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: Delaware Bay Rehab & Healthcare Center **DATE SURVEY COMPLETED:** October 22, 2025

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced Complaint survey was conducted at this facility from October 20, 2025, through October 22, 2025. The deficiencies contained in this report are based on observation, interview, review of clinical records and other facility documentation, as indicated. The facility census on the first day of the survey was one hundred and sixteen (116) residents. The survey sample size was three (3) residents.		
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed October 22, 2025: F686 and F692.		

Provider's Signature _____ Title NHA Date 11/5/2025

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 10/22/2025

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

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F0000	INITIAL COMMENTS An unannounced Complaint survey was conducted at this facility from October 20, 2025 through October 22, 2025. The deficiencies contained in this report are based on observation, interview, review of clinical records and other facility documentation, as indicated. The facility census on the first day of the survey was one hundred and sixteen (116) residents. The survey sample size was three (3) residents. Abbreviations/definitions used in this report are as follows: CNA - Certified Nursing Assistant; DON - Director of Nursing; LLAM - Low air loss mattress; LPN - Licensed Practical Nurse; RN - Registered Nurse; WCMD - Wound care Physician; WCN - Wound care Nurse; Acute kidney injury (AKI) - an abrupt decrease in kidney function, leading to the retention of waste products and dysregulation of fluid and electrolytes. It is characterized by a sudden episode of kidney failure or damage that occurs within hours or days, causing a buildup of waste products in the blood. AKI can result in serious complications and is associated with an increased risk of mortality and progression to chronic kidney disease; Braden Scale – tool used to determine risk for development of pressure ulcers; Buttocks - refers to the rounded muscular structure located on the posterior aspect of the pelvis; CMP (comprehensive metabolic panel) – blood test that measures sugar (glucose) level, electrolyte and fluid	F0000		12/02/2025

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 balance, kidney function, and liver function; Coccyx- the tailbone; small triangular bone at the base of the spinal column; Debridement – removal of necrotic (dead) tissues so that healthy tissue can regenerate or surgical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue OR the process of removing nonliving tissue from pressure ulcers; Eschar – dead tissue that is tan, brown or black and tissue damage more severe than slough in the wound bed or dead tissue forming a hard scab; usually black in color; Gangrene – death of body tissue due to lack of blood flow; Medi-honey - a brand name wound and burn gel made from Manuka honey that has anti-bacterial properties; Necrosis / Necrotic – tissue death, usually due to interruption of blood supply or injury or dead; non-viable tissue Purulent – containing pus; thick pus; PU - pressure ulcer; Sacrum – large triangular bone at base of spine; Sepsis – potentially deadly medical condition characterized by a whole-body inflammatory state; symptoms include fever, difficulty breathing low blood pressure, fast heart rate, and mental confusion; Silvadene - topical antibiotic that fights bacteria and yeast on the skin; Slough – yellow, tan, gray, green or brown dead tissue; Stage II (2) pressure ulcer - skin blisters or skin forms an open sore. The area around the sore may be red and irritated; Subcutaneous - beneath, or under, all the layers of the skin; Unstageable pressure ulcer - Tissue loss in which actual depth of the ulcer is unable to be determined due to the presence of slough (yellow, tan, gray, green or brown dead tissue) and/or eschar (dead tissue that	F0000		

