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: Country Rest Home

DATE SURVEY COMPLETED: October 6, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from October 1, 2025, through October 6, 2025. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was fifty-one (51). The survey sample totaled thirteen (13) residents. Abbreviations/definitions used in this state report are as follows: ADON – Assistant Director of Nursing; CNA – Certified Nursing Assistant; DON – Director of Nursing; HR – Human Resources; LPN – Licensed Practice Nurse; MD – Medical Doctor; NHA – Nursing Home Administrator; NP – Nurse Practitioner; RN – Registered Nurse; Atrial fibrillation - a common heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly and rapidly; BIMS – (Brief Interview for Mental Status) – assessment of the resident's mental status. The total possible BIMS Score ranges from 0 to 15 with 15 being the best;		

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	Continuous Positive Airway Pressure (CPAP) – a machine for breathing assistance during sleep; cm – Centimeter; Dementia – a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation; Hyperlipidemia - high cholesterol &/or triglycerides (fat proteins) associated with increased risk for heart disease & stroke; Hypertension – high blood pressure; Ipratropium-albuterol – a medicine that helps open up your airways, making it easier to breathe; Left Bundle Branch Block (LBBB) – a medical heart condition when the electrical signal telling the left side of your heart to beat is delayed or blocked, causing the right side to beat first; Medication Administration Record (MAR) – list of daily medications to be administered; Metoprolol succinate – a medication used to relax blood vessels and slow the heart rate; mg – milligram; mL – milliliter; mmHg – millimeter of mercury; Obstructive sleep apnea (OSA) – a sleep disorder where the muscles in the back of your throat relax too much, causing your		

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	airway to narrow or close completely during sleep.		
3201	**Skilled and Intermediate Care Nursing Facilities**	A. Individual/Resident Impacted Resident (R5) Unable to correct. The resident involved does not speak to the correction that was made.	11/21/2025
3201.1.0	Scope	B. Identification of other residents with potential to be affected	
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:**	All current residents and future admissions have the potential to be affected by this deficient practice. To identify any other residents who may have experienced a similar issue, the Director of Nursing (DON), RN, or designee conducted a facility-wide audit of all residents' medical records for the previous 30 days to review for any unreported or undocumented changes in condition. The audit included a review of: * 24-hour reports, *Nurse's notes, *Physician communication logs Any instances where physician or family notification was missing or delayed were immediately corrected by the DON.	
F580 S/S D	**§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**	C. System Changes The root cause was identified as unclear expectations and lack of standardized guidance regarding what constitutes a "change in condition" requiring physician or family notification. Nursing staff demonstrated inconsistent understanding of which situations required notification, particularly when symptoms appeared mild or transient. This inconsistency resulted in delayed or missed communication to the physician and family. A new Change in Condition Policy has been implemented (see	

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	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—** **(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).** **This requirement was not met as evidenced by:** Based on record review, interview, and a review of other facility documentation, it was determined that for one (R5) out of one sampled resident reviewed for change of condition, the facility failed to assess and monitor a change of condition. Findings include: Cross refer F711. Review of R5's clinical record revealed: 1/31/25 - R5 was admitted to the facility.	Document 1). This policy defines "change in condition," outlines required steps for physician and family notification, and sets expectations for timely documentation. A "When to Report" Binder has been created for each nurses' station (see Document 2). The binder provides clear, practical guidance for nurses on when and how to report changes in condition, including urgent and non-urgent examples. All licensed nursing staff will be in-serviced on the new policy and binder by the Director of Nursing (E2), RN, at the mandatory staff meeting on 11/14/2025. The DON or designee will also provide this education to all new hires during orientation and as needed thereafter to reinforce proper notification procedures. D. Success Evaluation **Goal:** 100% of residents experiencing a change in condition will have timely physician/NP and family notification, with documentation completed in the clinical record as required. **Monitoring:** The Director of Nursing (DON), RN, or designee will review the 24-hour report daily to identify residents with a change in condition. For each identified resident, the DON or designee will verify that: The physician or NP was notified either by phone or through an entry in the MD communication book, and the family or responsible party was notified and documentation is present in the clinical record. All residents with a change in condition each day will be reviewed until 100% compliance is	

