		5/6/25

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F 689	Continued From page 48 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and review of clinical records and other documentation as indicated, it was determined that for four (R63 and R23) out of eight residents reviewed for falls, the facility failed to ensure that each residents' plan of care was followed to prevent accidents. For R63, the facility improperly transferred the resident using one staff person stand and pivot when R63 required two staff persons and hoyer lift. As a result, R63 was harmed when the resident sustained a lower leg laceration requiring sutures in the emergency room. For R23, a dependent resident for bed mobility, rolled off the bed on to the floor during incontinence care. R23 was sent to the emergency room after the fall. Findings include: A facility policy titled "Falls" revised 3/2025 documented... 1. "To institute individualized practices to minimize the resident's risk of falling and to maximize safety from fall; and to assess each resident of their fall risk on admission, and on a regular basis... 2. The fall risk assessment will categorize the risk for falling according to the following criterion: 1. Low - Risk - a fall risk evaluation score of less than 6. 2. High - Risk - a fall risk evaluation score of 6 or greater." 1. Review of R63's record revealed:	F 689	1a. Unable to correct in the past. 1b. Unable to correct in the past. R23, was moved into a bariatric bed on 5/6/25. 2a. All residents with orders to utilize a Hoyer lift have the potential to be affected. DON, or designee, will audit residents with Hoyer lift orders to ensure use of lift and two-person assist by May 6, 2025. 2b. All residents weighing greater than 300 pounds have potential to be affected. DON (or designee) will audit residents with new admission weight greater than 300 pounds to ensure they are evaluated by therapy for ability to turn and reposition in a standard size bed By April 30, 2025. There are no other residents weighing greater than 300 pounds in the facility. 3a. RCA: CNA stated she was unaware of the transfer status. The information is available in the EMR under Kardex, but CNA's do not routinely check this area. The facility will create a transfer sheet with the residents□ current transfer status for each resident and place it on the inside of	

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KUTZ REHABILITATION AND NURSING	704 RIVER ROAD WILMINGTON, DE 19809

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F 689	Continued From page 49 9/19/24 - R63 admitted to the facility with diagnoses including, but were not limited to, dementia, aphasia and history of falls. 10/21/24 - A physician's order documented, "Hoyer lift transfer assist of two person." 12/5/24 - R63's Fall Risk Evaluation documented that the resident was a high fall risk. 1/3/25 at 11:05 AM - The facility's incident report documented that E20 (CNA) "was assisting resident with transfer from bed to wheelchair where he obtained a laceration to right lower extremity. Resident unable to give description...". R63's POA and E11 (contracted Physician) were notified. 1/3/25 at 11:49 AM - E20's written statement as part of the facility's investigation documented, "... was transferring patient from bed to chair and leg was up against the leg rest connector... blood running down patient leg, along with a (sic) open area... Were you being assisted by anyone... no assistant (sic) from anyone...". 1/3/25 at 1:19 PM - The hospital record documented, "... suffered a laceration of... right leg while transferring from his bed into... wheelchair... Wound was thoroughly irrigated... and then repaired with... sutures and then Steri-Strips were placed over top of the area...". The facility failed to report R63's 1/3/25 incident to the State Agency as required. In response to this incident, the facility did the following: - on 1/6/25, E3 (SD) provided E20 (CNA)	F 689	their wardrobe door to maintain confidentiality by May 5, 2025. When the transfer status order is changed, nursing will update the transfer sheet. The Staff Development nurse will educate all nursing staff on the location of the transfer status in the residents room on the inside of their wardrobe, as well as on the electronic Kardex in the EMR and how to update the transfer status when new orders are written by May 6, 2025. 3b. RCA: The Statement of Deficiencies (SOD) states the facility did not follow the plan of care to prevent an accident. However, at the time of the fall, the resident was care planned as a one-person assist for turning and repositioning in the bed. The SOD stated that the bed mobility was updated on 3/18/25 (under ADL focus) by LNAC, however it was already updated on the fall focused care plan on 12/31/2024 by DON after the fall. 4a. DON (or designee) will conduct audits of residents ordered to use lifts and two-person assist daily x 3 to ensure the transfer sheet is updated, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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F 689	Continued From page 50 one-on-one education and return demonstration for safe resident transfers. The skill competency was documented and signed by both E3 and E20. 3/24/25 10:34 AM - During an interview, E20 confirmed that she stood R63 up to transfer, his feet got twisted, leg was bleeding and he was sent to the emergency room. E20 stated that it was her first day shift and she asked another staff person how R63 transferred and was told stand and pivot transfer. When asked about her training, E20 confirmed that she had training on resident transfers during her orientation in April 2024 and had one-to-one education after R63's incident. 3/21/25 12:21 PM - Finding was reviewed with E1 (CEO) and E2 (DON). 3/25/25 at 1:08 PM - During an interview with E1 and E2 regarding the QAPI efforts in the facility, E1 stated that the facility currently has an ongoing initiative with a high fall risk committee reviewing falls every Monday. 2. R23's clinical record revealed: 8/24/23 - R23 was admitted to the facility with the following diagnoses including, but were not limited to, large habitus (body structure), compressed lower back nerves, muscle weakness, nerve pain, anxiety and osteoporosis. 9/23/23 - R23's care plan for ADL (activities of daily living) self-care performance deficit related to (sic) unspecified abnormalities of gait and mobility with interventions to include: 1. "Bed mobility the resident requires (sic) x1 staff to turn and reposition in bed and as necessary."	F 689	4b. No audits are required.	

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F 689	Continued From page 51 12/3/24 - R23's quarterly MDS documented, "R23 required substantial maximum assistance to roll from lying on back to left and right side and return to lying on back on the bed." 12/3/24 - R23's fall risk evaluation revealed a score of 7 and was a high risk for falls. 12/4/24 - R23's quarterly MDS assessment revealed the resident was cognitively intact. 12/22/24 - R23's fall risk evaluation revealed a score of 7 and was a high risk for falls. 12/22/24 3:55 AM - A facility incident report documented, "CNA did not assure resident positioning safety prior to attempting to provide care therefore contributing to the resident's fall onto floor. [E40] CNA assigned to educational courses for resident safety. Resident taken to ER (sic) for evaluation for complaints of pain and returned to facility within 24 hours with no acute findings. Bed enablers applied for additional positioning assistance." 12/22/24 - A facility statement for E40 (CNA) documented, "I was giving [R23] care this morning at 4 AM she went to turn to her left side and continued forward out of the bed she had little to no room to actually move well from side to side when asked about a bigger bed for her I was told she was unable to get a bigger bed." 3/5/25 - R23's quarterly MDS assessment revealed the resident was cognitively intact. 3/18/25 - R23's care plan created on 9/23/25 was updated with a new intervention to "turn and	F 689		

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F 689	Continued From page 52	F 689		

reposition: two-person assist with all turns and repositioning for safety."

The intervention was added to R23's care plan at least three (3) months after the residents fall from the bed on 12/22/24.

3/20/25 2:05 PM - During an interview, R23 was observed lying in a standard sized bed on her back with a fall mat on the right and left side of the bed. R23 stated, "I slipped out of the bed I was turning over and I fell out of the bed, the bed is not wide enough for me if I turn over, I am right here on the edge." R23 also stated. "I'm afraid when I am being turned in the bed, I'm always on the edge of the bed no matter what, when I fell off the bed, I was right on the edge the aide could not grab me and then after that they put down mats, but I am still afraid of falling."