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F0000	Continued from page 2 is tan, brown or black and tissue damage more severe than slough in the wound bed); UTD - unable to determine; Vashe - a name brand wound cleanser;	F0000		
F0686 SS = G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, it was determined that for one (R1) out of three (3) residents reviewed for pressure ulcer (PU), the facility failed to ensure that R1 received the necessary treatment and services, consistent with professional standards of practice, to prevent pressure ulcers (PU's) from developing. R1 had an avoidable unstageable PU develop on bilateral buttocks at the facility causing harm to the resident. Findings include: Cross refer F692 Review of R1's clinical record revealed: 8/25/25 - A progress note from the hospital documented that R1 had a stage II pressure ulcer to the sacrum measuring /4.5 cm L x 0.5 cm W. A wound photograph provided from hospital revealed R1's sacrum open, pink in color, matching the measurements. Additionally, a smaller open area noted approximately 2 cm L and 0.5 cm W, location distally, pink in color, and intact edges.	F0686	1. The facility is unable to correct the deficient practice for R1. R1 was discharged from the facility on 9/25/2025. 2. Pressure injury risk assessments and skin assessments were completed for all residents on October 29, 2025 by the nursing management team. For those residents at risk, care plans were reviewed to ensure appropriate interventions. 3. A root cause analysis revealed a breakdown in staff adherence to established wound assessment and documentation policies and procedures. Specifically, staff failed to document wound measurements on admission and weekly thereafter and did not notify or consult the wound care provider upon admission of the wound. Due to this communication failure, the resident's care plan was not updated to reflect the wound and necessary interventions. The wound nurse responsible was replaced on 11/3/2025. All licensed nursing staff have received education on the importance of documenting wound measurements on admission, completing weekly wound assessments, and ensuring resident care plans are updated with identified problems and individualized interventions. 4. The facility has reviewed and revised its wound management procedures to ensure all licensed nursing staff clearly understand the required steps for wound identification, documentation, notification, and weekly monitoring. The admission process has been enhanced to require that any wound identified on admission is immediately documented in the electronic health record with complete measurements and staging, and the wound care provider is notified prior to the end of the admitting nurse's shift. The Care Plan Review Process has been strengthened to ensure that any new wound triggers an automatic care plan update within 24 hours, including individualized interventions and monitoring parameters. The Director of Nursing or designee will review all new admission documentation daily to confirm wound documentation is complete, provider notification has occurred, and the care plan has been updated.	12/02/2025

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F0686 SS = G	Continued from page 3 9/2/25 - R1 was admitted to the facility. 9/2/25 8:07 PM – A Braden scale assessment was completed for R1 with a score of 18 indicating moderate risk of skin breakdown. 9/2/25 8:13 PM – An admission skin check documented that R1 had a wound noted to the sacrum upon admission. The admission skin check lacked evidence of assessment, measurement, or staging related to the wound. 9/2/25 - A baseline care plan documented that R1 had a potential for pressure ulcers related to impaired mobility, decreased activity, potential for alteration in nutrition and potential for friction with the following interventions: barrier cream to buttocks, coccyx, sacrum and perineum every shift after each incontinent episode, monitor for adequate nutrition and hydration, offload heels while in bed, pressure reducing mattress to bed, pressure reducing cushion to wheelchair, turn and reposition every two hours, and weekly skin checks. 9/3/25 - A physician's order documented to wash sacral wound with Vashe, apply Medi-honey, and cover with boarder foam dressing daily on night shift. This treatment is consistent with a Stage II pressure ulcer treatment guidelines per standard practice. 9/3/25 – A review of R1's new wound alert assessment documented an open area noted to sacrum. The assessment lacked evidence of measurement, staging, and description of the wound. On the bottom of the form in the lower right-hand corner was an unsigned note dated 9/4/25 that documented, "buttocks/coccyx 12 cm L x 15 cm W x UTD (unable to determine) D. 100% necrotic, continue same treatment and LLAM (low air loss mattress) to bed." The added note does not appear to be written in the same handwriting as the original form was documented and lacked signature. The facility lacked evidence that a consultation with the physician on 9/4/25 about the change in the wound and no new treatment was ordered for the wound. 9/6/25 - An admission MDS documented that R1 had a stage II pressure ulcer on admission with the following interventions: pressure relieving device to chair, pressure ulcer/injury care, and applications of medications or ointments. The MDS also documented that R1 was dependent for all ADL's including turning, repositioning, and incontinence care.	F0686	Continued from page 3 A new communication workflow has been implemented requiring the admitting nurse to notify the Unit Manager and Wound Nurse of any newly identified wounds at the time of admission. The Wound Nurse will verify all wound assessments, measurements, and staging during the weekly wound rounds and ensure accuracy and completeness. The Director of Nursing Services, or designee, will audit 8 residents with wounds to monitor for improvement of wound, or alternate treatment and interventions implemented, weekly for three months, then 4 residents with wounds twice per month thereafter until 100% compliance, unless otherwise determined by the Risk Management/Quality Assurance Committee. Audits will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 5. Compliance date: December 2, 2025	