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	2/2/25 - A care plan for R5 documented at risk for injury related to cardiovascular deficits: hypertension, atrial fibrillation, hyperlipidemia, and left bundle branch block with the following interventions: monitor vitals signs and blood pressure as ordered by physician and administer cardiac medications per order. 4/24/25 8:55 AM - A physician's order for R5 documented metoprolol succinate 25 mg give 0.5 tablet by mouth once daily, hold for SBP (systolic blood pressure) and heart rate below 60. September 2025 MAR revealed the following: 9/1/25 - Heart rate 40 bpm (beats per minute). 9/2/25 - Heart rate 32 bpm. 9/16/25 - Heart rate 31 bpm. 9/20/25 - Heart rate 36 bpm. 10/1/25 1:55 PM - During an interview, E9 (LPN) stated that the expectation for a change in condition was to call the provider and place a note in the provider's book for the onsite provider to review. E9 also stated that a nurse would initiate vital signs for three days and to continue to monitor the resident for further changes, if changes continued, to notify the provider as well. 10/2/25 2:55 PM - During an interview, E10 (MD) and E11 (NP) confirmed that a heart rate under 40 bpm was a critical value and would expect a notification about a level this low. E10 and E11 confirmed that holding the medication and monitoring R5's heart rate would be an expectation.	achieved for three consecutive weeks. Monitoring will then occur three times weekly for four weeks, followed by weekly audits for three months. Results will be documented on the Change in Condition Audit Tool (Document #3) to track compliance and identify trends. The DON will summarize findings monthly for six consecutive months and present them to the QAPI Committee. **Evaluation:** If 100% compliance is maintained for three consecutive monthly audits, monitoring will transition to quarterly. If noncompliance or trends are identified, DON will take immediate corrective action and provide staff re-education, and findings will be reviewed during the next QAPI meeting for follow-up and performance improvement. **Responsible Person:** The Director of Nursing (DON), RN (E2) is responsible for ongoing monitoring, documentation, and ensuring corrective actions are implemented as needed.	

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	10/2/25 3:04 PM - A physician's order for R5's metoprolol was discontinued by E11. 10/3/25 10:05 AM - During an interview, E8 (RN) confirmed that R5's heart rate was 40 bpm on 9/1/25 and 32 bpm on 9/2/25. E8 confirmed that she did not notify a provider of the critical heart rate and did not document an assessment of R5. 10/3/25 10:20 AM - During an interview, E2 (DON) confirmed the facility lacked evidence of an assessment for R5 and lacked evidence of a provider being notified of R5's critically low heart rate. 10/6/25 2:30 PM - Findings reviewed with E1 (NHA), E2 and E3 (ADON) during the exit conference.		
F609 S/S D	**§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 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.** **This requirement was not met as evidenced by:**	A.Indiviual/Resident Impacted Residents R3, R4, and R6 were involved in the deficient practice. Unable to correct, as the residents involved do not speak to the correction that was made. B.Indentification of other residents with the potential to be affected All current residents and future admissions C.System Changes The root cause was a lack of staff education and awareness regarding abuse identification and reporting procedures. Staff on duty did not recognize the events as potential abuse and were unaware of the two-hour reporting requirement to DHCQ via WellSky. Not all nurses had	11/21/2025

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	Based on record review and interview, it was determined that for two (R3 and R6) out of six residents reviewed for abuse, the facility failed to report allegations of abuse to the State Agency within two hours. Findings include: A facility policy, "Allegations of Abuse," last revised 3/7/17, failed to include a time frame for reporting an allegation of abuse. 1. Review of R3's clinical record revealed: 3/7/25 - R3 was admitted to the facility. 5/13/25 8:24 PM - An incident report, from the facility, was submitted to the State Agency and documented an allegation of sexual abuse. The report documented that staff witnessed R4 touching R3 in an inappropriate manner. 10/3/25 12:25 PM - During an interview, E3 (ADON) revealed that the expectation was for staff to report any allegation of abuse to management immediately. 10/3/25 12:30 PM - During an interview, E2 (DON) confirmed that the incident occurred on 5/13/25 at 3:30 PM and the report was submitted on 5/13/25 at 8:24 PM. The facility did not submit the report to the State Agency within the two-hour timeframe. 2. Review of R6's clinical record revealed: 7/23/21 – R6 was admitted to the facility with the diagnoses of dementia and chronic pain. R6 had a BIMS score of 99 (indicating R6 was unable to complete the interview or gave	access or training to submit reports in the system, and administrative personnel were off site at the time. **Systemic Changes Implemented: WellSky Access:** All licensed nurses have been trained by DON and provided with the WellSky link, provider ID, and login instructions. Access is now available on all nurse's station computers to allow 24/7 reporting. **Policy Review:** The Abuse Prevention and Reporting Policy (Document #4) was revised to include specific steps and clear expectations for reporting alleged abuse within two hours **Education:** All staff will be in-serviced by the DON (E2), RN, on abuse identification and reporting, at the mandatory staff meeting on 11/14/2025 (See inservice sign-in sheet, Document #5 for staff who have been educated to date). In-services include the "How to Report Online" procedure (Document #6), which was also posted for reference at nurse stations on 11/6/25. Training will be repeated annually and after any occurrence of alleged abuse. **Verification:** The Charge Nurse on each shift will verify that all alleged abuse incidents are reported within two hours. The DON or designee will review the incident log and WellSky submissions daily for accuracy and timeliness. **Oversight:** Compliance will be reviewed through daily monitoring and discussed during monthly QAPI meetings.	