3/21/25 11:00 AM - During an interview E2 (DON) stated, "[R23] is not bariatric weight we moved her room to give her more space in her room. E2 also confirmed "all residents in the building have enablers that are attached on their bed." When E2 was asked about approaches to assist with preventing another fall for R23, E2 stated, "I think the CNA was educated on proper turning and repositioning and to be careful when providing care for R23 when in the bed."

3/21/25 1:10 PM - During an interview with E16 (DOR), it was revealed that the current therapy department arrived in "October 2024" and that all the beds in the facility had enablers on them. E16 stated and confirmed, "[R23] had enablers on the bed in October 2024." Additionally, E16 stated, "she is in a standard bed and because she is a large lady it is a tight fit she is afraid when turning

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F 689	Continued From page 53 in the bed, and nursing said that she does not meet the classification for a larger bed." The facility failed to ensure R23's safety when E40 asked R23 to turn in the bed during incontinence care and R23 rolled off the bed on to the floor. The resident was sent to the hospital emergency room after the fall. R23's ADL care plan intervention was not updated for 2 person staff assist for turn and reposition with all turns and repositioning for safety until 3/18/25. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding	F 693		5/10/25

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F 693	Continued From page 54 including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that for one (R17) resident out of three residents reviewed for tube feedings, the facility failed to consistently and correctly label R17's tube feeding solution. Findings include: 3/6/25 10:06 AM - The Surveyor observed that R17's tube feeding solution was not labeled with the resident's name, the room number, the date and time that the tube feeding was given, or flow rate for the feeding to be administered. 3/7/25 9:04 AM - R17's tube feeding solution was labeled improperly, missing the date and the time that the tube feeding was started, as well as the flow rate for the feeding to be administered. 3/14/25 9:29 AM - R17's tube feeding solution and water bag were unlabeled. Findings were confirmed with E3 (SD/ICP) 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 and nine department managers/representatives.	F 693	1. Unable to correct in the past. 2. Unable to correct in the past 3. RCA: Enteral Feeding Policy did not include the labeling of the feeding and water bag with resident name, room number, date, and time it was started and the flow rate. The facility updated the policy to include the labeling of the feeding and water bag with resident name, room number, date, and time it was started and the flow rate. Order template will be created to accompany each feeding order that includes the directions for labeling. Licensed nursing staff will be educated by Staff Development nurse, or designee, on new policy. 4. DON (or designee) will conduct audits of residents with tube feeding daily x 3 to ensure the bottles and bags are labeled, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning	F 695		5/10/25

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F 695	Continued From page 55 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, record review and interview, it was determined that for one (R72) out of one resident reviewed for respiratory, the facility failed to ensure R72's O2 tubing was replaced weekly as per professional standards of care. Findings include: Facility's Oxygen Administration policy - "Oxygen is administered to residents who need it, consistent with professional standards of practice... Policy Explanation and Compliance Guidelines:... 5. Staff shall perform hand hygiene... when in contact with oxygen equipment. Other infection control measures include:... b. Change oxygen tubing and mask/cannula weekly and as needed...". 2/5/25 - R72 was admitted to the facility with diagnoses including, but was not limited to, acute respiratory failure with hypoxia. 2/5/25- E4 (contracted MD) ordered in R72's EMR, "Oxygen 2-4 liters via nasal cannula or facemask for dyspnea... as needed for pulse ox to remain above 92%... change oxygen tubing weekly on Wednesday 11-7 shift... every night	F 695	1. Unable to correct in the past. 2. All residents with oxygen have potential to be affected. DON, or designee, will audit residents with oxygen for tube labeling By May 6, 2025. 3. RCA: The order does not state to label the oxygen tubing with date and time each time it is changed. The nurse does sign off the tubing change on the MAR/TAR. The facility updated the order template to include the instruction to label the oxygen tubing with date and time and initial. (Wednesday 11p-7a and PRN). Staff Development nurse, or designee, will educate professional nursing staff on need to label the oxygen tubing with date, time, and initials with each tubing change per order. 4. DON (or designee) will conduct audits of residents with oxygen daily x 3 to ensure tubing is labeled, until 100%	

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F 695	Continued From page 56 shift every Wednesday for oxygen therapy." 3/5/25 night shift - E10 (LPN) signed off in R72's MAR that she had changed R72's oxygen tubing. 3/6/25 Thursday 1:59 PM - The surveyor observed R72 lying in bed with supplemental oxygen 3L (liters) via nasal cannula with no date or time label on the cannula tubing. 3/10/25 Monday 3:36 PM - The surveyor observed R72 in her wheelchair in her room with supplemental oxygen 3L (liters) via nasal cannula with no date or time label on the cannula tubing. 3/11/25 Tuesday 2:32 PM - The surveyor observed R72 lying in bed with supplemental oxygen 3L (liters) via nasal cannula with no date or time label on the cannula tubing. 3/11/25 2:32 PM - During an interview, E7 (LPN) stated, "The O2 (oxygen) tubing is changed on the Wednesday overnights. They are suppose to date the tubing with a label." 3/12/25 Wednesday 11:16 AM- The surveyor observed R72 in the gym performing therapy with supplemental oxygen 3L (liters) via nasal cannula with no date or time label on the cannula tubing. E5 (contracted OT) confirmed there was no date and time label on the cannula tubing. 3/12/25 12:53 PM - E6 (CNA) confirmed there was no date and time label on R72'S oxygen nasal cannula tubing. 3/13/25 3:39 PM - During an interview, E2 (DON) stated, "I don't know if they have to label the tube feeding or oxygen tubing with the date and time at	F 695	compliance is achieved. Audits will continue weekly x +L273, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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F 695	Continued From page 57 the point of changing the tubing. I will check the policy and get back to you." 3/21/25 11:10 AM - During an interview with E8 (LPN) and E9 (RN), E8 (LPN) stated, "It is the standard of care that you label the oxygen tubing with the date and time when you change the tubing. Night shift does that task here once a week." 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.	F 695		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing	F 700		5/10/25

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F 700	Continued From page 58 and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, it was determined that for four (R5, R23, R27, R47) out of four residents reviewed for bedrails, the facility failed to assess the residents prior to installing the bedrails/enablers and failed to obtain consent from the resident/POA/resident representative. Findings include: 1. Review of R5's clinical record revealed: 1/3/23 - R5 was admitted to the facility with diagnoses including, but was not limited to, stroke with left-sided weakness. 3/12/25 9:29 AM - The surveyor observed R5 lying in his bed, which had bilateral enablers at the head of the bed. 3/13/25 12:01 PM - The surveyor observed R5 lying in his bed, which had bilateral enablers. 3/20/25 4:10 PM- The surveyor requested evidence of therapy's assessment of R5 for the bedrail/enabler and a copy of the POA's consent for enablers. The facility was not able to produce evidence of R5's assessment by therapy for bedrails/enablers nor a copy of the consent from R5's POA for installing bedrails/enablers on his bed. 3/24/2511:24 AM - During an interview, E16 (contracted DOR) stated, "We don't have a consent or assessment." 2. Review of R47's clinical record revealed:	F 700	1. R5, R47, R27, R23 will be evaluated for need for enablers and complete assessment, consents, and orders as required by May 10, 2025. 2. All residents with enablers have potential to be affected. DON or designee will audit residents with enablers for need By May 10, 2025 3. RCA: knowledge deficit related to knowing that Enablers are considered Bedrails in LTC. The facility created a policy for enablers called: Proper Use of Enablers. The facility created a consent for use of enablers. The therapy department will screen residents upon admission and when requested for changes for enabler use for mobility. The Staff Developer (or designee) will educate licensed nursing staff on the new policy and need to obtain consent of enablers if recommended by therapy department. 4. DON (or designee) will conduct audits of new residents with enablers daily x 3 to ensure they have been screened and have a consent, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure	