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F0686 SS = G	Continued from page 4 9/9/25 – The facility lacked evidence of a weekly pressure ulcer assessment including staging, measurement, and assessment of the wound. 9/11/25 - The admission MDS was signed off by E11 (MDS coordinator) as complete and the accuracy of the data that R1 had a stage II pressure ulcer noted. 9/11/25 - A review of R1's new wound alert assessment documented an "area noted to coccyx measuring 15 cm L x 18 cm W x UTD D. Black in color and necrotic. Continues on LLAM." The note documented coccyx which is inconsistent to the previous note with handwritten assessment that documented "buttocks/coccyx". The facility lacked evidence of an order for the use of the LLAM in the clinical record. 9/16/25 - A progress note from WCN documented that R1 had an "'unstageable bilateral sacrum: measuring 17 cm L x 20 cm W. The wound was 100% necrotic. A new order for Silvadene cover with ABD pad twice a day." The note is inconsistent with documentation from previous WCN progress notes as the documentation uses sacrum and coccyx. The note is unclear regarding location of wound. 9/17/25 - A physician's order documented "unstageable to sacrum: apply Silvadene cream and cover with ABD pads twice a day." The physician's order mentions sacrum and lacks evidence of treatment to bilateral buttocks. 9/17/25 - A physician's order was added for a low air loss mattress (LLAM) for wound care healing. 9/23/25 - A progress note from WCN documented "[R1] was seen by WC physician (WCMD) for unstageable wound bilateral sacrum measuring 23 cm L x 22 cm W and 100% necrotic, odiferous, with purulent drainage noted. [R1] to continue on Silvadene BID. Verbal consent from wife to debride next week." The note does not mention area noted to buttocks or evidence of treatment to buttocks. 9/25/25 11:13 AM - A progress note documented that R1 was sent to the emergency room due to altered mental status, abnormal labs, and strong foul odor to sacral wound. 9/25/25 - R1 was admitted to the hospital with a diagnosis of sepsis, AKI (kidney injury), and a large sacral ulcer with suspicion of gangrene. A photograph provided from the hospital revealing R1 with bilateral buttocks wounds that were black in color, yellow slough	F0686		

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F0686 SS = G	Continued from page 5 noted around border of bilateral wounds, measuring approximately 28 cm L and 22 cm W extending to bilateral buttocks, and pink tissue noted under lifting edges. 9/25/25 – A hospital progress note documented a gluteal excision debridement of skin, subcutaneous tissue, gluteal muscle, and sacrum measuring 28 cm L and 22 cm W was completed. A photograph provided from hospital revealing R1's bilateral buttocks post debridement exposing muscle, ligaments, connective tissue, adipose measuring approximately 28 cm L and 22 cm W extending to bilateral buttocks. 10/20/25 2:50 PM – During an interview, E6 (CNA) and E7 (CNA) confirmed that R1 was dependent for ADL's and verified the sacral wound was present on admission. E6 and E7 both confirmed R1 did not have a low air mattress when R1 was admitted and confirmed the wound did become larger in size over the time R1 was at the facility. 10/21/25 9:45 AM – During an interview, E4 (LPN) stated that the expectation of an admission with a new wound is to notify the WCN about presence of wound and an assessment of wound was to be completed by an RN. E4 confirmed there was a wound form to be completed and submitted to WCN. 10/21/25 10:00 AM – During an interview, E5 (LPN) confirmed that the expectation was all new admissions to have a full head to toe assessment completed by an RN, document any wounds with measurements in the medical record and notify the WCN. E5 also stated the admitting nurse was responsible to implement preventative measures and interventions for wounds upon admission. 10/21/25 10:30 AM – During an interview, E4 confirmed that R1's was present on admission and described the wound as a small open area on the coccyx/sacrum. E4 stated the treatment was completed on overnight shift and was seen when E4 completed a PRN (as needed) dressing change to wound, could not recall exact date but stated it was around 9/16/25. E4 stated the wound was necrotic noted on bilateral buttocks, very large in size compared to size on admission and not in the same area. E4 stated she notified E3 (WCN) immediately of these changes. E4 confirmed that the Silvadene treatment was initiated on 9/17/25 and the treatment would soften the necrotic areas of buttocks. E4 confirmed the wound had an odor and noted purulent drainage shortly before R1 went to the hospital.	F0686		