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	nonsensical responses to four or more questions). 6/1/25 4:15 PM – An incident report documented that R8 walked up to R6 and began slapping her in the face with both hands. Another resident, who witnessed the incident, yelled for help. A nurse responded and separated the residents. R6 sustained a 2 cm in diameter bruise to the right outer eye and a 3.5 cm bruise to the right inner forearm. E21 (MD) was made aware of the incident. 6/1/25 4:45 PM – R6's representative was made aware of the incident. 10/3/25 11:15 AM – During an interview, R14 confirmed that she had witnessed the incident and stated, "A lady in a wheelchair passed by me. The man came up to her and began to hit the woman in the face." 10/3/25 11:34 AM – During an interview, E2 (DON) confirmed that the incident occurred on 6/1/25 at 4:15 PM and that the report was submitted on 6/1/25 at 8:32 PM. The facility did not submit the report to the State Agency within the two-hour timeframe. 10/6/25 2:30 PM - Findings reviewed with E1 (NHA), E2 and E3 (ADON) during the exit conference.	**Responsible Individuals:** DON (E2, RN): Verifies daily compliance and reviews reports. Conducts staff education. Charge Nurse: Ensures immediate identification and initiation of reporting. **D.Success Evaluation** **Goal:** 100% of alleged abuse incidents will be reported to the DON or designee immediately and to DHCQ within two hours. 100% of nursing staff will demonstrate competency in identifying and reporting abuse and in using the WellSky system. **Monitoring:** The DON or designee will review 100% of all incident reports daily to verify timely reporting and proper WellSky submission, using a monitoring tool to document compliance (Document #7). A random sample of three staff per week will be interviewed for the first 30 days following the in-service to assess understanding of abuse identification and reporting. Monitoring will continue daily until 100% compliance is achieved for 3 consecutive weeks, then weekly for 4 additional weeks, and monthly for 3 months thereafter. **Evaluation:** If 100% compliance is maintained for three consecutive monthly audits, the correction will be considered effective and incorporated into the facility's QAPI program. **Responsible Person:** The Director of Nursing (DON) or designee will oversee and document monitoring and report findings to the	

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		Administrator during quarterly QAPI meetings.	
F656 S/S D	**§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.** **This requirement was not met as evidenced by:** Based on record review and interview it was determined that for one (R10) out of thirteen residents in the investigative sample, the facility failed to develop a comprehensive resident centered care plan for an identified care area. Findings include: Review of R10's clinical record revealed: 4/28/25 - R10 was admitted to the facility. 4/28/25 1:22 PM - A physician's order for R10 documented, "Eliquis (blood thinner) 2.5 mg give one tablet by mouth two times a day." 4/30/25 - A care plan documented that R10 had "decreased cardiac output related to diagnosis of atrial fibrillation and hypertension as manifested by irregular heart rate and high blood pressure with the following interventions: administer prescribed medications as ordered, heart rate and blood pressure will remain stable, and	A.Individual/Resident Impacted Resident (R10) The cardiac care plan of resident (R10) was revised on 10/3/2025, to include monitoring for signs and symptoms of bleeding related to use of Eliquis, after the surveyor brought it to the attention of E2 (DON) B.Identification of other residents with potential to be affected All current residents and future admissions. C.System Changes The root cause of this deficient practice was determined to be a lack of a formal process to verify that baseline care plans were revised into comprehensive care plans within the required time frame. This resulted in Resident R10's care plan not being updated to include monitoring for adverse effects of anticoagulant therapy (Eliquis). To prevent recurrence, the facility implemented an **Initial Care Plan Checklist Tool** (Document #8) to ensure that all baseline care plans are reviewed and revised to reflect each resident's comprehensive needs within seven days of admission. All current residents' care plans were audited, and no additional deficits were identified. The Care Plan Policy (Document #9) was reviewed and updated to include the checklist process. The Director of Nursing (DON) or designee will be responsible for verifying completion of comprehensive care plans using the checklist and ensuring ongoing compliance through routine audits. D. Success Evaluation **Goal:** 100% of all new residents will have a comprehensive care plan developed within seven days of admission, accurately reflecting their assessed needs	11/21/2025