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F 700	Continued From page 59 2/3/21 - R47 was admitted to the facility with diagnoses that included, but were not limited to, hemiplegia and hemiparesis following a stroke affecting the right dominant side and a cognitive communication deficient. 1/9/25 - The annual MDS assessment documented that R47 had a functional limitation in range of motion on one side of upper extremity and both sides on lower extremities. 3/18/25 9:08 AM - Observation of R47 in bed with bilateral 1/4 enablers positioned up. 3/18/25 9:16 AM - During an interview, E16 (contracted DOR) confirmed that no bed rail assessment has been completed for R47 at this time. E16 also stated that her therapy company, which started providing services in November 2024, does not have access to the previous therapy provider records. 3/18/25 10:35 AM - During an interview, E34 (CNA) stated that R47 uses the bed enablers with only his good arm (left). E34 stated that R47 cannot use his right arm or right leg. E34 stated that when she rolls him over toward the window (on the right side), R47 was able to use the right enabler to hold onto with his left hand; however, when he rolls over on his left side, R47 cannot use his right hand to grab the left sided enabler although he tries to grab it with his left hand. 3/18/25 10:43 AM - During an interview, E35 (LPN) was asked if she could provide the surveyor with R47's signed consent for the use of bed enablers. E35 reviewed R47's electronic clinical record and was unable to locate the	F 700	compliance is obtained and maintained.	

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F 700	Continued From page 60 signed consent. E35 stated that she would have to talk to therapy. The surveyor mentioned that the current therapy provider does not have access to the prior therapy company's documentation. E35 then said that she would have to elevate this request to someone higher that has access to the resident's therapy records. 3/21/25 11:30 AM - During a combined interview, finding was reviewed with E1 (CEO/LNHA) and E2 (DON). No further documentation was provided to the surveyor. The facility failed to ensure R47 was assessed for bilateral bed enablers and a signed consent was obtained before placing bilateral enablers on the resident's bed. 3. Review of R27's clinical record revealed: 4/12/21 - R27 was admitted to the facility. 3/7/25 9:00 AM - An observation revealed side rails (enablers) present on both sides of R27's bed. 3/10/25 9:30 AM - An observation revealed side rails (enablers) present on both sides of R27's bed. 3/12/25 - A review of R27's clinical records revealed the lack of the following documentation: -Bed rail use assessments, including appropriate alternatives to the bed rails/enablers, risk of entrapment in the bed rail/enabler, and the risks versus benefits of the use of bed rails/enablers. -Informed consent.	F 700		

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F 700	Continued From page 61 3/13/25 10:31 AM - During an interview, E16 (contracted DOR) stated that an effort to obtain assessments for the facility bed rails/enablers was in progress, but that there were no bed rail/enabler assessments that her department had completed for any resident at that point. 4. Review of R23's clinical record revealed: 8/24/23 - R23 was admitted to the facility with the following diagnoses including, but were not limited to, large body habitus, anxiety, compressed lower back nerves, muscle weakness, nerve pain and osteoporosis. 3/6/25 10:34 AM - An observation revealed bilateral enablers on R23's bed. 3/21/25 11:00 AM - During an interview E2 (DON) stated, "We didn't know that a side rail assessment or consent was needed for a resident to have enablers on their bed. We are starting the process for the assessment for side rails and consent, therapy is now starting the evaluations for the enablers." 3/21/25 1:10 PM - During an interview E16 (contracted DOR) stated, "We are starting to do the enabler evaluations for the residents that are curently on therapy case load." 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.	F 700		
F 711 SS=D	Physician Visits - Review Care/Notes/Order CFR(s): 483.30(b)(1)-(3)	F 711		5/10/25

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F 711	Continued From page 62 §483.30(b) Physician Visits The physician must- §483.30(b)(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; §483.30(b)(2) Write, sign, and date progress notes at each visit; and §483.30(b)(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R72) out of thirty-five residents reviewed for physician services, the facility failed to ensure that the physician reviewed the residents' total program of care. Findings include: Review of R72's clinical record revealed: 2/5/25 - R72 was admitted to the facility with diagnosis including, but was not limited to, acute respiratory failure with hypoxia. 2/13/25 10:30 AM - E4 documented in R72's EMR physician progress note, "... Assessment/Plan:... has been weaned off O2...". This physician note inaccurately documented that R72 had been weaned off of her supplemental oxygen.	F 711	1. R72 was not on Oxygen at the time of physician assessment. E4 will write an addendum to their progress note of 2/13/25 stating R72 was off their oxygen at the time of E4's visit, but was still intermittently utilizing her oxygen for SOB. 2. All residents with PRN Oxygen orders and a primary respiratory diagnosis have potential to be affected. DON, or designee, will audit Physician documentation for residents with PRN oxygen orders and a primary respiratory diagnosis since May 1st to ensure respiratory care and oxygen use were addressed where applicable. 3. RCA: Although care was appropriate, and the physician accurately assessed the resident and oxygen was not in use at the time of the visit, the progress note did not	

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F 711	Continued From page 63 2/13/25 11:16 AM - E35 (LPN) documented in R72's EMR progress notes, "Resident continues on O2 at 4L N/C. Pulse ox is at 99 at rest. Res stated that she got sob [short of breath] while in the middle of therapy. Resident stated that she was on O2 at the time. Resident was able to catch her breath once at rest." 2/14/25 10:46 PM - E29 (LPN) documented in R72's EMR progress notes, "... Oxygen via nasal cannula...". 2/16/25 10:39 PM - E48 (LPN) documented in R72's EMR progress notes, "... Oxygen via nasal cannula...". 2/17/25 9:42 AM - E11 (contracted MD) documented in R72's EMR physician progress note made no mention of R72 utilizing supplemental oxygen despite her admission diagnosis of acute respiratory failure with hypoxia. This physician note failed to provide an overview of R72's total program of care by not addressing R72's respiratory status whether R72 was still requiring supplemental oxygen. 2/17/25 8:03 PM - E48 (LPN) documented in R72's EMR progress notes, "... Oxygen via nasal cannula...". 2/20/25 11:05 AM - E4 (contracted MD) documented in R72's EMR physician progress note made no mention of R72 utilizing supplemental oxygen. This physician note failed to provide an overview of R72's total program of care by not addressing R72's respiratory status whether R72 was still	F 711	explicitly acknowledge the resident□s ongoing PRN oxygen order tied to her admitting diagnosis. The absence of a consistent communication process around intermittent oxygen use contributed to this documentation gap. Both attending physicians were educated on expectations to document PRN oxygen use (or non-use) when the resident has a primary respiratory diagnosis, regardless of whether oxygen is in use at the moment, unless the physicians are completing a Physician Progress Note unrelated to the resident□s respiratory or oxygen issues. Residents with PRN oxygen orders and a primary respiratory diagnosis will be discussed during the weekly High-Risk Clinical Meeting to ensure interdisciplinary awareness and to support accurate documentation during upcoming physician visits. For all residents with PRN Oxygen orders and a primary respiratory diagnosis who were discussed at the weekly High- Risk Clinical Meeting, the RNAC will write a note in the Physician's communication book stating if the resident is still on their oxygen full-time, intermittently and if so why (ie: sob with exertion), or if they are completely weaned off their oxygen. The DON, or designee, will educate the RNAC and the Physicians on the new process.	