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F0686 SS = G	Continued from page 6 10/21/25 2:45 PM – During an interview, E3 (WCN) stated R1's wounds were assessed on 9/4/25, the week of admission and confirmed that the wound started in the coccyx and then new areas was noted affecting the buttocks. On the second week (9/11/25), E3 stated the edges of the buttocks wounds were starting to lift but the center of the wound was hard and necrotic. E3 confirmed that R1 did not see E8 (WC MD) on 9/9/25 due to R1 being at an appointment. E8 (WC MD) assessed R1 and ordered the Silvadene on 9/16/25. E8 assessed R1 on 9/23/25 but did not change the treatment and did not order anything orally for the purulent drainage noted on the wound assessment. E3 stated she initiated the LLAM on 9/4/25 and confirmed the order was not put in until 9/17/25. There was lack of evidence that the low air loss was initiated on 9/4/25. R1 entered the facility with a stage II sacral wound and within 15 days was diagnosed with an unstageable pressure ulcer on the right and left buttocks. 10/22/25 - Findings reviewed with E2 (DON) during exit conference.	F0686		
F0692 SS = G	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by:	F0692	F692 1. The facility is unable to correct the deficient practice for R1. R1 was discharged from the facility on 9/25/2025. 2. A whole-house audit was completed to identify any residents at risk for dehydration. For residents identified with dehydration risk, immediate interventions were implemented, including but not limited to: Increased staff-assisted fluid offers during and between meals, routine laboratory monitoring, speech therapy consults to evaluate swallowing safety and appropriate fluid textures, addition of foods naturally high in water content to meal trays, education for residents and families on the benefits of fluids and risks of refusal, physician notification and treatment plan adjustments as indicated. All findings and interventions were documented in the EHR. 3. A comprehensive Root Cause Analysis (RCA) identified multiple communication- and process-based failures resulting in the deficient practice. Key findings are included: CNA staff had no standardized method to know residents' recommended daily fluid intake, fluid goals were not embedded in the EHR in a visible location for CNA reference, verbal communication during shift report	12/02/2025