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	monitor vital signs and blood pressure as ordered: hold blood pressure medication for systolic blood pressure less than 120 mmHg." Although R10 had a diagnosis of atrial fibrillation, the facility failed to implement a care plan to monitor for adverse effects of the use of anti-coagulant medications and failed to identify what side effects to monitor for related to anti-coagulant use. 10/2/25 10:53 AM - During an interview, E5 (LPN) confirmed that the R10 was taking an anti-coagulant medication. 10/2/25 11:25 AM - During an interview, E2 (DON) confirmed that R10 did not have a care plan related to anti-coagulant use. 10/6/25 2:30 PM - Findings reviewed with E1 (NHA), E2 and E3 (ADON) during the exit conference.	and any required monitoring for medication side effects. **Monitoring:** The Director of Nursing (DON) or designee will audit all new admissions using the Initial Care Plan Checklist Tool (Document#8) to verify that each baseline care plan has been revised to a comprehensive care plan within seven days. A sample of three residents per week will be reviewed for the first 30 days, then weekly until 100% compliance is achieved for three consecutive weeks, and monthly for three months thereafter. **Evaluation:** If 100% compliance is maintained for three consecutive monthly audits, the corrective system will be considered effective, and ongoing monitoring will become part of the facility's QAPI program. **Responsible Person:** The Director of Nursing (DON) or designee is responsible for implementing and maintaining this monitoring process and will report results to the Administrator during quarterly QAPI meetings.	
F695 **S/S D**	**§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 was not met as evidenced by:**	A.Individual/Resident Impacted Resident (R2) and Resident (R11). **Resident R2:** Upon being alerted by the surveyor that the CPAP tubing was outdated, the nurse on duty immediately replaced the air tubing with new tubing. The equipment was labeled and verified for proper functioning. **Resident R11:** When notified that the nebulizer tubing was unlabeled and not in a protective bag, the nurse on duty replaced the nebulizer tubing, dated it appropriately, and placed it in a newly dated protective bag.	11/21/2026

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	Based on observation, interview, and record review, it was determined that for two (R2 and R11) out of two residents sampled, the facility failed to provide respiratory care per professional standards. For R2, the facility failed to change the CPAP tubing every three months. For (R11), the facility failed to label the tubing and place it in a protective bag when not being utilized. Findings include: 1. Review of R2's clinical record revealed: 5/30/24 – R2 was admitted to the facility with a diagnosis of obstructive sleep apnea. 5/31/24 8:30 PM – A physician order for R2 documented that the CPAP machine was to be used at bedtime. 3/18/25 2:17 PM - A physician order for R2 documented to change the CPAP tubing for the device every three months. 10/2/25 9:50 AM - An observation revealed that R2's CPAP tubing was dated 6/18/25. 10/2/25 10:10 AM - During an interview, E5 (LPN) stated they clean the CPAP tubing daily and changes the CPAP tubing every three months. E5 confirmed that the CPAP tubing did not reflect that it was changed per the physician's order. E5 changed the CPAP tubing immediately. 2. Review of R11's clinical record revealed: 9/10/25 – R11 was admitted to the facility with a diagnosis of respiratory conditions due to smoke inhalation. 9/10/25 – A physician's order for R11 documented Ipratropium 0.5mg – albuterol 3mg (2.5 mg base)/ 3 mL nebulization	B.Identification of Other Residents with the potential to be affected All residents who are prescribed respiratory therapy and equipment C.System Changes The root cause of this deficient practice was a lack of consistent monitoring and accountability to ensure respiratory equipment was labeled, dated, and replaced per policy. Respiratory Equipment Audit Tool has been implemented on all units, one for CPAP (Document #10) and one for nebulizers (Document #11). Each RN and LPN on every shift will be responsible to verify and document in the EMR that all CPAP and nebulizer tubing is properly labeled, dated, and replaced according to policy during their shift. The Director of Nursing (DON) or designee will use the audit tool to verify thorough compliance. All nursing staff will be educated on the revised Respiratory Equipment Policy (Document #12), including labeling, dating, and replacement procedures. Education will be conducted by the Assistant Director of Nursing (ADON, RN) at the mandatory staff meeting on 11/14/2025. D.Success evaluation **Goal:** 100% of all respiratory equipment will be labeled, dated, and replaced according to policy during each nurse's shift. **Monitoring:** The Director of Nursing (DON) or designee will review the Respiratory Equipment Audit tools (Documents 10 and 11) daily to ensure that each nurse has verified and documented proper labeling and	

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	solution. Give 3 ml by nebulization route every 6 hours as needed. 10/1/25 10:18 AM – Upon entering R11's room, this surveyor observed the nebulizer tubing and mask on the floor beside the bed and not labelled with date and initials as to when it was changed. 10/1/25 10: 30 AM – During an interview, E12 (RN) confirmed that the nebulizer tubing and mask was on the floor and wasn't labelled. E12 also confirmed that when R11 wasn't being administered a treatment the tubing and mask should be stored in a protective bag and labelled with date and time when it was last changed. 10/6/25 2:30 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	replacement. Review will be daily until there has been 100% compliance for 7 days. After that, the DON or designee will review the audit tools on a monthly basis. **Evaluation:** If 100% compliance is maintained for three consecutive monthly audits, the corrective system will be considered effective and integrated into the facility's QAPI program for ongoing monitoring. **Responsible Person:** The Director of Nursing (DON) or designee will oversee the monitoring process, document results, and report findings to the Administrator during quarterly QAPI meetings.	
F711 S/S D	**§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 was not met as evidenced by:** Based on record review and interview, it was determined that for one (R5) out of thirteen	A.Individual/Resident Impacted Resident (R5) Unable to correct B.Indentification of other residents with the potential to be affected All current residents and future admissions. C. System Changes The root cause of this deficient practice was that physician and nurse-practitioner user settings in SigmaCare did not include access to the clinical monitoring section, preventing visibility of resident data. The SigmaCare entry format and permissions have been corrected so that all current and future medical	11/14/2025

