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 POST IDR

NAME OF FACILITY: Delaware Bay Rehab & Healthcare Center **DATE SURVEY COMPLETED:** July 31, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual, Complaint and Extended Survey was conducted at this facility from July 21, 2025, through July 31, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was one hundred - ten (110). The investigative sample totaled twenty - eight (28) residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** This requirement is not met as evidenced by: Cross refer: F644, F655, F656, F686, F695, F760, F880, and F908.		

Provider's Signature _____ Title NHA Date 9/10/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085029	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

(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
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from July 21, 2025 through July 31, 2025. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		09/16/2025
F0000	INITIAL COMMENTS An unannounced Annual, Complaint and Extended Survey was conducted at this facility from July 21, 2025 through July 31, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was 110. The investigative sample totaled 28 residents. Abbreviations/definitions used in this report are as follows: ADON - Assistant Director of Nursing; CNA - Certified Nurse's Aide; DON - Director of Nursing; EMS – Emergency Medical Services EMAR – Electronic Medication Administration Record EMR – Electronic Medical Record EMR - electronic medical record; LPN - Licensed Practical Nurse; MD - Medical director; RN - Registered Nurse; < - Less than; ABT - Antibiotic; Medication to treat bacterial	F0000		09/16/2025

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

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

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F0000	Continued from page 1 infections; Antipsychotic Medication - Type of psychiatric medication which are available on prescription to treat psychosis; Accu Check – Blood glucose measuring system; Activities of Daily Living (ADL) - daily resident activities such as bathing, grooming, toileting and eating; BiPAP - bilevel positive airway pressure machine - A non-invasive ventilation device used to assist with breathing; Brief Interview for Mental Status (BIMS) - Assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best. 0-7: Severe impairment (never/rarely made decisions) 08-12: Moderately impaired (decisions poor; cues/supervision required) 13-15: Cognitively intact (decisions consistent/reasonable); COPD - chronic obstructive pulmonary disease - A progressive lung disease that makes it difficult to breathe; Diaphoretic – Excessive sweating; FSG – Fingerstick glucose; FSBS - Fingerstick blood sugar; Humidifier bottle -connects to concentrator to provide additional humidification; Hypoglycemia – Low Blood Sugar; Insulin - A type of hormone that allows glucose in the blood to enter cells, providing them with the energy to function; IV - intravenous; MDS assessment - Federally mandated comprehensive, standardized, clinical assessment of all residents in Medicare/Medicaid nursing homes that evaluates functional capabilities and health needs;	F0000		

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F0000	Continued from page 2 Medication Administration Record (MAR) - List of daily medications to be administered; Nasal Cannula Device- delivers extra oxygen through a tube and into your nose; Pallor – Abnormally pale appearance in skin and mucous membranes; PASSAR - Preadmission Screening and Resident Review - Screening for evidence of serious mental illness and/or intellectual disabilities, developmental disabilities or related conditions. to ensure that individuals are thoroughly evaluated and they are placed in nursing homes only when appropriate and that they receive all necessary services while in the facility.	F0000		
F0644 SS = D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for two (R31 and R10) out of two residents reviewed for PASRR the facility failed to ensure that a new referral for PASRR was completed upon a new mental health diagnosis and start of new psychotropic medications Findings include: The facility policy regarding PASRR undated, indicated "The social services director shall be responsible for keeping track of each resident PASRR screening status,	F0644	A. Social Services updated the PASRR for residents R31 and R10 to reflect new diagnoses and/or medications and resubmitted prior to survey end. The attending physicians and interdisciplinary team were notified of the updated PASRR status. B. Social Services will review all residents with new mental health diagnoses and/or psychiatric medications from the last 30 days for the appropriate update to resident PASRR. If new orders aren't captured on the PASRR, the PASRR will be updated and resubmitted and care plans will be updated. Review will be completed by September 16, 2025. C. The Nursing Home Administrator (NHA), or designee, will provide education by September 16, 2025 to Social Services, licensed nursing staff, and MDS staff to review and update residents' PASRR with each new mental health diagnosis or psychiatric medication as outlined in the PASRR instructions. A root cause analysis identified a gap in communication between clinical staff receiving provider orders with new mental health diagnoses and/or psychiatric medications and social services being aware of those orders to change the PASRR. Orders will be reviewed daily during IDT to identify any new mental health diagnoses and/or psychiatric medications. Social Services will note any appropriate orders, update the PASRR and resubmit, and update the care plan. D. The Director of Nursing (DON), or designee, will complete a random audit of 6 residents three times per week for accurate capture of diagnoses and medications as outlined in the PASRR instructions until 100% compliance is achieved, then a random audit of 10 residents weekly until 100% compliance is achieved at three consecutive evaluations, then 20 random residents	09/16/2025

