DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Long-Term Care Residents Protection

263 Chapman Road, Ste 200, Cambridge Bldg.
Newark, Delaware 19702
(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Newark Manor Nursing Home

DATE SURVEY COMPLETED: October 24, 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 21, 2025, through October 24, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census for the first day of the survey was fifty nine (59). The survey sample totaled six (6) 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 24, 2025: F580, F610, F656, F657, F689, F700 and F776.		

Provider's Signature _____ Title Administrator Date 11-11-2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWARK MANOR NURSING HOME	254 WEST MAIN STREET , NEWARK, Delaware, 19711

(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
F0000	INITIAL COMMENTS An unannounced Complaint Survey was conducted at this facility from October 21, 2025, through October 24, 2025. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documents, as indicated. The facility census for the first day of the survey was fifty-nine (59). The survey sample totaled nine (9) residents. Abbreviations/definitions in this report are as follows: ADLs – activities of daily living/ tasks needed for daily living, e.g. dressing, hygiene, eating, toileting, bathing; ADON - Assistant Director of Nursing; 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. 0-7: Severe impairment (never/rarely made decisions); Cardiologist - doctor specializing in finding, treating and the prevention of heart disease and associated blood vessels; CNA – Certified Nurse's Aide; Dependent – Per MDS assessment, defined as "Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity." DON – Director of Nursing; Enabler – type of bed rail that is used to assist in movement within the bed; ER – emergency room; Humeral neck – bone at the top of the arm; LPN - Licensed Practical Nurse;	F0000		11/18/2025

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

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F0000	Continued from page 1 MDS – Minimum Data Set/standardized assessment forms used in nursing homes; Morse fall scale: High risk – 45 and higher, Moderate risk – 25-44, Low risk – 24 – 0. NHA – Nursing Home Administrator; Pacemaker - small device that's placed under the skin near your heart to help control your heartbeat; POA – Power of Attorney; PRN – as needed; RN – Registered Nurse; Sick Sinus Syndrome – heart rhythm disorder that causes slow heartbeats, pauses or irregular heartbeats; STAT – immediately.	F0000		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure	F0580	1. Immediate Corrective Action for the Affected Resident The resident was evaluated in the ED and diagnosed with a left humeral neck fracture The resident returned to the facility with updated treatment orders, which were implemented promptly (pain management, activity modification, and monitoring for pain). The nursing staff involved were counseled and re-educated on the policy for notifying the physician when STAT diagnostic results are delayed. 2. Identification of Other Residents Potentially Affected The DON/designee reviewed all STAT diagnostic orders (x-rays, labs, and imaging) from the past 30 days to ensure timely physician notification and documentation. No other residents were found to have delays in STAT results without physician notification.	11/21/2025

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F0580 SS = D	Continued from page 2 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). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of clinical record, it was determined that for one (R1) out of three residents reviewed for accidents, the facility failed to notify the on-call provider of R1's delayed STAT x-ray results ordered 7/18/25. Findings include: Cross refer to F689, example 1 Review of R1's clinical record revealed: 7/18/25 – A physician's order stated to obtain a STAT elbow x-ray for R1's increased pain and decreased movement of left arm. A nursing note, at 5:49 PM, documented that the x-ray was completed in the facility. 7/20/25 8:20 PM – R1's mobile STAT x-ray results were	F0580	Continued from page 2 3. Systemic Changes to Prevent Recurrence Policy Revision The facility's "Timing of Clinical Results" policy has been revised to state: STAT diagnostics will no longer be performed in-house. Residents requiring urgent evaluation will be sent to the ED for testing. Licensed nurses must immediately notify the attending physician of the resident's condition and the need for urgent evaluation. Nurses must document notification, ED transfer, and any interventions in the medical record. Tracking & Oversight A Resident Urgent Evaluation Log will be implemented to track: Resident name, date/time of notification, reason for ED transfer, interventions, and follow-up. Charge nurses will review residents with urgent diagnostic needs each shift. DON/designee will monitor and verify ED transfers during shift change reports. Staff Education All licensed nurses were re-educated on: Immediate physician notification for urgent conditions	