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	residents reviewed for physician services, the facility failed to ensure that the physician reviewed the residents' total program of care. Findings include: Cross refer F580. Review of R5's clinical record revealed: 1/31/25 - R5 was admitted to the facility. 2/2/25 - A care plan for R5 documented at risk for injury related to cardiovascular deficits: hypertension, atrial fibrillation, hyperlipidemia, and left bundle branch block with the following interventions: monitor vital signs and blood pressure as ordered by physician and administer cardiac medications per order. September 2025 MAR revealed the following: 9/1/25 - Heart rate 40 bpm (beats per minute). 9/2/25 - Heart rate 32 bpm. 9/16/25 - Heart rate 31 bpm. 9/20/25 - Heart rate 36 bpm. 9/12/25 - A physician's progress note documented that "[R5's] blood pressures are acceptable for age and condition. Heart rate within normal limit." The progress note lacked evidence that the heart rate was checked or reviewed during the physical exam by E11 (NP). 10/2/25 2:55 PM - During an interview, E10 (MD) and E11 (NP) confirmed they were not notified of R5's critically low heart rates earlier in the month. 10/2/25 3:04 PM - A physician's order for R5's metoprolol was discontinued by E11.	providers and nurse practitioners in the physician user group can view and enter clinical monitoring information. Access settings are verified by the Director of Nursing (DON) and IT Coordinator for each new provider. A Change-in-Condition Policy has been developed (Document 1), and a "When to Report" reference binder is now available on every nursing unit (Document 2). All nurses will be in-serviced on the policy and binder by the Assistant Director of Nursing (ADON, RN) at the mandatory staff meeting on 11/14/2025. The DON or designee will ensure the policy and SigmaCare access settings remain current and will verify compliance during routine audits. **D.Success Evaluation** **Goal:** 100% of medical providers will have access to the clinical monitoring section in SigmaCare, and 100% of nursing staff will demonstrate understanding of the Change-in-Condition Policy and use of the "When to Report" binder. **Monitoring:** The Director of Nursing (DON) or IT Coordinator will verify SigmaCare access settings for all current and newly added medical providers. The DON will audit all provider progress notes weekly for four weeks, then a sample of five notes monthly for three months, to ensure clinical monitoring entries are visible, accurate, and complete. A discrepancy of care will be defined as any missing or incomplete clinical monitoring entry, failure to document	

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	10/3/25 10:20 AM - During an interview, E2 (DON) confirmed that E11 discontinued R5's metoprolol after E11 was notified today of R5's critically low heart rates by surveyor. E2 also stated that E10 and E11 recommended R5 follow up with cardiology. The physician failed to review R5's total program of care when the electronic medical record documented critically low heart rates and the physician's progress note did not address the aforementioned change. 10/6/25 2:30 PM - Findings reviewed with E1 (NHA), E2 and E3 (ADON) during the exit conference.	follow-up for a noted change in condition, or evidence that a provider could not view necessary clinical data. The Assistant Director of Nursing (ADON, RN) will maintain documentation of all nursing in-services for the new Change-in-Condition Policy. **Evaluation:** Audits will continue until 100% compliance is achieved for three consecutive monthly reviews. If compliance is maintained, the process will be incorporated into the facility's QAPI program for ongoing monitoring. **Responsible Person:** The Director of Nursing (DON) or designee will conduct and document audits, address discrepancies, and report results to the Administrator during quarterly QAPI meetings.	
F757 S/S D	**§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** **§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 was not met as evidenced by:**	A.Individual/Resident Impacted Resident (R10) order for monitoring was added to the resident's medication administration record on 10/2/2025. B.Identification of other residents with the potential to be affected All current residents or future admissions on anticoagulant medication C. System Changes The root cause of this deficient practice was a lack of consistent review to ensure residents on anticoagulant medications had appropriate monitoring orders and care plan interventions in place. The Director of Nursing (DON) audited all residents' medication orders using the Medication Management Review (MMR) and confirmed that all residents on anticoagulants (Eliquis, Coumadin, Xarelto) now have active MAR orders to	11/21/2025