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F0692 SS = G	Continued from page 7 Based on record review and interview, it was determined that for one (R1) out of one resident reviewed for hydration, the facility failed to ensure that R1 was offered sufficient fluids to maintain proper hydration. This failure resulted in harm when R1 was transferred to the hospital on 9/25/25 with a diagnosis of metabolic acidosis, hypokalemia and AKI (acute kidney injury) and elevated lab values indicative of dehydration. Findings include: Cross refer F686 The BUN (blood urea nitrogen) lab measures the amount of urea nitrogen in the blood. The BUN is directly related to the metabolic function of the liver and the excretory function of the kidney ... BUN levels also may vary according to the state of hydration, with increased levels seen in dehydration and decreased levels seen in overhydration. Mosby's Diagnostic and Laboratory Test Reference 2023. Review of R1's clinical record revealed: 9/2/25 – R1 was admitted to the facility. 9/2/25 – A physician's order was written for lisinopril hydrochlorothiazide 20 mg – 12.5 mg one tablet by mouth twice a day for hypertension. The aforementioned medication is an antihypertensive as well as a diuretic. 9/3/25 - A review of R1's labs (CMP) revealed a sodium level (NA) of 135 mmol/L (normal value is 137 - 145 mmol/L.) The blood urea nitrogen level (BUN) was 17.0 mg/dL (normal value is 9.0 - 20.0 mg/dL). As of 10/21/25 there was no evidence that these labs were reviewed by the provider. 9/3/25 - An admission nutritional assessment documented that R1's recommended fluid intake was 1724 - 2155 mL/day. 9/3/25 - A baseline care plan documented that R1 was as risk for alteration in hydration related to impaired mobility, medications and diagnosis of recent AKI (acute kidney injury), UTI, and course of antibiotic and the following interventions: encourage adequate fluid intake and monitor for signs and symptoms of dehydration such as poor skin turgor, dry mucous membranes, concentrated foul smelling urine, decreased urine output, change in mental status, notify nursing and MD as appropriate.	F0692	Continued from page 7 was inconsistent, and hydration reminders were not reinforced during care delivery. The Registered Dietitian (RD) did not address R1's hydration concerns before the scheduled assessment date of 9/24/25.The RD reported reliance on routine 30-day nutritional assessments unless a specific nursing referral was submitted. Nursing staff inconsistently communicated low fluid intake patterns to the RD. The RD did not review daily or weekly fluid intake logs as part of ongoing hydration monitoring. Residents with AKI or UTI require increased frequency of hydration review, RD reassessment outside of the routine schedule, and interdisciplinary communication regarding fluid intake trends. Root Cause: The facility lacked a formalized hydration communication protocol and EHR visibility for direct care staff. A breakdown in interdisciplinary communication, lack of a trigger-based referral process, and absence of expectations requiring the RD to review hydration data more frequently when residents exhibit hydration-risk indicators. A dehydration risk evaluation will be completed on admission, quarterly, annually, and with any significant change in condition. The results will be incorporated into the resident's Plan of Care and interventions updated as necessary/appropriate. The form will be uploaded into the EHR. Resident's calculated daily fluid intake will be added to the EHR for ease of reference by all clinical staff. The Unit Manager (UM) or shift supervisor will pull a fluid intake report each shift and review for residents not meeting their fluid goal. Any resident who does not meet their fluid intake goal will be discussed during morning IDT. Collaboration between the dietitian, the IDT team, and the provider will address any changes or orders for further interventions. The changes in order or plan of care will be updated in the EHR and communicated to the direct care staff at huddle each shift. The RCA found that E10 did not act on R1's hydration decline noted on the 9/3/25 review and failed to intervene between 9/3/25 and 9/24/25 despite fluid intake consistently falling below 50% of the recommended goal. Education completed with E10 included expectation to review hydration data for high-risk residents more frequently than the routine assessment schedule, requirement to address inadequate intake immediately	

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F0692 SS = G	Continued from page 8 The daily totals obtained from CNA flow sheets for R1's fluid intake were: -9/3/25 – Intake: 600 mLs. Output: 2050 mLs. -9/4/25 – Intake: 600 mLs. Output: 800 mLs. -9/5/25 – Intake: 480 mLs. Output: 1125 mLs. -9/6/25 – Intake: 600 mLs. Output: 1070 mLs. 9/6/25 - An admission MDS documented that R1 was dependent on staff for all ADL's including eating and hydration. The daily totals obtained from CNA flow sheets for R1's fluid intake were: -9/7/25 – Intake: 360 mLs. Output: 2650 mLs. -9/8/25 – Intake: 600 mLs. Output: 1400 mLs. -9/9/25 – Intake: 720 mLs. Output: 1050 mLs. -9/10/25 - Intake: 360 mLs. Output: 1550 mLs. -9/11/25 – Intake: 720 mLs. Output: 1250 mLs. -9/12/25 – Intake: 640 mLs. Output: 1500 mLs. -9/13/25 – Intake: 840 mLs. Output: 950 mLs. -9/14/25 – Intake: 720 mLs. Output: 850 mLs. -9/15/25 – Intake: 360 mLs. Output: 670 mLs. -9/16/25 – Intake: 600 mLs. Output: 300 mLs. -9/17/25 – Intake: 600 mLs. Output: 240 mLs. -9/18/25 – Intake: 360 mLs. Output: 0 mLs. -9/19/25 – Intake: 600 mLs. Output: 50 mLs. -9/20/25 – Intake: 480 mLs. Output: 110 mLs. -9/21/25 – Intake: 600 mLs. Output: 300 mLs. -9/22/25 – Intake: 600 mLs. Output: 460 mLs. -9/23/25 – Intake: 600 mLs. Output: 500 mLs. -9/24/25 – Intake: 360 mLs. Output: 750 mLs.	F0692	Continued from page 8 upon identification, increased responsibility for timely communication with the nursing team, mandatory documentation of follow-up attempts and intervention recommendations, reviewing hydration data trends for all residents with wounds, AKI, or recent infection. E10 provided written acknowledgment of understanding. An in-service education program will be conducted on November 19, 2025 by the Director of Nursing Services or the Registered Dietitian with all direct care staff addressing the significance of accurate reporting of fluids consumed during meals, the need to encourage fluid intake, and the provision of sufficient intake between meals to maintain adequate hydration. The in-service will also address the importance of reporting conditions that alter a resident's fluid needs. 4. The nursing management team, and/or Registered Dietician will review each new resident with risk factors for dehydration to ensure appropriate interventions are implemented and an updated plan of care is completed. The Director of Nursing Services (DNS), or designee, will complete 10 random weekly chart audits for four weeks then 10 random chart audits twice per month to review all fluid intake records to ensure that appropriate interventions have been put in place to reduce the risk of dehydration. Audits will assure that care plans remain updated to reflect these interventions. Audited records will be reviewed by the Risk Management/Quality Assurance Committee until such time consistent substantial compliance has been achieved as determined by the committee. 5. Compliance date: December 2, 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 10/22/2025