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F0580 SS = D	Continued from page 3 finally read and faxed to the facility revealing a left humeral neck fracture. 10/23/25 11:00 AM – During an interview, E6 (RN) stated that she called the mobile x-ray company on 7/19/25 and was told they were running behind. E6 stated that she did not notify the on-call provider. E6 stated that when she returned to work on 7/20/25 evening shift and found out the results were still not received. E6 stated R1's POA was very upset and requested R1 to be sent to the ER. E6 stated that the on-call provider was notified and an order to send R1 to the ER (emergency room) for an x-ray was obtained. R1 was sent to the ER at 5:10 PM. The facility lacked evidence that R1's physician or an on-call provider was notified that the physician ordered STAT x-ray results were not received until approximately 48 hours later. 10/24/25 2:30 PM – Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0580	Continued from page 3 ED transfer procedures for urgent evaluation Accurate documentation of notification, interventions, and follow-up New hires will receive this training during orientation. F580 Root Cause The root cause of the deficient practice was a breakdown in the facility's processes for timely communication of urgent diagnostic results and the absence of a standardized approach for managing STAT tests when delays occur. Contributing factors included: 1. Lack of a Standardized Process for STAT Diagnostics The facility previously did not have a clear protocol for situations when STAT diagnostic results were delayed. As a result: Nursing staff were unsure of the appropriate steps to notify the physician immediately when results were not available within expected timeframes. STAT x-rays were performed in-house without a defined monitoring or escalation procedure for delayed results. 2. Insufficient Oversight and Tracking Mechanisms There was no reliable system to: Track STAT diagnostic orders and ensure results are received and reviewed promptly. Escalate delays to the physician or supervisory staff. Ensure consistent documentation of communications and interventions. 4. Monitoring and Quality Assurance	

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F0580 SS = D		F0580	Continued from page 4 DON/designee will audit all urgent evaluations: Weekly for 4 weeks until 100% compliance is achieved, then monthly for 3 months, until 100% compliance is achieved. Audits will verify: Timely physician notification Proper ED transfer when indicated Documentation of notification and follow-up in the medical record Results will be reviewed in Quarterly QAPI meetings.	
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review and other facility documentation, it was determined that	F0610	1. Immediate Corrective Action for the Affected Resident The Director of Nursing (DON) and Assistant Director of Nursing (ADON) immediately reviewed the incident once the discrepancy was discovered on 9/11/25. A new investigation was initiated and completed, confirming that R2 was left unattended in the bathroom when the fall occurred. The CNA involved (E7) was immediately suspended pending investigation and subsequently terminated for failure to provide appropriate supervision and for falsifying information. The LPN (E8) and RN Supervisor (E5) were counseled and re-educated on post-fall assessment, staff reporting responsibilities, and accurate documentation requirements. The resident's fall care plan was reviewed and revised to include increased supervision and reminders to staff regarding safety during toileting assistance.	11/21/2025

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F0610 SS = D	Continued from page 5 for one (R2) out of three residents sampled for falls, the facility failed to thoroughly investigate an allegation of neglect when R2 was left unattended in the bathroom and had a fall. Findings include: An undated facility document entitled, "Falls" included, "... The nurse and charge nurse are to be notified immediately, and the resident is not to be moved until assessed by a nurse unless otherwise directed." 2/28/22 - R2 was admitted to facility with diagnoses including but not limited to dementia, left eye absolute glaucoma (permanent vision loss), and difficulty walking. 1/16/24 – R2's fall care plan documented, "Resident with poor safety awareness and impulse control." 8/30/25 2:41 PM – R2's clinical record documented, "...S/P [status post] fall hit head, has a superficial laceration to the back of the right side of head that is 0.5cm..." 8/30/25 7:40 PM – A facility reported incident submitted to the Division documented, "Resident found on the floor in the bathroom of the third-floor day room...." 8/30/25 7:47 PM – E8 (LPN) documented in R2's clinical record, "At approximately 1400 [2:00 PM], staff reported an unwitnessed fall in the dining room immediately after lunch. Resident was noted on the floor in a seated/side-lying position with active bleeding from the head...." 10/21/25 1:30 PM – A review of the facility's post-fall investigative record revealed, "During the multidisciplinary care conference for [R2] on 9/11/25, it was brought to the attention of staff that the fall occurred in the bathroom after the resident was left unattended by the CNA [E7.] The CNA misrepresented the location and details of the incident." The facility's new investigation revealed that R2 was left unattended in the bathroom while the CNA went down the hall to obtain an incontinent brief. When she returned, R2 had fallen to the floor. E7 put R2 into the wheelchair and told the supervisor that [R2] had fallen in the dining room. 10/21/25 2:30 PM – During an interview, the Surveyor asked E8 (LPN) if she had seen or assessed R2 post fall, E8 stated, "No, I was on break, and I did not see her on the floor after the fall. The RN supervisor [E5]	F0610	Continued from page 5 The resident was medically assessed following the incident, 08.30.25 2. Identification of Other Residents Potentially Affected The DON/ADON reviewed all reported falls and incidents over the prior 60 days to ensure: Each incident was accurately reported and documented. All investigations were initiated promptly and completed thoroughly. Staff statements were obtained in a timely manner. No other incidents were identified where investigation or reporting was delayed or incomplete. All residents identified as requiring assistance with toileting were reviewed to ensure care plans reflect appropriate supervision levels. Updates were added to each Resident Status Sheet, as appropriate Task added to each Kardex, as appropriate 3. Systemic Changes to Prevent Recurrence Policy Revision and Reinforcement: The facility's "Abuse, Neglect, and Incident Investigation" policy has been reviewed and revised to include: Clear timeframes for initiating and completing internal investigations (initiate immediately, complete within 5 business days).	