Provider's Signature [signature], NHA Title Administrator Date 11/7/25

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	Based on record review and interview it was determined that for one (R10) out of five residents reviewed for medication review, the facility failed to ensure adequate monitoring of adverse effects. Findings include: Review of R10's clinical record revealed: 4/28/25 - R10 was admitted to the facility. 4/28/25 1:22 PM - A physician's order for R10 documented, "Eliquis (blood thinner) 2.5mg give one tablet by mouth two times a day." 4/30/25 - A care plan documented that R10 had "decreased cardiac output related to diagnosis of atrial fibrillation and hypertension as manifested by irregular heart rate and high blood pressure with the following interventions: administer prescribed medications as ordered, heart rate and blood pressure will remain stable, and monitor vital signs and blood pressure as ordered: hold blood pressure medication for systolic blood pressure less than 120 mmHg." The care plan lacked intervention to monitor for the adverse side effects of anti-coagulant use. 10/2/25 10:53 AM - During an interview, E5 (LPN) confirmed that the R10 was taking an anti-coagulant medication and confirmed that R5 was not being monitored for adverse side effects. 10/2/25 11:25 AM - During an interview, E2 (DON) confirmed that nursing staff was expected to monitor for adverse effects of medications. E2 confirmed that R10 was not being monitored for adverse effects of Eliquis.	monitor for signs of bleeding each shift, and care plans reflecting these interventions. All nursing staff present were educated on anticoagulant monitoring, documentation, and care plan requirements by the Assistant Director of Nursing (ADON, RN), and all nursing staff will receive this education at the mandatory staff meeting on 11/14/2025. The DON will continue to oversee compliance through periodic audits of MARs and care plans. **D. Success Evaluation** **Goal:** 100% of residents receiving anticoagulant medications will have corresponding MAR orders and care plan interventions for monitoring and documentation of bleeding signs each shift. **Monitoring:** The Director of Nursing (DON) or designee will audit a sample of five residents on anticoagulant therapy each week until at 100% compliance is shown for 4 consecutive weeks, then on a monthly vasis, to verify that MAR orders, care plans, and documentation are complete and accurate. The Anticoagulant Monitoring Audit Tool (Document 12) will be used to track results. All pharmacy recommendations related to anticoagulant medications will be reviewed by the DON and pharmacist consultant during the facility's monthly medication regimen review (MMR) process to ensure care plans and orders are updated as needed. **Evaluation:** Audits will continue until 100% compliance is achieved and maintained for three consecutive monthly audits. Once sustained, the process will be incorporated into the facility's QAPI program for ongoing monitoring. **Responsible Person:** The Director of Nursing (DON) or designee will conduct and document audits, review pharmacy	

Provider's Signature Lisa [illegible], NHA Title Administrator Date 11/7/25

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	10/6/25 2:30 PM - Findings reviewed with E1 (NHA), E2 and E3 (ADON) during the exit conference.	recommendations, and report findings to the Administrator during quarterly QAPI meetings	
F868 S/S D	**§483.75(g) Quality assessment and assurance.** **§483.75(g) Quality assessment and assurance.** **§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:** **(i) The director of nursing services;** **(ii) The Medical Director or his/her designee;** **(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and** **(iv) The infection preventionist.** **§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:** **(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.** **This requirement was not met as evidenced by:**	<u>A. Inviduals/Residents Impacted</u> E2 (DON), E1 (NHA) Unable to correct <u>B .Indentification of other residents with the potential to be affected</u> All current residents and future admissions have the potential to be affected. <u>C. System Changes</u> The root cause of this deficient practice was the lack of a defined process for filing, storing, and sharing QAPI meeting minutes and attendance records, which led to missing documentation during a transition in nursing leadership. To prevent recurrence, all QAPI meeting minutes, attendance records, and related documentation will be stored in a centralized electronic QAPI folder accessible to the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON). This ensures continued access in the event of staffing changes. The Administrator will be ultimately responsible for verifying that QAPI documentation is complete, filed promptly after each meeting, and readily available for review by regulatory agencies. The DON or designee will serve as backup to maintain documentation continuity. All members of the QAPI team have been informed of the new process. <u>D. Success Evaluation</u> **Goal:** 100% of QAPI meeting minutes and attendance records will be complete, filed, and readily available for review. **Monitoring:** The Administrator or designee will verify the presence and completeness of all QAPI meeting	11/6/2025