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F0692 SS = G	Continued from page 9 -9/25/25 – Intake: 100 mLs. Output: 100 mLs (went to hospital) The facility failed to meet R1's recommended daily hydration goal on all the above dates. 9/25/25 – A hospital progress note documented that R1 "presented to the emergency department with an acute kidney injury (AKI) with creatinine value of 9.1 mg/dL (high) and a BUN (blood urea nitrogen) level of 155 mg/dL (high). [R1] with severe metabolic acidosis." 10/20/25 2:50 PM – During an interview, E6 (CNA) and E7 (CNA) confirmed that R1 required total care with ADL's including feeding and drinking. E6 stated that R1 had a poor appetite and would pocket food and confirmed that staff would try to feed and encourage R1's intake. E6 confirmed that the staff nurses were aware of R1's decreased intake. 10/21/25 10:30 AM – During an interview, E4 (LPN) confirmed R1 had decreased intake and notified the UM (unit manager) and provider of these concerns. E4 stated that staff encouraged fluid intake for R1 and requested R1 be sent to the hospital related to decreased intake. 10/21/25 11:05 AM - Review of R1's EMR progress notes lacked evidence of efforts to address R1's decreased oral fluid intake including approaches to increase hydration and consultation with the doctor. 10/21/25 1:45 PM – During an interview, E2 (DON) confirmed that the provider was not consulted regarding R1's decreased intake and no interventions were ordered to increase hydration. 10/22/25 12:34 PM – During an interview, E9 (LPN UM) stated that staff did not report decreased intake for R1 during the aforementioned dates. E9 stated that the dietician usually follows resident's closely regarding intake and hydration status. 10/22/25 2:57 PM - During an interview, E10 (Dietician) confirmed that she reviewed R1's nutritional status on 9/3/25 and again on 9/24/25. E10 confirmed that she reviewed R1's intake and addressed nutritional needs based on low oral intake (food) and the presence of the wound. E10 confirmed that a liquid protein supplement and nutritional supplement were added to R1's regimen. E10 confirmed that she did not address R1's hydration status or provide suggestions how to increase it. The lack of monitoring and interventions led to R1 being sent out for further evaluation. R1 was admitted to the	F0692		

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F0692 SS = G	Continued from page 10 hospital with a diagnosis of AKI and metabolic acidosis which is directly related to a decreased intake of fluids resulting in harm to R1. 10/22/25 3:15 PM - Findings were reviewed with E2 (DON) during the exit conference.	F0692		