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F0610 SS = D	Continued from page 6 told me that she had fallen." 10/22/25 2:45 PM – During an interview, the Surveyor asked E6 (3-11RN supervisor) how she became aware of the location of R2's fall. E6 stated, "The day shift supervisor [E5] told me that the aide said that the resident had fallen in the bathroom. The location was on the report that I submitted to the state." The facility failed to thoroughly investigate the location of the fall until 12 days after the event. 10/24/25 12:00 PM - Findings were confirmed with E2 (DON). 10/24/25 2:30 PM – Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0610	Continued from page 6 Requirements that all staff reports of an incident include accurate details of time, location, and witnesses. A mandatory staff statement form to be completed by all employees involved or present at the time of an incident, prior to the end of their shift. A requirement for the DON or designee to verify location and circumstances through direct interviews and, when available, environmental review or camera verification. A secondary review by the Administrator prior to final submission to the State Agency. Staff Education: Facility staff were re-educated by the DON on regarding: Immediate reporting of any allegation or suspicion of abuse, neglect, or misrepresentation. Accurate, factual, and timely completion of incident reports. Duty to remain with residents requiring supervision during toileting until assistance is complete. Expectations for honesty and integrity in documentation. Newly hired employees will receive this training during orientation and annually thereafter. F610 Root Cause: The root cause of the deficient practice was the breakdown in the facility's incident reporting and investigation process, specifically related to timely verification of event details, accuracy of staff reporting, and oversight of the investigation workflow.	

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F0610 SS = D		F0610	Continued from page 7 Contributing factors include: 1. Failure to Immediately Verify Incident Details There was no standardized process requiring supervisory staff to confirm the reported location, circumstances, and witness accounts at the time of the incident. As a result, the inaccurate report that the fall occurred in the dining room was accepted without verification, leading to a delay in identifying the true event location. 2. Insufficient Oversight of Incident Investigations There was no consistent secondary review by leadership (DON/Administrator) to ensure investigations were accurate, thorough, and timely before finalization. This lack of oversight contributed to the delayed discovery of the true circumstances surrounding the fall. 4. Monitoring and Quality Assurance The DON/designee will conduct weekly audits for four (4) weeks until 100% compliance is achieved, then monthly for three (3) months until 100% compliance is achieved, of all incident and investigation reports to ensure: Investigations are initiated promptly and completed within required timeframes. All staff statements are obtained. Documentation accurately reflects event details (time, location, actions taken). Audit findings will be reviewed in the monthly QAPI Committee for three consecutive months and ongoing as needed. Any deficiencies identified during audits will result in immediate re-education or corrective action.	
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3)	F0656	1. Immediate Corrective Action for the Affected Resident	11/21/2025