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F 711	Continued From page 64 requiring supplemental oxygen. 2/22/25 5:05 PM - E48 (LPN) documented in R72's EMR progress notes, "... Oxygen via nasal cannula...". 3/24/25 3:54 PM - During a telephone interview when questioned about R72's supplemental oxygen usage, E4 stated, "... They (the nurses) were suppose to wean the oxygen off. She (R72) was on room air at the time that I wrote my notes. She (R72) must have been put back on it (supplemental oxygen)." 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.	F 711		
F 726 SS=E	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident	F 726		5/10/25

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F 726	Continued From page 65 assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined that for five (R4, R47, R52, R68 and R84) out of fourteen residents reviewed for medications, one (R7) out of eight residents reviewed for falls, the facility failed to have competent nursing staff to meet the needs of the residents. For R7, the facility failed to ensure the licensed nurses had the specific competencies to recognize when R7 became bradycardic from 10/16/24 to 10/18/24. For R68, the facility failed to ensure the licensed nurse had the specific competencies to administer IVSS medication. For R4, R47, R52 and R84, the facility failed to ensure a nurse had a medication administration competency when each resident was not administered prescribed medications. Findings include: Facility's Orientation policy: "It is the policy of this facility to develop, implement, and maintain an effective orientation process for all new staff..., consistent with their expected roles... 5. Checklists will be used to document training and competency evaluations during the orientation	F 726	1a. Unable to correct in the past. E24, E10 Vital Signs (VS) competencies completed on 4/29/2025 by Staff Development nurse. 1b. Unable to correct in the past. E14 Intravenous (IV) competency completed on 4/29/2025 by Staff D Development nurse 1c. E46-Unable to correct as E46 was terminated after this event. 2a. All residents with bradycardia have potential to be affected. An audit done by the NHA on 4/29/25 showed no residents with Bradycardia. 2b. All residents receiving IVPB medications have potential to be affected. Staff Development nurse will audit licensed nursing staff for IVPB administration competencies. Those without IVPB competencies will be	

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F 726	Continued From page 66 process... 11. All documentation to support completion of the orientation process shall be maintained in the employee's educational file." Date reviewed/revised 2/2025. 1. Cross refer F580, F684, F755 and F760 Review of R7's clinical record revealed: 1/10/20 - R7 was admitted to the facility with diagnoses including, but were not limited to, seizure disorder and hypopituitarism. 10/16/24 12:22 AM - E24 (RN/shift supervisor) documented in R7's EMR progress note, "Fall details: Date/Time of fall: 10/15/24 11:50 PM fall was not witnesses... Provider: [E4] Time notified 10/16/24 Notified of: fall... Resident found sitting on the floor legs facing the head board of the bed... Resident stated she was self transferring from wheelchair to the bed, when she fell. VS (vital signs) 154/66, p (pulse) 43, 97.6 T (temperature), 18 rr (respiratory rate), bs (blood sugar) 89...". 10/16/24 1:13 AM - R7's heart rate was documented in the EMR as "43 bpm (beats per minute) (irregular- new onset)". 10/16/24 3:36 AM - R7's heart rate was documented in the EMR as "43 bpm". 10/16/24 6:45 AM - E10 (LPN) documented in R7's EMR progress note, "Resident rang at 2350h (11:50 PM), employee went into the room and found the resident sitting on her buttocks on the floor... VS were obtained BP (blood pressure) 154/66, HR 43...".	F 726	completed by 5/30/2025. 2c. 2c. All residents receiving oral medication administration have potential to be affected. Staff D will audit licensed staff for competencies. Medication Administration competencies will be completed by 5/30/2025. 3a.- c. RCA: There was no standard process to ensure all competencies, including those for VS, IV medication administration, and oral medication administration were completed on hire and annually and then filed properly. All licensed staff will complete competencies during orientation and the Annual Skills fair in May of each year, and competencies will be placed in their education file. 3c. E46 was educated multiple times related to medication administration errors, but did not complete a competency form. Future residents will be protected by updating the Medication Error policy to include a medication administration competency weekly x 4 after any medication error. The facility will ensure personnel are required to complete current competencies, including VS, IV, and Medication Administration, during the Annual Skills Fair held in May and on an annual basis thereafter. At the conclusion of the New Hire Floor Orientation, both Preceptors and new employees will convene with the Staff Developer to	

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F 726	Continued From page 67 10/16/24 10:45 PM - R7's heart rate is documented in the EMR as "41 bpm". 10/17/24 1:58 PM - C4 (hospital emergency room MD) documented in R7's heart rate as 42. R7 was documented in her EMR as having a low heart rate in the 40's from 10/15/24 at 11:50 PM until 10/16/24 at 10:45 PM, which was almost 24 hours in duration. R7 was found to be bradycardic with a heart rate of 42 upon arrival to the hospital emergency room on 10/17/24 at 1:58 PM. Review of R7's EMR progress notes revealed no mention of R7's low heart rate other than documentation of the number by any of staff that cared for R7 from 10/15/24 night shift until 10/17/24 dayshift when R7 was sent to the hospital for a change in mental status. 3/21/25 10:10 AM - Review of E10 (LPN)'s skills checkoff for vital signs revealed that E10, who was hired on 1/22/24 and cared for R7 on 10/16/24 night shift, was signed off by her preceptor [E28 (ADON)] on each skill. However, the form was not signed or dated as completed by the assessor, nor was a final score documented. Additionally, E10 did not fill in the five test questions at the bottom of the checkoff sheet. Question four was pertinent to this situation as it asked "4. The appropriate pulse range for an adult is: _____ to _____ beats per minute." For E24, who worked as the RN supervisor on night shift on 10/16/24, the facility was not able to produce any skills checkoff list for this employee. 3/21/25 3:45 PM - During an interview, E3 (SD/ICP) stated that E24 was hired prior to her	F 726	ensure that all competencies are finalized and documented in the staff education file. In addition, the VS, IV medication administration, and oral medication administration competencies were integrated on 4/30/25 into the new hire orientation checklist designated for licensed nurses during their floor orientation. The Staff Development nurse will educate schedulers, preceptors, and directors about the new competency process. 4a. Staff Development nurse (or designee) will conduct audits of new nursing staff weekly x 3 to ensure they have completed VS competencies in their education file, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained. 4b. Staff Development nurse (or designee) will conduct audits of new nursing staff weekly x 3 to ensure they have completed IV medication administration competencies in their education file, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and	