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F0644 SS = D	Continued from page 3 and referring to the appropriate authority... any resident who exhibits newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include a resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder." 1. Review of R31's clinical record revealed: 12/26/23 - A PASRR level I screening was completed for R31 that documented a diagnosis of dementia/neurocognitive disorder and use of anxiety medication. 1/18/24 - R31 was admitted to the facility with multiple diagnoses including dementia with psychotic disturbance and anxiety. 1/20/24 - An admission MDS assessment documented that R31 had diagnoses of dementia and anxiety. 5/23/24 - A diagnosis of psychotic disorder with delusions was added to R31's diagnosis list. 3/19/25 - A significant change MDS assessment documented that R31 had diagnoses of dementia, anxiety disorder and a psychotic disorder. 4/30/25 - A physician's order was written for R31 to receive an antipsychotic medication every evening at bedtime. 6/11/25 - A quarterly MDS assessment documented that R31 had diagnoses of dementia, anxiety disorder and a psychotic disorder with use anti-anxiety and anti-psychotic medications. 7/23/25 3:11 PM - During an interview E11 (SW) confirmed a referral for a PASRR review was not completed for R31 following a new diagnoses and medications. 7/24/25 2:44 PM - E2 (DON) provided a copy of the new	F0644	Continued from page 3 will be audited monthly until 100% compliance is achieved for three consecutive months, at which time it will be concluded that the issue is resolved; If not, then monthly audits will continue until 100% compliance is achieved. Audits will be submitted and reviewed at the facility's monthly QAPI meeting and the committee will decide if further audits are needed. E. Compliance date: September 16, 2025	

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F0644 SS = D	Continued from page 4 PASRR assessment completed for R31 that day. This PASRR screening was updated to include anxiety disorder, and psychotic disorder with delusions to the diagnoses. Medications added to this PASRR included the use of an antipsychotic. 2. Review of R10's clinical records revealed: 1/20/25 – R10 was transferred to this long term care facility from another long term care facility. R10's diagnoses included, but were not limited to, unspecified dementia with psychotic disturbance and anxiety disorder. 1/21/25 – A new diagnosis of delusional disorder was added to R10. 7/23/25 – A review of R10's medical record revealed a PASRR Level II screen dated 10/5/23, which documented, "Level II - Excluded from PASRR – Primary Neurocognitive Disorder." There was no diagnosis of neurocognitive disorder during R10's stay at the facility and a lack of evidence for resubmitting a PASRR for a new diagnosis of delusional disorder. 7/30/25 10:33 AM – During an interview, E20 (SW) stated that they were unaware if there was a PASRR resubmission for R10 due to the added diagnosis of delusional disorder. 7/30/25 1:00 PM – E20 entered the PASRR resubmission for R10 and the document was dated as 7/30/25. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F0644		
F0655 SS = A	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F0655		09/16/2025

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F0655 SS = A	Continued from page 5 (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview it was determined that for one (R9) out of four new admissions reviewed the facility lacked evidence of a resident/responsible party received a copy of the baseline care plan. Findings include:	F0655		