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F0656 SS = D	Continued from page 8 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for 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:	F0656	Continued from page 8 The resident referenced in the citation passed away in September 2025; therefore, no direct corrective action was required for the resident. Following her passing, the facility was notified by the New Jersey cardiologist who placed the pacemaker that the device had not been functioning/in use, and no cardiology follow-up had been completed by the resident's Power of Attorney prior to her admission to our facility. 2. Identification of Other Residents Potentially Affected A 100% audit was completed for all current residents with: Implanted cardiac devices Cardiac histories requiring specialist follow-up The audit ensured: All documented medical devices are active and functioning as intended All needed specialist follow-ups are scheduled or verified Admission documentation includes complete cardiac device history and specialist information Care planes include Implanted Cardiac Device type, settings, and serial number Any missing or unclear information identified during the audit was corrected immediately. 3. Systemic Changes to Prevent Recurrence The root cause of this issue was a gap in the	

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F0656 SS = D	Continued from page 9 Based on interview and review of clinical record, it was determined that for one (R1) out of three residents reviewed for accidents, the facility failed to ensure a person-centered care plan was initiated and implemented that included measurable objectives and timeframes to meet R1's medical need with respect to the resident's pacemaker. Findings include: Review of R1's clinical record revealed: 1/31/23 – R1 was admitted to the facility with diagnosis that included, but was not limited to, dementia, legal blindness and sick sinus syndrome. 1/31/23 2:15 PM – The Resident Assessment-Data Collection Form documented that R1 had a pacemaker on her left upper chest. 1/31/23 – R1 was care planned for a "pacemaker r/t [related to] sick sinus syndrome" with goals and interventions that included: "Goals: -will remain free from s/sx [signs/symptoms] of pacemaker malfunction or failure through the review date. Interventions: -Monitor vital signs monthly and as needed. Notify MD (medical doctor) of significant abnormalities. Notify MD of significant abnormalities. -Monitor/document/report PRN (as needed) any s/sx of altered cardiac output or pacemaker malfunction: dizziness, syncope (fainting), difficulty breathing (dyspnea), pulse rate lower than programmed rate, lower than baseline B/P (blood pressure)." The facility failed to ensure that R1's pacemaker care plan was person-centered. Specifically, the care plan lacked R1's pacemaker's function information (type, settings/rate, battery status); education for the resident/family on the purpose and function of the pacemaker, signs and symptoms of pacemaker complications and the importance of follow-up appointments with R1's Cardiologist; and monitoring of skin integrity at location site.	F0656	Continued from page 9 facility's admission verification process for implanted medical devices and specialty follow-up, specifically: 1. Incomplete admission documentation from external providers The facility did not receive complete specialist records from the New Jersey cardiologist prior to or after admission. The pacemaker status (active vs. inactive) was not included anywhere in the transfer packet, hospital records, or POA-provided information. 2. No system in place to verify the operational status of implanted cardiac devices The facility relied solely on the medical records and information provided at admission. There was no structured process or checklist requiring staff to verify device functionality or confirm the most recent specialist follow-up when documentation is incomplete or unclear. Admission procedures were updated to require: Verification of all implanted medical devices upon admission (e.g., pacemakers, defibrillators) Confirmation of most recent specialist follow-up Contact with outside specialists if documentation is incomplete Nursing and MDS staff received re-education by Director of Nursing, Tiffany Hodgdon, RN, on: Requirements of F656 person-centered care planning Ensuring care plans accurately reflect device status	

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NEWARK MANOR NURSING HOME	254 WEST MAIN STREET , NEWARK, Delaware, 19711

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F0656 SS = D	Continued from page 10 10/23/25 approximately 3:00 PM – During an interview, surveyor reviewed that R1's pacemaker care plan was not person-centered with E2 (DON). 10/24/25 2:30 PM – Finding was reviewed during the exit conference with E1 (NHA) and E2.	F0656	Continued from page 10 and specialist involvement The importance of obtaining external care records, especially for implanted cardiac devices An updated Admission Device Verification Checklist was implemented. 4. Monitoring and Quality Assurance The DON/designee will conduct weekly audits to verify that device status and care plans are accurate for four (4) weeks until 100% compliance is achieved then monthly for three (3) months until 100% compliance is achieved.	
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F0657	1. Immediate Corrective Actions for Affected Residents: R1: Passed away 09.19.25 R4 and R5: Residents were reassessed for appropriateness and need Discontinuation of bed rail as appropriate Clear criteria for initiating, continuing, and discontinuing bed rail use in place Identification of responsible staff for monitoring and evaluating bed rail use Observed bed rail usage corrected to align with updated care plans. 2. Identification of Other Residents Potentially Affected: DON/designee conducted a review of all residents using bed rails or bed enablers.	11/21/2025