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	Based on interview and record review, it was determined that the facility failed to ensure attendance of required members at the quarterly quality assurance and performance improvement (QAPI) meetings. Findings include: 10/2024 – Quarter 3 2024 Quality Assurance and Performance Improvement Committee Meeting Attendance record and the minutes were missing. 1/29/25 – Quarter 4 2024 Quality Assurance and Performance Improvement Committee Meeting Attendance record was missing and therefore unable to account for the attending members. 10/1/25 11:54 AM – During an interview, E2 (DON) stated that they could not find the sign-in sheets for the October 2024 and the January 2025 QAPI meetings. 10/6/25 2:30 PM - Findings reviewed with E1 (NHA), E2 and E3 (ADON) during the exit conference.	minutes and attendance records each quarter for four consecutive quarters to ensure documentation is maintained without interruption. QAPI minutes and attendance records will continue to be kept in a labeled binder in the nursing office, and electronic copies will be downloaded and emailed to QAPI team members after each meeting for accountability. **Evaluation:** If 100% of QAPI documentation is verified and maintained for four consecutive quarters, the system will be considered effective and incorporated into the facility's QAPI program for ongoing oversight. **Responsible Person:** The Administrator will be responsible for quarterly verification and ensuring documentation is maintained and accessible.	
F947 S/S D	**§483.95 Training Requirements.** **Training topics must include but are not limited to—** **§483.95(g) Required in-service training for nurse aides.** **In-service training must—** **§483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.** **§483.95(g)(2) Include dementia management training and resident abuse prevention training.** **§483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at §483.71**	A. Individuals Impacted Employees (E14, E15, E16, E17, and E18). Unable to correct B. Identification of other individuals potentially affected All current and future CNAs, and residents under their care C. System Changes The root cause of this deficient practice was the absence of a structured, ongoing system to track and schedule CNA in-service training, resulting in inconsistent completion. HR has implemented a monthly facility-provided training schedule in which every CNA receives one hour of in-service each	11/7/2025

Provider's Signature Jim Yoder, NHA Title Administrator Date 11/7/25

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	and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. **This requirement was not met as evidenced by:** Based on record review and interview it was determined that for five (E14, E15, E16, E17, and E18) out of five CNA'S reviewed, the facility failed to ensure that the required minimum twelve hours of in-service training was completed. Findings include: 10/3/25 - A review of the facility training worksheet lacked evidence of the required twelve hours minimum in-service training for the following CNA's: E14 had a hire date of 3/18/24. From 3/18/24 to 3/18/25, 3.0 hours of training were completed. E15 had a hire date of 6/28/24. From 6/28/24 to 6/28/25, 3.0 hours of training were completed. E16 had a hire date of 1/11/24. From 1/11/24 to 1/11/25, 3.0 hours of training were completed. E17 had a hire date of 3/2/24. From 3/2/24 to 3/2/25, 3.0 hours of training were completed. E18 had a hire date of 3/2/24. From 3/2/24 to 3/2/25, 3.0 hours of training were completed. 10/6/25 2:30 PM - Findings reviewed with E1 (NHA), E2 (DON) and E3 (ADON) during the exit conference.	month. Training includes *In The Know* resources, live sessions, and online CEUs. HR has also created a tracking spreadsheet (Document 13)to log completion dates for each CNA. The Human Resources Department will be responsible for ensuring CNA training remains current. The Administrative Assistant will serve as the designee to verify training compliance and documentation during monthly audits. **D. Success Evaluation** **Goal:** 100% of CNA staff will remain current with required monthly in-service training. **Monitoring:** The Human Resources (HR) Director will review the CNA training log monthly on an ongoing basis to verify that all CNAs have completed required training. Any missing or overdue training will be addressed immediately, and completion will be verified at the next monthly review. **Evaluation:** If 100% compliance is consistently maintained for three consecutive months, the monitoring process will continue monthly on an ongoing basis as part of the facility's QAPI program. **Responsible Person:** The HR Director will oversee monitoring and documentation, with the Director of Nursing (DON) as designee for verification and follow-up.	