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F0655 SS = A	Continued from page 6 Review of R9's clinical record revealed: 7/3/25 - R9 was admitted to the facility. undated, untimed - A baseline care plan was initiated for R9 after admission on 7/3/25. 7/23/25 10:04 AM - During an interview, E14 (LPN) confirmed that when residents are admitted to the facility the baseline care plan is initiated and coincides with the initial care plan meeting which occurs in the resident's room. E14 confirmed that R9 had a baseline care plan initiated within forty-eight hours of admission. 7/23/25 10:47 AM - During an interview, E15 (RN UM) confirmed that resident's or representatives receive a copy of the baseline care after completion. E15 confirmed that R9's baseline care plan lacked evidence of signature verifying that the resident received a copy. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F0655		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will	F0656	A. Resident R3 had a care plan put in place on 7/28/2025 which includes individualized objectives, goals, and timeframes to meet the resident's needs related to a change in condition and hospice services. B. All residents currently on hospice services will have their care plans reviewed by 8/31/2025 by the MDS coordinator to ensure individualized objectives, goals, and timeframes are included related to a change in condition and hospice services. Orders will be reviewed during IDT meetings to identify residents with a change in condition and new hospice orders with care plan updates occurring at time of review. C. The NHA, or designee, will provide education by 8/29/2025 to the MDS coordinator to ensure all residents who sign hospice have an individualized care plan developed that identifies objectives, goals, and timeframes to meet their needs. Root cause analysis identified a lapse related to which staff is responsible for initiating a care plan when a change in condition is identified or hospice is signed. The MDS coordinator will maintain responsibility for care plan compliance. D. The DON, or designee, will audit the care plan of all residents who sign hospice twice per week until 100% compliance is achieved, then weekly until 100% compliance is achieved, then a random audit of 5	09/16/2025

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F0656 SS = D	Continued from page 7 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 interview and record review it was determined that for one (R3) out of twenty eight residents reviewed the facility failed to develop a care plan to address an identified need. Findings include: Review of R3's clinical record revealed: 5/7/25 - R3 was admitted to hospice. 5/26/25 - A significant change MDS assessment documented that R3 had a poor prognosis and was receiving the specialized service of hospice. 7/23/25 - R3's care plan for ADL's was reviewed. The care plan focus documented that on 5/21/25 a significant change MDS was opened due to R3 signing with hospice. Review of R3's care plans lacked development of a care plan for hospice that included individualized objectives, goals, and timeframes to meet R3's needs. 7/28/25 1:13 PM - During an interview E2 (DON) confirmed the findings. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F0656	Continued from page 7 residents who sign hospice monthly until 100% compliance is achieved for three consecutive months at which time it will be concluded the issue is resolved; if not, then monthly audits will continue until 100% compliance is achieved. Audits will be submitted and reviewed at the facility's monthly QAPI meeting and the committee will decide if further audits are needed. E. Compliance date: September 16, 2025	
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F0686	A. Resident R74 doesn't always allow turning and repositioning but was immediately turned and repositioned at time of survey and continued every 2 hours as tolerated. A skin assessment was completed with no new areas of skin breakdown. The Unit Manager	09/16/2025