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F 726	Continued From page 68 and therefore, she does not have copies of her skills checkoff lists. The facility was unable to provide evidence that these two nurses had the specific competency to recognize that R7's heart rate was too low and needed to be intervened upon. 2. Cross refer F760, example 1 and F940 Review of R68's clinical record revealed: 12/5/24 - R68 was admitted to the facility with diagnoses including, but were not limited to, Parkinson's disease, diabetes and osteomyelitis of the vertebrae and sacral region. 1/14/25 - E4 (contracted MD) ordered in R68's EMR, "Piperacillin Sod- Tazobactam (Zosyn) solution 4.5 gm - Give 4.5 gm intravenously every 6 hours for wound infection." As a result of this order, February 2025 Medication Administration Record (MAR) scheduled R68 to receive this antibiotic at 12 midnight, 6:00 AM, 12:00 PM and 6:00 PM. 2/11/25 approximately 3 PM - During change of shift report, E14 (LPN) reported to E29 (LPN) that she [E14] gave IVSS (intravenous soluset solution) Zosyn at both 8:30 AM and 1:19 PM. E29 alerted [E30] RN supervisor of the incorrect timed medication error. Review of R68's February 2025 MAR revealed E14 signed out the 1:19 PM Zosyn dose at the 1200 time slot but did not document the 8:30 AM dose on the MAR. Further review revealed E29 documented appropriately holding the 6 PM	F 726	maintained. 4c. Staff Development nurse (or designee) will conduct audits of new nursing staff weekly x 3 to ensure they have completed oral medication administration competencies in their education file, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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F 726	Continued From page 69 Zosyn dose as was instructed by E4 when she was alerted to this medication error. 3/17/25 1:34 PM - During an interview, E14 (LPN), who was a new nurse and was hired on 7/23/24, stated, "I was pulled to the 400 unit. It was the first time that I worked there. I had never given an IVSS antibiotic before... I was not trained about IV (intravenous) antibiotics during orientation because we did not have anyone in the building with IV antibiotics...". The facility was not able to provide evidence of E14's skills checkoff with regard to medication administration: intravenous. 3/21/25 3:45 PM - During an interview, E3 (SD/ICP) confirmed that that the facility did not have a skills checkoff for "Medication Administration: Intravenous" for E14. The facility failed to ensure E14 had the specific competencies to administer medications to R68. 3. Cross refer to F760, example 4 On 10/28/24 at 2:10 PM, the facility reported the following medication error incident to the State Agency: "On Monday, October 7, 2024 nursing supervisor informed DON that medications had been found on a medication cart and left un-administered. Supervisor investigated and found that all medications had been documented as 'Administered'. Schedule review showed that LPN [name of E46] had been assigned to the residents whose medications were left un-administered...". The incident occurred on 10/3/24 day shift and involved the following four residents: R4, R47, R52 and R84.	F 726		

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F 726	Continued From page 70 11/4/24 - The facility's 5-day follow-up investigation submitted to the State Agency reported: "... the facility is able to SUBSTANTIATE...". The facility discharged E46 (LPN) on 10/9/24 from working in the facility for "progressive disciplines r/t [related to] medication administration resulting in termination." Review of E46's discipline record revealed previous medication administration occurrences: - 5/30/24 Medication Administration Error: E46 did not administer an anticonvulsant medication prescribed for an unidentified resident's seizure disorder as it was found in the medication cart still in the packaging. Medication was administered two hours after it was due. E46 received verbal coaching documented in E46's file on 6/4/24. - 9/18/24 Falsification of Medical Records: E46 documented administration of medication and assessments on an unidentified resident that was not in the building. E46 received a FINAL written coaching with a day off without pay and was documented in E46's file on 9/19/24. - 10/9/24 Falsification of Medical Records: On 10/3/24, E46 documented administration of medication for four residents which were later found in the medication cart during the next shift. E46 was terminated and documented in her file on 10/10/24. 3/21/24 10:26 AM - Surveyor requested evidence of E46's competency for medication administration since her hire date of 3/4/24. 3/26/25 2:00 PM - During an interview, E3 (SD/RN) confirmed that the facility did not have a medication administration competency for E46.	F 726		

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F 726	Continued From page 71 The facility failed to ensure that E46 had a medication administration competency since her hire date of 3/4/24. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.	F 726		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		5/10/25

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F 755	Continued From page 72 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for two (R41 and R7) out of fourteen residents reviewed for pharmacy services, the facility failed to provide pharmaceutical services to meet the needs of each resident. Findings include: The facility's policy and procedure for "Unavailable Medications:... 4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: a. Determine the reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. B. Notify the physician of the inability to obtain the mediation upon notification or awareness that the medication is unavailable... c. Notify the Nurse Supervisor/Unit manager of delay, so they can escalate the issue." Date revised: 3/2025 1. Review of R41's clinical record revealed: 10/21/23 - R41 was admitted to the facility with multiple diagnoses including human immunodeficiency virus (HIV) disease and chronic obstructive pulmonary disease (COPD). The following medications were ordered on 10/21/23: -Dovato Oral Tablet 50-300 mg, give one tablet daily for antiviral.	F 755	1. Unable to correct in the past 2. All residents have the potential to be affected. Nursing Supervisor runs a missing medication report every shift to monitor medication availability and contacts the pharmacy regarding delivery status and updates. Physician and DON notified of outcomes via email every shift. 3. RCA: The pharmacy continually put off delivery dates, and telling Kutz staff they were unable to obtain medications from an outside emergency pharmacy as they were not available. It was later acknowledged that they were having financial hardships, and they were unable to purchase medications and were in the middle of an acquisition. After meeting with Vice President of Pharmacy, finally told medications were not being sent as the Pharmacy company did not have the money to purchase them. VP promised we would have no problems moving forward and he would personally ensure we receive the residents' medications timely. Despite this meeting, Kutz continued to have trouble obtaining medications for their residents. Due to continuing issues with obtaining resident medications, the NHA and DON met with a new pharmacy	

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F 755	Continued From page 73 -Formoterol Fumarate Inhalation Nebulization Solution 20mcg/2ml, inhale 2 ml orally two times a day for COPD. 3/25/25 -The following chart documents were reviewed for the medications Dovato and Formoterol: Dovato: Review of Medication Administration Record (MAR) for January 2025, February 2025 and March 2025 revealed that the antiviral medication Dovato was not administered to R41 on the following dates: 1/13/25, 1/14/25, 2/15/25, 2/16/25, 2/18/25, 2/19/25, 3/24/25 and 3/25/25. The MAR for the Dovato administration for dates above had the charting code 9 listed in each date. Review of the chart coding section of the MAR revealed that 9 meant: Other/See Progress Notes. Review of progress notes for several of the missed doses of Dovato medication revealed the following: "1/14/25 9:56 AM - Orders Administration Note:...Medication not available, awaiting pharmacy delivery. 2/16/25 10:49 AM - Called pharmacy regarding Dovota (sic). Per pharmacy, Dovota (sic) needs to be ordered from their supplier and should be available tomorrow. Md and primary nurse made aware. 2/17/25 3:42 PM - Dovato is out of stock at	F 755	and will be transitioning to the new pharmacy within 30-60 days. The DON or designee will run a missing medications report from the EMR every shift to identify unavailability. The nurse will then contact the pharmacy for an update on delivery status and communicate with the physician for further instruction. The nurse will monitor delivery status until medication arrives and continue communication with pharmacy and physician. A daily call has been scheduled with the current pharmacy Vice President, Pharmacist, LNHA and DON to regularly address concerns and alternative delivery options. New pharmacy Nursing Educators will educate nursing staff on their new procedures and processes. New pharmacy has guaranteed resident medications within 24 hours of ordering, at the most. Pharmacy will contact Provider directly if medications not approved to get approval or new orders. Pharmacy guaranteed they will utilize Emergency pharmacy in Wilmington area for medications not available from their pharmacy within 24 hours 4. DON (or designee) will conduct audits of medication arrivals once new pharmacy starts daily x 3 to ensure there is no delay in receiving resident medications, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will	