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F0657 SS = D	Continued from page 11 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and review of clinical record, it was determined that for three (R1, R4 and R5) out of seven residents reviewed for bed rails, the facility failed to review and revise each resident's bed rail care plan to ensure they were person-centered to meet their medical needs and included, but were not limited to, ongoing assessment and monitoring of the bed rail usage. Findings include: 1. Review of R1's clinical record revealed: 3/7/23 – R1 was care planned for "left bed enabler for assistance to change position while in bed." Interventions included: -"Document that the enabler is being used to help assist resident to change position in bed; -Ensure a valid consent is on chart prior to initiating enabler; and -Obtain order for enabler." R1's bed rail care plan lacked evidence of the monitoring and supervision to be provided during the use of the bed rail; ongoing assessment to make sure that the bed rail was used to meet the resident's needs; ongoing evaluation of risks; identification of the person who will determined when the bed rail will be discontinued, and the identification and interventions to address any adverse effects of the bed rail use. 10/23/25 approximately 3:00 PM – During an interview, finding was reviewed with E2 (DON). 2. Review of R4's clinical record revealed: 5/17/24 – R4 was care planned for "right side rail enabler to assist with changing position while in bed." Interventions were: -"anticipate and meet the resident's needs;	F0657	Continued from page 11 Side Rail Assessment completed to ensure each side rail/enabler order was appropriate. Each resident with an order or resident who was deemed appropriate for a side rail/enabler was informed of the risks and benefits of the device. POA on record was notified verbally of the risk and benefits of the device. Care plans for all residents using bed rails were audited to ensure they included: Person-centered approach and need Ensure a valid consent is in the chart prior to initiating rail/enabler Any deficiencies found were corrected immediately. 3. Systemic Changes to Prevent Recurrence: The root cause of the deficient practice was the failure in the facility's assessment, documentation, and care-planning processes related to bed rail/enabler use, which resulted in incomplete, non–person-centered care plans for R1, R4, and R5. The contributing factors include: 1. Inadequate Person-Centered Care Planning Care plans for residents using bed rails lacked required elements because staff relied on generic interventions rather than individualized assessments. 2. Insufficient Staff Training on Bed Rail Risk, Monitoring, and Documentation Nursing staff lacked full competency in: Person-centered care planning requirements Identifying and communicating risks related to bed rail/enabler use	

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F0657 SS = D	Continued from page 12 -document the rail is being used to help assist the resident in changing position; -ensure a valid consent is in the chart prior to initiating rail; -obtain order for rail enabler; and -PT referral as ordered by MD." R4's bed rail care plan lacked evidence of the monitoring and supervision to be provided during the use of the bed rail; ongoing assessment to make sure that the bed rail was used to meet the resident's needs; ongoing evaluation of risks; identification of the person who will determined when the bed rail will be discontinued, and the identification and interventions to address any adverse effects of the bed rail use. 10/23/25 approximately 3:00 PM – During an interview, finding was reviewed with E2 (DON). 3. Review of R5's clinical record revealed: 7/3/24 (last revised) – R5 was care planned for "... right sided bed enabler for assistance to change position while in bed." Interventions were: -"anticipate and meet the resident's needs; -document the rail is being used to help assist the resident in changing position while in bed; and -ensure a valid consent is in the chart prior to initiating rail." R5's bed rail care plan lacked evidence of the monitoring and supervision to be provided during the use of the bed rail; ongoing assessment to make sure that the bed rail was used to meet the resident's needs; ongoing evaluation of risks; identification of the person who will determined when the bed rail will be discontinued, and the identification and interventions to address any adverse effects of the bed rail use.	F0657	Continued from page 12 Monitoring changes in mobility or cognition that affect bed rail safety Documenting resident/POA consent and risk-benefit discussions Updated Consent Form: A new consent form was initiated for each resident, which clearly explains the risks and benefits of using bed rails or enablers. All residents with a current bed rail/enabler order have an updated consent in their chart. Staff Education: All nursing staff trained on updated bed rail policies and care plan requirements. Education includes: Person-centered care planning appropriateness and need Monitoring and supervision of bed rail use Change in Mobility Notification Risk assessment and documentation PT/OT will continue with quarterly assessment and relay findings to the Director of Nursing. New hires receive training during orientation.	