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F0686 SS = D	Continued from page 8 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Number of residents sampled: Number of residents cited: Based on observation, interview and record review, it was determined that for one (R74) out of one resident reviewed for positioning, the facility failed to turn and reposition the resident and promote the healing of a pressure ulcer in accordance with professional standards of practice to prevent skin breakdown. Findings include: Review of R74's record revealed: 7/7/23 – R74 Was admitted to facility with diagnoses including cerebral Infarct, hemiplegia, muscle wasting, and contractures 8/27/24 - R74's Braden Scale for pressure ulcer risk documented a score of 14 (moderate risk). 5/28/25 – An annual MDS documented R74 as dependent for turning and repositioning. 7/09/25 - R74's A care plan documented that R74 received turning and repositioning at least every two hours and as needed. 7/23/25 - An observation of R74 position in the bed on right side at 9:09 AM, 10:00 AM, 11:00 AM, 12:30 PM, and 1:07 PM. 7/23/25 1:19 PM - During an interview with E8 (CNA), she stated that when she does total care for a dependent resident, she will turn and reposition them	F0686	Continued from page 8 educated the Certified Nursing Assistant (CNA) responsible for the resident. B. All residents on a turn and reposition schedule will be audited for 8 hours by September 16, 2025 by the DON and designees to ensure they are turned and repositioned in accordance with professional standards. Those who are not repositioned timely will be turned and repositioned immediately and education provided to the staff responsible for completing the schedule. C. The DON, or designee, will educate all nursing staff by August 29, 2025, on turning and repositioning residents in accordance with professional standards and per policy. D. The DON, or designee, will audit 10 residents at risk for skin breakdown or with a care planned turn and reposition intervention twice per week until 100% compliance is achieved, then 15 residents weekly until 100% compliance is achieved, then a random audit of 20 residents monthly until 100% compliance is achieved for three consecutive months at which time it will be concluded the issue is resolved; if not, then monthly audits will continue until 100% compliance is achieved. Audits will be submitted and reviewed at the facility's monthly QAPI meeting and the committee will decide if further audits are needed. E. Compliance date: September 16, 2025	

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F0686 SS = D	Continued from page 9 2-3 times a shift, depending on their needs, such as wound care. 7/23/25 1:45 PM – An interview with E4 (LPN) confirmed that R74 had not been repositioned and would have E8 complete the task. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F0686		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for two (R98 and R18) out of four residents reviewed for respiratory care, the facility failed to ensure the oxygen tubing and humidifier bottle were changed weekly for R18. Also, R98's BiPAP equipment was not stored in a protective plastic bag. Findings include: Review of the facility's policy and procedure titled "Oxygen Administration", dated 10/1/24, documented "…Keep delivery devices covered in plastic bag when not in use…". 1. Review of R98's clinical record revealed: 12/19/24 – R98 was readmitted to the facility. 7/23/25 – A care plan documented R98 as receiving oxygen therapy related to COPD, respiratory failure, obesity and hypoventilation. R98 has a BiPAP for OSA (obstructive sleep apnea). 7/14/25 – An annual MDS documented R98 as using oxygen and a non-invasive mechanical ventilator such as a BiPAP. 7/16/25 - A physician order for R98 documented to encourage and apply BiPAP every night at bedtime. The	F0695	A. Resident R98 had their BiPAP mask placed in a bag immediately during survey. Resident R18 had their oxygen tubing and humidifier bottle replaced and dated immediately during survey. B. All residents with a BiPAP, oxygen tubing, and/or humidifier bottle will be reviewed by the DON, or designee, for storage bags and dated for a week or less by August 29, 2025. A root cause analysis determined that not all staff were aware to provide storage bags or to date tubing and/or humidifier bottles when they are changed outside of the normally scheduled days for change. C. The DON, or designee, will provide education by September 16, 2025 to all RNs and LPNs on the process of providing a storage bag for oxygen supplies and dating oxygen tubing and humidifier bottles any time they're changed. D. The DON, or designee, will complete an audit of all residents on BiPAP for storage bags and a random audit of 10 residents on oxygen for tubing and/or humidifier bottle appropriately dated twice per week until 100% compliance is achieved, then weekly until 100% compliance is achieved, then monthly until 100% compliance is achieved for three consecutive months as which time it will be concluded the issue is resolved; if not, then monthly audits will continue until 100% compliance is achieved. Audits will be submitted and reviewed at the facility's monthly QAPI meeting and the committee will decide if further audits are needed. E. Compliance date: September 16, 2025	09/16/2025

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DELAWARE BAY REHABILITATION AND HEALTHCARE CENTER	110 W. NORTH STREET , GEORGETOWN, Delaware, 19947