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F 755	Continued From page 74 pharmacy. This writer spoke with the pharmacy today. They will try and get medication through there (sic) backup pharmacy. 2/19/24 2:44 PM - Call out to pharmacy, med is on back order not sure when it will be ordered. MD made aware. 3/25/25 9:18 AM - Spoke with pharmacy, medicatipon (sic) is on order and will be sent out as soon as they receive medication." Formoterol: Medication Administration Record (MAR) for February 2025 and March 2025 revealed that Formoterol was not administered to R41 on the following dates and times: 2/6/25 AM, 2/23/25 AM, 2/26/25 AM, 3/17/25 PM thru 3/22/25 AM. -Progress notes for several of the missed doses of Formoterol medication revealed the following: 2/23/25 6:08 AM - Medication has not arrived. Pharmacy called multiple times and no answer. Message left for on call but no answer.... 3/17/25 3:17 - Formotorol not available from pharmacy or back up.... 3/25/25 10:15 AM - During an interview, E9 (RN) confirmed the dates and times of the missed doses of Dovato and Formpterol. The facility failed to ensure resident medications were available. 2. Review of R7's clinical record revealed:	F 755	continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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F 755	Continued From page 75 Cross refer F580, F684, F726 and F760 1/10/20 - R7 was admitted to the facility with diagnoses including, but were not limited to, seizure disorder, diabetes insipidus, central blindness and hypopituitarism. 10/28/24 Monday - R7 readmitted to the facility after a hospitalization. 10/28/24 - E4 (contracted MD) ordered in R7's EMR, "Cortef (hydrocortisone) oral tablet 10 mg - give 1 tablet by mouth one time a day for hypopituitarism." 10/29/24 9:56 AM - E7 (LPN) documented in R7's EMR, "Cortef oral tablet 10 mg... for hypopituitarism... Medication n/a (not available)." 10/29/24 1:21 PM - E7 (LPN) documented in R7's EMR, "Cortef oral tablet 5 mg... for hypopituitarism... Medication n/a (not available)." 10/30/24 9:10 AM - E26 (LPN) documented in R7's EMR, "Cortef oral tablet 10 mg... for hypopituitarism... awaiting arrival." 10/30/24 2:20 PM - E26 (LPN) documented in R7's EMR, "Cortef oral tablet 5 mg... for hypopituitarism... awaiting arrival." 10/31/24 10:48 AM - E7 (LPN) documented in R7's EMR, "Cortef oral tablet 10 mg... for hypopituitarism... awaiting pharmacy delivery." 10/31/24 2:04 PM - E7 (LPN) documented in R7's EMR, "Cortef oral tablet 5 mg... for hypopituitarism... awaiting pharmacy delivery."	F 755		

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F 755	Continued From page 76 10/31/24 11:03 AM - R7's facility lab results reported serum sodium level as 153 mmol/L (normal range 135-145 mmol/L). 11/1/24 8:17 AM - E27 (RN) documented in R7's EMR, "Cortef oral tablet 10 mg... for hypopituitarism... not available in passport machine." 11/1/24 2:45 PM - E27 (RN) documented in R7's EMR, "Cortef oral tablet 5 mg... for hypopituitarism... N/A (not available) waiting for pharmacy delivery." R7 missed nine doses of her ordered Cortef (hydrocortisone). 11/1/24 Friday 2:53 PM - E27 (RN/ADON) documented in R7's EMR as a communication with physician, "Situation: Medication (hydrocortisone) unavailable per pharmacy, uncovered by insurance. Background: Sodium level high as result. Per Endocrinology, should be sent to emergency department for assessment and treatment. Assessment (RN)/ Appearance (LPN): Lethargy presented as longer response on questions. Recommendations: Physician [E4] to send e-script for hydrocortisone to commercial pharmacy [name of pharmacy] for family to self-pay/private pay and bring in to (sic) facility. Per physician, consulted and confirmed with endocrinology, this will avoid emergency room visit. Endo (endocrinology) also requesting to increase fluid intake by 500 ml and obtain urine for a specific gravity to potentially adjust medication." 11/1/24 2:57 PM - E27 documented in R7's EMR	F 755		

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F 755	Continued From page 77 communication with family, "Family notified of need for medication (Hydrocortisone) and that resident has not received this medication due to pharmacy not making the medication delivery. Per pharmacy, the medication is not covered by insurance any longer. Family requested to have prescription sent to commercial pharmacy for self-pay/private pay by family who will supply to the facility." 11/1/24 4:49 PM - E27 documented in R7's EMR, Resident father delivered bottle of 45 hydrocortisone tabs at 10 mg with direction to take 1.5 tabs twice daily. Counted and verified by [E27]. Bottle has two refills. Orders placed in PCC (point click care). " 3/21/25 11:41 AM - During a telephone interview, E19 (contracted consultant pharmacist) stated, "I don't have anything to do with supplying the medications." 3/24/25 10:15 AM - During an interview, E26 (LPN) stated, "the pharmacy was not sending the medication." 3/24/25 11:46 AM - During a telephone interview, C2 (contracted pharmacy pharmacist director) stated, "Cortef is a pretty common drug and the pharmacy should have it on hand." C2 stated that R7's Cortef order was ordered and only profiled on 10/28/24 as the medication required a prior authorization. 3/24/25 3:54 PM - During a telephone interview, E4 (contracted MD) stated that due to the hydrocortisone not being available, she reached out and spoke with R7's endocrinologist (C3) who informed her that if R7 did not receive the	F 755		

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F 755	Continued From page 78 medication by 11/1 afternoon, she should be sent to the hospital emergency room for care. 3/25/25 10:54 AM - During a telephone interview, E19 (contracted consultant pharmacist) stated that he was unaware that R7's Cortef was not available from 10/28/24 to 11/2/24. He stated that the facility does not tell him if there are issues with obtaining medications due to prior authorizations being required. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.	F 755		
F 756 SS=D	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, 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	F 756		5/10/25

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F 756	Continued From page 79 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 interview and review of a clinical record and the Medication Regimen Review (MRR) policy and procedure, it was determined that the facility failed to ensure the MRR policy had specified response time frames included for the different steps. In addition, for one (R48) out of eight residents reviewed for pharmacy, the facility failed to ensure that R48's pharmacy recommendation was acted upon before a second recommendation was made. Findings include: 1. A facility policy titled "Policy & Procedures Pharmaceutical Services" revised 2/2025 documented ... 1. Steps to performing DRR (drug regimen review) c. The next time the physician is in the building, they will check their communication book for any orders. The physician will then document directly on the resident's DRR form, sign off that identified	F 756	1a & b. Unable to correct in the past. 2a. Unable to correct in the past. 2b. All residents with medication administration time changes on the MRR have potential to be affected. DON, or designee, will audit residents with medication time changes on the MRR for April to ensure all changes have been made by May 5, 2025. 3a. RCA: The Medication Regimen Review (MRR) Policy stated next time in the building without specific response periods. However, the physicians are in the building Monday-Friday excluding weekends and holidays. The "Medical/Consultative/Special Services" policy specifically states "the Medical Director will have daily care hours in the	