Provider's Signature Zia Yasin, NHA Title Administrator Date 11/7/25

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3201.7.0 3201.7.5 S/S D	**Plant, Equipment and Physical Environment** **Kitchen and Food Storage Areas. Facilities shall comply with the Delaware Food Code.** **Delaware Food Code** **6-20111 Floors, Walls, and Ceilings.** **Except as specified under § 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are SMOOTH and EASILY CLEANABLE.** **This requirement is not met as evidenced by:** Based on observation, interview and review of other facility documentation, it was determined that the facility failed to comply with the Delaware Food Code. Findings include: 10/1/25 1:00 PM – During the survey of the facility, the surveyor observed the appearance of water damage on the kitchen ceiling between the large, canned goods display and the juice machine. The paint appears to be chipping, with a medium-sized brownish discoloration on the ceiling. Discussed findings with E7 (Dietary Manager) on 10/1/2025 at 2:45 PM and E13 (NHA 2) on 10/2/2025 at 11:15 AM. 10/6/25 2:30 PM - Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	**A.Individuals/Residents Impacted** All residents and employees that utilize dietary services **B.Identification of other residents with the potential to be affected** All current residents and employees that utilize dietary services **C.System Changes** The root cause of this deficient practice was a breakdown in the maintenance reporting process — the damaged ceiling area had not been communicated to maintenance because kitchen staff were unaware of the procedure for reporting non-urgent repairs. Going forward, all maintenance concerns, including any signs of water intrusion, paint damage, or discoloration, will be reported in writing via email/text to the Administrative Assistant immediately upon discovery. The Administrative Assistant will log all repair requests, assign corrective action, and ensure completion within 48 - 72 hours. Maintenance is responsible for all kitchen repairs. In their absence, the Administrative Assistant will serve as designee to verify that repairs are addressed promptly and documented. **D.Success Evaluation** **Goal:** The kitchen and food service areas will remain free of ceiling damage and other maintenance deficiencies. **Monitoring:** The Dietary Manager will conduct a weekly inspection of the kitchen and food service areas to identify any needed repairs. Findings will be documented on a Kitchen Inspection Checklist (Document 14) and forwarded to the Maintenance Director for timely correction. The Maintenance Director will verify completion of any repairs within 48 hours and log the actions taken.	11/1/2025

Provider's Signature [signature], NHA Title Administrator Date 11/7/25

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		Evaluation: If no unreported maintenance issues are identified during three consecutive months of weekly inspections, the monitoring process will be incorporated into the facility's QAPI program and continue on an ongoing monthly basis. **Responsible Person:** The Dietary Manager will monitor for needed repairs, and the Maintenance Director will ensure timely completion and documentation.	
	Title 16 Health and Safety **Chapter 11 Long-Term Care Facilities and Services** **Subchapter IV. Criminal Background Checks; Mandatory Drug Screening; Long-Term Care Facilities; Nursing Home Compliance with Title XIX of the Social Security Act.** **§ 1142. Mandatory drug screening.** **(a) An employer may not employ an applicant without first obtaining the results of that applicant's mandatory drug screening.** **(b) All applicants must submit to mandatory drug screening, as specified by regulations promulgated by the Department.** **(c) The Department shall promulgate regulations, regarding the pre-employment testing of all applicants, for use of all of the following illegal drugs:** **(1) Marijuana/cannabis.** **(2) Cocaine.** **(3) Opiates.** **(4) Phencyclidine ("PCP").** **(5) Amphetamines.**	A. Individual Impacted Employee E19. No further corrective action is possible for this employee; the mandatory drug screening was completed, but late. B. Identification of other individuals potentially affected All future facility employees. C. System Changes The root of the problem was determined to be our facility's practice of scheduling drug tests on the same days as employees' start dates. Human Resources (HR) will ensure that all future employees receive drug screening prior to employment by scheduling drug screenings on days prior to the start dates. The Onboarding Checklist form {see Document 8} that guides each hire's onboarding process will be revised to include the drug screening at an earlier stage in the hire process. Additionally, HR will revise our Employee Onboarding monitoring spreadsheet {see Document 9} to	10/24/2025

Provider's Signature [signature], NHA Title Administrator Date 11/7/25

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	(6) Any other illegal drug specified by the Department under regulations promulgated under this section. **(d) An agency, including temporary agencies, must provide the drug screening results it receives regarding an applicant referred to work in a facility to that particular facility so that the facility is better able to make an informed decision whether to accept the referral.** **(e) The employer must provide confirmation of the drug screen in the manner prescribed by the Department's regulations.** **(f) Any employer who fails to comply with the requirements of this section is subject to a civil penalty of not less than $1,000 nor more than $5,000 for each violation.** **This requirement was not met as evidenced by:** Based on interview and record review, it was determined that for one (E19) out of ten (10) employees reviewed, the facility failed to complete the required pre-employment drug screening. Findings include: 10/3/25 - A review of the facility personnel audit worksheet documented that E19 (CNA) received a pre-employment drug screen on 3/5/25 after the start date (2/26/25) in the facility. 10/3/25 1:30 PM - During an interview, E20 (HR) confirmed that the facility did administer the drug screen for E19 until after the start date in the facility. 10/6/25 2:30 PM - Findings reviewed with E1 (NHA), E2 (DON), and E3 (ADON) during the exit conference.	include a column to track drug screening. HR will be responsible for verifying that all pre-employment drug screenings are complete before start dates. In the absence of HR, the Director of Nursing (DON) will serve as the designee to review and confirm screening completion. **D. Success Evaluation** The goal is for all new hires to have completed drug screening prior to employment. HR will review the Employee Onboarding monitoring spreadsheet on a monthly basis, checking the drug screening and employment dates for all new employees, until drug screening dates have been 100% compliant for 6 consecutive months. HR will also continue to update and review the spreadsheet on an ongoing basis as new employees are hired.	

Provider's Signature Lisa Gott, NHA Title Administrator Date 11/7/25