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F0695 SS = D	Continued from page 10 resident needs encouragement to use BiPAP. Ensure that the humidifier chamber is filled with sterile water. BiPAP settings at: IPAP 20/EPAP 8. 7/21/25 8:50 AM – An observation noted R98's BiPAP mask sitting on top of the bedside table. There was no bag for the BiPAP to be placed into. 7/21/25 8:57 AM – An observation of E13 (RN Educator) entering R98's room with clear bags. E13 proceeded to take out a clear plastic bag and label it with R98's name. E13 then put R98's BiPAP mask into the clear plastic bag and set it back down on the bedside table. During an interview, E13 stated that the BiPAP "should probably be in a bag." 2. Review of R18's record revealed: 3/14/25 - R18 was admitted to the facility with a diagnosis including but not limited to COPD and interstitial lung disease. 7/25/25 - A physician's order for R18 documented "change mask, nasal cannula tubing, and humidifier bottle every night shift on Fridays." 7/21/25 9:23 AM - An observation of R18's nasal cannula oxygen tubing and the humidifier bottle undated. 7/21/25 9:26 AM - During an observation and interview with E4 (LPN), it was confirmed there were no dates on R18's oxygen tubing and the humidifier bottle, and she replaced and dated them immediately. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F0695		
F0760 SS = SQC-J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for two (R129 and R123) out of two residents reviewed for a change in condition, the facility failed to ensure residents were free from experiencing a significant medication error. For R129, staff	F0760	"Past Noncompliance - no plan of correction required"	09/16/2025

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F0760 SS = SQC-J	Continued from page 11 administered another resident's medication resulting in the need for emergency medical intervention of Narcan for opioid overdose and transport to hospital for further medical intervention. The facility's failure placed R129 at risk for a serious adverse outcome including anaphylaxis, depressed respiratory status, and even death related to administration of a significant medication in error. Due to this failure an Immediate Jeopardy was called on 7/19/25 at 9:55 AM. Based on the facility's evidence at the time of the survey, the deficiency as determined to be past non-compliance as of 7/20/25 at 11:59 PM. For R123, staff administered insulin for a blood glucose outside of parameters, resulting in interventions related to critically low blood sugar. The facility's error caused hypoglycemia and placed R123 at risk for a serious adverse outcome including diabetic coma or even death from a critically low blood sugar. Due to this failure an Immediate Jeopardy was called on 12/13/24 at 12:08 PM. Based on the facility's evidence to correct at the time of the survey, the deficiency was determined to be past non-compliance as of 12/14/24 at 11:00 PM. Findings include: 1. Review of R129's clinical record revealed: 7/17/25 - R129 was admitted to the facility with diagnoses including diabetes, metabolic encephalopathy, and unspecified congestive heart failure. 7/18/25 - A physician's order documented that R129 was prescribed the following medication: sodium chloride (supplement), sodium bicarbonate (supplement), rosuvastatin calcium (reduces cholesterol), latanoprost eye drops (treat glaucoma), dorzolamide eye drops (treat glaucoma), and Lasix (diuretic). The EMR also documented R129 had an allergy to aspirin. 7/19/25 - An admission MDS documented that R129 was dependent for ADLs and documented a 99 in the BIMs section indicating R129 did not complete the interview. 7/19/25 9:55 AM - A facility incident report documented that R129 was administered another resident's medication. R129 received the following medications: ms contin 60 mg (narcotic for pain), xanax 0.5mg (narcotic for anti-anxiety), tizanidine 2mg (muscle relaxer) and aspirin 81 mg. Additionally, the report documented that R129 was administered a one-time dose of Narcan and supplemental oxygen. R129 was then sent to the hospital	F0760		