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F 756	Continued From page 80 irregularities have been reviewed, and list any actions taken. 3/18/25 1:35 PM - During an interview with E2 (DON) the Surveyor asked, "what is the facility's expectation for the physician to respond to the pharmacist consultant's monthly recommendations and medication irregularities?" E2 stated, "the pharmacist emails the recommendations to me I print them out give it to the physician and within the week she normally gives it back to me." E2 confirmed and stated, 'the policy is not clear on the time frames for the physician to respond, I will make sure that is fixed." The facility did not ensure to include all the time frame requirements for the physician in their policy and procedure for drug regimen review. 2. Review of R48's clinical record revealed: 11/2/22 - R48 was admitted to the facility. 11/6/24 - A physician's order was entered, "Omeprazole oral capsule delayed release 40 MG... Give 1 capsule by mouth one time a day for GERD [gastroesophageal reflux disease]." 10/12/24 - The monthly Consultant Pharmacist Report by E19 (contracted pharmacist) documented, "Omeprazole being charted at 9 AM; suggested for dosing 30 minutes before breakfast." In response, E11 (contracted Physician) checked that she agreed with the pharmacist recommendation and signed the document. However, this document was not dated when signed by E11 nor acted upon.	F 756	facility, except for weekends and holidays..., including 24-hour coverage availability." The facility will update the MRR policy to state that the reviews will be completed the next business day, not including weekends and holidays. The Medical Director approved of this change on April 28, 2025. 3b. RCA: One recommendation was missed. A Nursing assessment will be created to document that the medication administration time changes are completed based on the physicians recommendations. The Staff Development Nurse, or designee, will educate the Professional Nursing staff on the new Nursing assessment and procedure for ensuring medication administration time changes occur timely. 4a & b. DON (or designee) will conduct audits of MRR recommendations from the consultant pharmacist monthly x 3 to ensure all recommendations are addressed by the Provider and appropriately changed in the patients' EMR within the time-period added to the policy, until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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F 756	Continued From page 81 1/24/25 - The monthly Consultant Pharmacist Report documented, "Omeprazole being charted at 9 AM; suggested for dosing 30 minutes before breakfast." In response, E11 (Physician) checked that she agreed with the pharmacist recommendation and signed the document but did not date it. E2 (DON) also signed the document, but did not date it. 2/12/25 - A physician's order was entered, "Omeprazole... Give 1 capsule by mouth one time a day for GERD Must give 30 min [minutes] before breakfast." The facility failed to act upon the 10/12/24 pharmacist recommendation and R48's Omeprazole timing was not changed until 2/12/24 until after the second pharmacist recommendation. 3/21/25 9:07 AM - During an interview, E2 (DON) confirmed the finding. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or	F 757		5/10/25

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 82 §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that for one (R48) out of five residents reviewed for unnecessary medications, the facility failed to identify and clarify a drug allergy with a medication ordered by a consultant physician before administering it to R48. Findings include: Review of R48's clinical record revealed: Review of R48's Allergy Report in the electronic health record documented that the resident had an allergy to NSAIDs (Nonsteroidal anti-inflammatory drugs/class of medications used to relieve pain, including Ibuprofen) on 11/2/22. 2/25/25 4:35 PM - A physician order was entered to give one Ibuprofen 800 mg tablet every 6 hours as needed for pain for five days. 2/25/25 4:35 PM - An auto-populated new	F 757	1. Unable to correct in the past. 2. All residents with allergies have potential to be affected. DON, or designee, will audit residents with Allergies for medication orders the resident is allergic to By May 12, 2025. No conflicting orders with allergies were identified. 3. RCA: The nurse bypassed the alert and did not address it immediately. The warning for ordering a medication with a potential allergy display in one small box on the side of the order summary, after the medication order is completed. The warning also comes up just prior to saving the order, stating that they need to enter a progress note, however staff routinely miss this step. Future residents will be protected by	

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	085043	A. BUILDING _____ B. WING _____	C 03/26/2025

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F 757	Continued From page 83 physician's order note stated, "The system has identified a possible drug allergy for the following order: Ibuprofen Oral Tablet 800 MG...". 2/25/25 4:55 PM - A nurse's note documented that R48 was seen by the "in house dental [doctor]... New order... Ibuprofen 800mg... 5 days PRN [as needed]...". Review of R48's clinical record lacked evidence that a physician was consulted after the order was entered and triggered an allergy alert. Review of the February 2025 eMAR revealed that R48 was administered two doses: 2/25/25 at 5:57 PM and 2/26/25 at 2:41 PM. 3/21/25 9:07 AM - During an interview, finding was reviewed with E2 (DON) with no further information provided to the surveyor. 3/26/25 11:45 AM - Finding was reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.	F 757	instituting a new system of putting all orders into the computer without finalizing them prior to calling the provider and keeping the provider on the line to address any alerts or warnings that populate as each order is finalized. A new process, to check all new orders to ensure there are no medications ordered that the resident has listed as an allergy, will be added to the 24-hour chart-check flow requirements and education. The Staff Development nurse, or designee, will educate licensed staff on the new processes, to pause during order creation when the warning comes up, and how to document in the progress note by adding that information to the warning acknowledgement. 4. DON (or designee) will conduct audits of new medication orders daily x 3 to ensure all potential allergies are acknowledged, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced	F 760		5/10/25

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F 760	Continued From page 84 by: Based on record review and interview, it was determined that for four (R7, R17, R41 and R68) out of fourteen residents reviewed for medications, the facility failed to ensure the residents were free from significant medication errors. For R68, the facility failed to prevent R68 from receiving three doses of Zosyn in six hours on 2/11/25. For R7, the facility failed to obtain R7's cortef (a critical med) from 10/28/24 to 11/2/24. For R17, the facility failed to have available R17's sevelamer medication causing R17 to miss twenty-seven out of seventy-two opportunities for this medication administration from 3/10/25 to 3/25/25. For R41, the facility failed to have the resident's Dovato and Formoterol medications available. Findings include: Facility's "Medication Administration Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physicians and in accordance with professional standards of practice, in a manner to prevent contamination or infection... 10. Ensure that the six rights of medication administration are followed: a. right resident, b. right drug, c. right dosage, d. right route, e. right time, f. right documentation. 11. Review MAR (Medication Administration Record) to identify medication to be administered...". Date reviewed/revised 12/2024. 1. Review of R68's clinical record revealed: Zosyn is an antibiotic combination of piperacillin and tazobactam, which are penicillin class antibiotics that are used to fight infections caused by bacteria. www.drugs.com/zosyn.html January	F 760	1. Unable to correct in the past 2. All residents have the potential to be affected. Nursing Supervisor runs a missing medication report every shift to monitor medication availability and contacts the pharmacy regarding delivery status and updates. Physician and DON notified of outcomes via email every shift. 3. RCA: The pharmacy continually put off delivery dates, and telling Kutz staff they were unable to obtain medications from an outside emergency pharmacy as they were not available. It was later acknowledged that they were having financial hardships, and they were unable to purchase medications and were in the middle of an acquisition. After meeting with Vice President of Pharmacy, finally told medications were not being sent as the Pharmacy company did not have the money to purchase them. VP promised we would have no problems moving forward and he would personally ensure we receive the residents' medications timely. Despite this meeting, Kutz continued to have trouble obtaining medications for their residents. Due to continuing issues with obtaining resident medications, the NHA and DON met with a new pharmacy and will be transitioning to the new pharmacy within 30-60 days. The DON or designee will run a missing medications report from the EMR every	