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F0760 SS = SQC-J	Continued from page 12 for further medical intervention and admitted. 7/19/25 12:59 PM - A nursing progress note documented that R129 received another resident's medication at 9:55 AM and vital signs were as follows: BP 139/84, P 73, T 97.0, R 20, and SPO2 80% (oxygen level) on room air. The progress note also documented that oxygen was applied at 4L/min and SPO2 (oxygen level) was 94% on 4L. Additionally, the note documented a new order for Narcan one dose and to send R129 to the emergency department via 911 for further treatment. 7/19/25 6:42 PM - A hospital progress note documented that "[R129] presented to the emergency department with lethargy due to administration or wrong medications including sedative medications and medications that can cause respiratory depression including ms contin, Xanax, duloxetine (anti-depressant), tizanidine, and citalopram. [R129] will be closely monitored overnight with telemetry, continuous pulse oximetry, capnography until drug effects wear off. If [R129] continues to worsen, intubation will be needed." 7/25/25 1:45 PM - During an interview, E5 (RN) confirmed that R129 received the wrong medication and E17 reported the error immediately. E5 confirmed that R129 received a dose of Narcan, supplemental oxygen, and was sent to the emergency department for further treatment. E5 also confirmed the facility provided education regarding the medication error and the importance of utilizing the rights of medication administration. 725/25 2:02 PM - During an interview, E17 (LPN) confirmed that R129 received the wrong medication and the error was reported immediately. E17 stated that R129 was a new admission and the EMR did not have a picture uploaded E17 thought R129 was a different resident. E17 stated that the physician was notified immediately after realizing the wrong medication was administered and R129 was provided medical care per orders. 7/25/25 2:30 PM - An Immediate Jeopardy was called and reviewed with the facility leadership including E1 (NHA) and E2 (DON). 7/25/25 – 4:30 PM – Based on a review of the facility's	F0760		

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F0760 SS = SQC-J	Continued from page 13 corrective actions, it was verified that past noncompliance was abated as of 7/20/25 at 11:59 PM. • The incident was promptly identified, and Resident R129 was immediately sent to the hospital for evaluation and treatment. • The root cause was determined to be the absence of a photo ID in R129's electronic medical record (EMR), which contributed to a medication error. • The facility updated its admission process to ensure photo identification is captured, expanding staff access to the EMR system to facilitate timely uploading of resident photos. • Additional staff were trained to take photographs at the time of admission, further supporting timely and accurate photo ID capture. • A facility-wide audit was conducted to confirm that all current residents had a photo ID included in their EMRs. • All nursing staff received re-education and training on the "7 Rights" of medication administration. • Staff interviews and medication administration observations conducted by surveyors verified the facility had returned to and maintained compliance. 2. 8/1/24 – R123 was admitted to facility with diagnoses including type 2 diabetes. 12/5/24 – The EMR documented a physician's order, "Accu check before meals and HS [bedtime]." 12/11/24 – The EMR documented a physician's order, "Aspart (fast acting insulin) flex pen subcutaneous solution pen-injector 100 unit/ml. Inject 5 units subcutaneously with meals for diabetes. Hold for FSG (finger stick glucose) <180 (less than 180) or if not eating."	F0760		

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F0760 SS = SQC-J	Continued from page 14 12/13/24 12:06 PM – The EMR documented, R123 did not eat any breakfast and their lunch time finger stick glucose as 124 mg/dl. 12/13/24 12:08 PM – The EMR documented, Aspart insulin 5 units was administered to R123's left arm subcutaneously. 12/13/24 - The EMR documented, R123 did not eat any lunch. 12/13/24 – A nursing progress note in the EMR written by E12 (RN - Agency) documented, "...approximately 1230 daughter reported that resident was not acting right...resident is laying supine (on back) in bed, leaned to the right, eyes closed, mouth open. Resident presents as disoriented, able to follow commands, A&Ox1, pallor skin color, diaphoretic. FSBS 46.... Administered glucose gel 1 tube, called 911 at 1321, EMS arrived 1325 rechecked fingerstick [and it was] 65..." 12/13/24 – The EMR documented that EMS transported R123 to the hospital, hypoglycemia resolved. 7/24/25 9:55 AM – During an interview, E2 (DON) confirmed that E12 administered Aspart insulin 5 units subcutaneously to R123 when the medication should have been held. Additionally, E2 stated that education was provided to all nursing staff regarding medication administration with medication parameters. 7/25/25 1:45 PM - 2:00 PM – During interviews with multiple nursing staff including LPN's and RN's it was verified that nursing staff received education and training on the facility's process when administering medications that have parameters. 7/25/25 - 2:50 PM - An Immediate Jeopardy was called and reviewed with the facility leadership including E1 (NHA) and E2 (DON). 7/30/25 10:10 AM – During an interview E13 (Staff Educator) stated when there is an incident that occurs in the facility that requires education she is notified	F0760		

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F0760 SS = SQC-J	Continued from page 15 by the DON or ADON and E13 is then responsible for providing the education specific to the incident. Additionally, E13 stated that education began promptly at 4:00 PM on 12/13/24 and was completed at 11:00 PM on 12/14/24. 7/25/25 1:45 PM /- 2:00 PM – During interviews with multiple nursing staff consisting of LPN's and RN's all nursing staff were able to correctly state the facility's process when administering medications that have parameters. Based on a review of the facility's investigation, documented response, completion of in-service training, and staff interviews, it was determined that past noncompliance occurred but was corrected prior to the survey. The plan of correction was initiated on 12/13/24 and completed on 12/14/24. • The incident was promptly identified and R123 was immediately sent to the hospital for evaluation and treatment. • The root cause was determined to be a failure to recognize or adhere to medication parameters outlined in the order. • Nursing staff received targeted in-service training on following physician orders, with a focus on understanding and applying medication parameters. • Staff interviews confirmed that nursing staff understood the expectations regarding physician order compliance. • Medication administration observations (med pass) were conducted by surveyors to ensure staff were accurately following physician orders, including parameter-based instructions. • Surveyor review of documentation and staff practices verified that the facility had returned to and maintained compliance. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA),	F0760		

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F0760 SS = SQC-J	Continued from page 16 E2 (DON), and E3 (ADON).	F0760		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F0880	A. Medications for R109 were discarded and re-prepared using appropriate technique. E18 was immediately re-educated on hand hygiene and safe medication handling practices. R97 suffered no adverse outcome from staff not following transmission-based precautions when accessing the PICC line. E19 was immediately re-educated on the use of transmission-based precautions when accessing a PICC line. B. A facility wide observation of medication administration and infection prevention practices was conducted on 8/4/2025 by the DON and Infection Preventionist. Non-compliant practices were corrected immediately. All residents with central lines were reviewed to ensure appropriate PPE and infection control precautions were in place. C. The DON, or designee, will re-educate all staff by 9/16/2025 on proper hand washing. All licensed staff will be re-educated on proper handling of medications during administration and use of transmission-based precautions when accessing a PICC line. D. The Infection Preventionist, or designee, will conduct random observations of 3 staff performing medication administration and/or PICC line care 5 days per week for 2 weeks, then 3 staff weekly for 2 weeks, then 5 random staff monthly for 3 months or until 100% compliance is achieved. Audits will be submitted and reviewed at the facility's monthly QAPI meeting and the committee will decide if further audits are needed. E. Compliance date: September 16, 2025	09/16/2025

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F0880 SS = D	Continued from page 17 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that for two (R109 and R97) out of twenty eight residents reviewed the facility failed to ensure practices to prevent infection were followed. Findings include:Review of the CDC's Clinical Safety: Hand Hygiene for Healthcare Workers indicated, " Protect yourself and your patients from deadly germs by cleaning your hands." https://www.cdc.gov/clean-hands/hcp/clinical-safety. Re view of the Nursing Skills checklist for oral medication administration indicated, "Multi-dose containers: When removing tablets or capsules from a multi-dose bottle, pour the necessary number into the bottle cap and then place the tablets or capsules in a medication cup. Cut scored tablets, if necessary, to obtain the proper dosage. If it is necessary to touch the tablets, wear gloves." https://wtcs.pressbooks.pub/nursingskills/chapter/15-4-checklist-for-oral-medication-administration. 1. 7/22/25 9:06 AM - During an observation of medication administration E18 (LPN) was observed giving medications to R111, then exiting the room without	F0880		