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F 760	Continued From page 85 2025 12/5/24 - R68 was admitted to the facility with diagnoses including, but were not limited to, Parkinson's disease, diabetes and osteomyelitis of the vertebrae and sacral region. 1/14/25 - E4 (contracted MD) ordered in R68's EMR, "Piperacillin Sod- Tazobactam (Zosyn) solution 4.5 gm - Give 4.5 gm intravenously every 6 hours for wound infection." As a result of this order, February 2025 Medication Administration Record (MAR) scheduled R68 to receive this antibiotic at 12 midnight, 6:00 AM, 12:00 PM and 6:00 PM. 2/11/25 approximately 3 PM - During change of shift report, E14 (LPN) reported to E29 (LPN) that she [E14] gave IVSS (intravenous soluset solution) Zosyn at both 8:30 AM and 1:19 PM. E29 alerted [E30] RN supervisor of the incorrect timed medication error. Review of R68's February 2025 MAR revealed E14 signed out the 1:19 PM Zosyn dose at the 1200 time slot but did not document the 8:30 AM dose on the MAR. Further review revealed E29 documented appropriately holding the 6 PM Zosyn dose as was instructed by E4 when she was alerted to this medication error. On 2/11/25, R68 received three doses of IVSS Zosyn between 6 AM and 1:19 PM, when R68 should have only received two doses during this time period. The third dose was given on the night shift at aprroximately 5:30 AM, prior to E14 (LPN) assuming care fo R68. 3/17/25 1:34 PM - During an interview, E14	F 760	shift to identify unavailability. The nurse will then contact the pharmacy for an update on delivery status and communicate with the physician for further instruction. The nurse will monitor delivery status until medication arrives and continue communication with pharmacy and physician. A daily call has been scheduled with the current pharmacy Vice President, Pharmacist, LNHA and DON to regularly address concerns and alternative delivery options. New pharmacy Nursing Educators will educate nursing staff on their new procedures and processes. New pharmacy has guaranteed resident medications within 24 hours of ordering, at the most. Pharmacy will contact Provider directly if medications not approved to get approval or new orders. Pharmacy guaranteed they will utilize Emergency pharmacy in Wilmington area for medications not available from their pharmacy within 24 hours 4. DON (or designee) will conduct audits of medication arrivals once new pharmacy starts daily x 3 to ensure there is no delay in receiving resident medications, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 3 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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(LPN), who was a new nurse and was hired on 7/23/24, stated, "I was pulled to the 400 unit. It was the first time that I worked there. I had never given an IVSS antibiotic before. I asked a nurse to help me at 9 AM and we hung the med [Zosyn] and ran it. Then I did it alone at the 12 noon dose We did not check the MAR for the 9 AM dose...".

2. Review of R7's clinical record revealed:

Cross refer F580, F684, F711, F726 and F755

1/10/20 - R7 was admitted to the facility with diagnoses including, but were not limited to, seizure disorder, diabetes insipidus and hypopituitarism.

10/28/24 - E4 (contracted MD) ordered in R7's EMR, "Cortef oral tablet 10 mg (hydrocortisone)- give 1 tablet by mouth one time a day for hypopituitarism" and "Cortef oral tablet 5 mg (hydrocortisone)- give 1 tablet by mouth one time a day for hypopituitarism."

Review of R7's October 2024 MAR revealed E7 (LPN) documented on 10/29/24 and 10/31/24 at both the 9 AM 10 mg Cortef and the 12 PM 5 mg Cortef doses "9", which per the MAR legend means "other/See progress notes". E26 (LPN) documented on 10/20/24 at both the 9 AM 10 mg Cortef and the 12 PM 5 mg Cortef doses "9", which per the MAR legend means "other/See progress notes".

10/29/24 9:56 AM - E7 (LPN) documented in R7's EMR, "Cortef oral tablet 10 mg... for hypopituitarism... Medication n/a (not available)."

10/29/24 1:21 PM - E7 (LPN) documented in R7's

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F 760	Continued From page 87 EMR, "Cortef oral tablet 5 mg... for hypopituitarism... Medication n/a (not available)." 10/30/24 9:10 AM - E26 (LPN) documented in R7's EMR, "Cortef oral tablet 10 mg... for hypopituitarism... awaiting arrival." 10/30/24 2:20 PM - E26 (LPN) documented in R7's EMR, "Cortef oral tablet 5 mg... for hypopituitarism... awaiting arrival." 10/31/24 10:48 AM - E7 (LPN) documented in R7's EMR, "Cortef oral tablet 10 mg... for hypopituitarism... awaiting pharmacy delivery." 10/31/24 2:04 PM - E7 (LPN) documented in R7's EMR, "Cortef oral tablet 5 mg... for hypopituitarism... awaiting pharmacy delivery." Review of R7's November 2024 MAR revealed E27 (RN) documented on 11/1/24 at both the 9 AM 10 mg Cortef and the 12 PM 5 mg Cortef doses "9", which per the MAR legend means "other/See progress notes". 11/1/24 8:17 AM - E27 (RN) documented in R7's EMR, "Cortef oral tablet 10 mg... for hypopituitarism... not available in passport machine." 11/1/24 2:45 PM - E27 (RN) documented in R7's EMR, "Cortef oral tablet 5 mg... for hypopituitarism... N/A (not available) waiting for pharmacy delivery." R7 missed nine doses of her ordered Cortef (hydrocortisone). 3/24/25 10:45 AM - During an interview, E26	F 760		

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stated, "The pharmacy was not sending the med [Cortef]."

3/24/25 11:46 AM - During a telephone interview, C2 (contracted pharmacist) stated, "The electronic transfer of R7's Cortef was on 10/28/24. It is a pretty common drug and the pharmacy should have it on hand." C2 stated that R7's Cortef was ordered and only profiled on 10/28/24 as the medication required a prior authorization.

3/24/25 1:38 PM - During a telephone interview, F1(R7's family member) stated, "The doctor [E4] called in a prescription to [local pharmacy]. [F2, R7's family member] went to [local pharmacy] and paid out of pocket for the medication... No, we were not reimbursed...".

3/24/25 2:30 PM - During a telephone interview, C3 (local [pharmacy] pharmacist) stated, "According to our records, they [F2] paid cash so they would not need a prior authorization. The script (prescription) was filled on 11/29/24."

3. Review of R17's clinical record revealed:

1/23/20 - R17 was admitted to the facility with diagnoses including, but was not limited to, end stage renal disease with dependence on renal dialysis.

12/27/23 - R17 was ordered in his EMR, "Sevelamer Carbonate oral packet 2.4 gm- give 1 packet via PEG (percutaneous endoscopic gastrostomy) tube with meals for ESRD (end stage renal disease)."

3/10/25 12:58 PM - E8 (LPN) documented in

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F 760	Continued From page 89 R17's EMR progress notes, "Spoke with pharmacy, medication [sevelamer] will be sent out on next run. Made MD aware. NNO (no new orders)." 3/10/25 1:01 PM - E31 (LPN) documented in R17's EMR progress notes, "Sevelamer carbonate oral packet... not available." 3/11/25 7:12 PM - E32 (LPN) documented in R17's EMR progress notes, "Sevelamer carbonate oral packet 2.5 gm, not available, on order from pharmacy." 3/14/25 11:44 AM - E9 (RN) documented in R17's EMR progress notes, "Message left for the nurse at the Nephrology office in reference to the pharmacy needing prior Orth (sic) in order for him [R17] to continue to receive his sevelamer Carbonate oral packet 2.4 gm. Awaiting return call." 3/14/25 6:21 PM - E32 documented in R17's EMR progress notes, "Sevelamer..., not available from pharmacy...". 3/15/25 6:03 PM - E31 documented in R17's EMR progress notes, "Sevelamer... not available." 3/16/25 6:48 PM - E31 documented in R17's EMR progress notes, "Sevelamer... not available." 3/17/25 4:37 PM - E32 documented in R17's EMR progress notes, "Sevelamer... on order from pharmacy...". 3/18/25 5:42 PM - E32 documented in R17's	F 760		