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F0880 SS = D	Continued from page 18 performing hand hygiene. 7/22/25 9:10 AM - E18 (LPN) was observed preparing medications to administer to R109. E18 grabbed a bottle of Tylenol and poured a tablet into the palm of her bare hand, then tilted her hand until the tablet landed in a medicine cup. Next, E18 grabbed a bottle of supplements and poured two capsules into the palm of her bare hand, then tilted her hand until the tablet landed into the medicine cup containing the Tylenol. E18 then turned to the medications in the cup to R109. Upon surveyor intervention E18 immediately confirmed that medications should not be touched with bare hands to prevent infection and that hand hygiene should have been performed between medication administrations. 2. Review of R97's clinical record revealed: 6/11/25 - R97 was admitted to the facility. 6/11/25 7:00 PM - A physician's order for R97 documented to flush PICC line (IV line) with 10 mL normal saline before and after each use. 6/12/25 6:00 AM - A physician's order for R97 documented to administer cefazolin sodium (antibiotic) every eight hours for left groin seroma. 7/21/2025 2:12 PM - During an interview, R97 stated that staff does not wear a gown when administering antibiotics through the PICC line or when flushing the tubing. 7/21/2025 2:20 PM - During an observation, E19 (Agency LPN) disconnected R97's tubing from antibiotic administration. E19 did not have on a gown while accessing R97's PICC line. 7/21/2025 2:23 PM - During an observation, E19 administered a saline flush to R97's PICC line and did not have a gown on. 7/21/2025 2:25 PM - During an interview, E19 confirmed that she did not have a gown on and did not follow transmission based precautions while accessing R97's	F0880		

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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
F0880 SS = D	Continued from page 19 PICC line. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F0880		
F0908 SS = E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview it was determined that the facility failed to ensure that essential kitchen equipment is maintained in safe operating condition. 1. 7/22/25 10:25 AM – During a tour of the kitchen, the sanitizing solution in 2 out of 2 red sanitizer buckets was tested for chemical concentration by E16 (Dietary Supervisor). The chemical concentration level was too low and did not register at the appropriate sanitizing level (400 ppm) on the test strip.The ineffective level of sanitizer in the bucket was confirmed by E16. 7/22/25 – 10:32 AM - The sanitizing solution was tested by E16 at the source where it leaves the container, mixes with water, and flows into the three compartment sink. The chemical concentration level tested below 200ppm on the test strip, which is too low to provide appropriate sanitization for food safety.The ineffective level of sanitizer at the three compartment sink was confirmed by E16. 7/30/25 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	F0908	A. On 7/22/2025, all sanitizer buckets and the three-compartment sink were emptied, refilled, and tested to ensure proper sanitizer concentration at the required 400ppm. The vendor servicing the chemical dispensing system was contacted the same day to inspect, calibrate, and adjust the sanitizer dispenser to ensure accurate chemical concentration. All dishware and utensils in use at the time were rewashed and sanitized once proper sanitizer concentration was restored. B. A facility-wide audit of all sanitizer stations and buckets was conducted on 7/22/2025 by the dietary manager to ensure correct concentration levels. Any that did not meet standards were corrected immediately. The vendor inspected the chemical dispensing system and made any necessary adjustments. C. The dietary manager will re-educate all dietary staff by 8/29/2025 regarding proper sanitizer testing procedures, required concentrations, and immediate corrective steps if levels are incorrect. D. The dietary manager, or designee, will test and document sanitizer concentration at the three-compartment sink twice daily for 2 weeks, then 3 times per week for 2 weeks, then weekly for 2 weeks, then monthly until 100% compliance is achieved for three consecutive months. Audits will be submitted and reviewed at the facility's monthly QAPI meeting and the committee will decide if further are audits are needed. E. Compliance date: September 16, 2025	09/16/2025