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F0657 SS = D	Continued from page 13 10/23/25 7:20 AM and 11:38 AM – Despite R5's care plan for a right sided bed enabler, observations of R5 in bed revealed that bilateral bed rails in the up position were still being used. 10/23/25 approximately 3:00 PM – During an interview, finding was reviewed with E2 (DON). 10/24/25 2:30 PM – Findings were reviewed during the exit conference with E1 (NHA) and E2.	F0657	Continued from page 13 Policy and Procedure Updates: Revised policy: "Bed Enabler" now includes: Requirement to explain risks and benefits of bed rails or enablers to the resident and/or POA before implementation. Documentation of verbal discussion and written consent in the resident's chart prior to initiating bed rail use. F657 Root Cause The root cause of the deficient practice was the failure in the facility's assessment, documentation, and care-planning processes related to bed rail/enabler use, which resulted in incomplete, non–person-centered care plans for R1, R4, and R5. The contributing factors include: 1. Inadequate Person-Centered Care Planning Care plans for residents using bed rails lacked required elements because staff relied on generic interventions rather than individualized assessments. 2. Insufficient Staff Training on Bed Rail Risk, Monitoring, and Documentation Nursing staff lacked full competency in: Person-centered care planning requirements Identifying and communicating risks related to bed rail/enabler use Monitoring changes in mobility or cognition that affect bed rail safety Documenting resident/POA consent and risk-benefit discussions 4. Monitoring and Quality Assurance:	

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F0657 SS = D		F0657	Continued from page 14 DON/designee will audit all residents with bed rails or enablers weekly for four weeks to ensure 100% compliance, then monthly for two months to ensure 100% compliance verifying: Care plans are person-centered and individualized Documentation of verbal discussion and written consent is completed. Side Rail Assessments are completed timely and accurately Audit results reviewed at QAPI Committee meetings for three consecutive months. Corrective action implemented immediately for any deficiencies identified.	
F0689 SS = G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of clinical record and facility documentation, it was determined that for two (R1 and R2) out of three residents reviewed for accidents, the facility failed to ensure each resident received adequate supervision to remain free of accident hazards. For R1, the facility failed to identify that R1's left bed rail was a potential hazard. R1, a dependent resident with dementia, was identified with a change of condition on 7/18/25 and diagnosed with a left upper extremity fracture. The facility's investigation documented that R1 sustained	F0689	1. Immediate Corrective Actions for Affected Residents: R1: The cause of the injury was identified as accidental contact with the bed enabler. The bed enabler was immediately padded to protect the resident from further injury. Side Rail Assessment completed on 07.22.25 by Physical Therapist. Assessment note is a follows: patient had a L side enabler, discharging said L enabler d/t patient recently has a L proximal humeral fracture and LUE in sling, and unable to utilize bed rail on L to reposition self in bed d/t LUE constraints,cognition and being total assist. Left rail removed on the same date: 07.22.25 by the Maintenance Director.	11/21/2025

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F0689 SS = G	Continued from page 15 the injury as an accidental contact with the bed enabler during care. As a result, R1 was harmed. R2, a severely cognitively impaired resident and dependent resident sustained a scalp laceration, and a subtle sacral fracture from a fall when she was left in the bathroom unsupervised. Findings include: An undated facility document entitled, "Falls" included, "... The nurse and charge nurse are to be notified immediately, and the resident is not to be moved until assessed by a nurse unless otherwise directed." 2/28/22 - R2 was admitted to facility with diagnoses including but not limited to dementia, left eye absolute glaucoma (permanent vision loss), and difficulty walking. 3/2/22 – R2's fall care plan (revised 7/18/24) included, "...At high risk for falls r/t [related to] gait/balance problems/ambulatory dysfunction." The interventions included, "Anticipate and meet [R2's] needs." 1/16/24 – R2's fall care plan documented, "Resident with poor safety awareness and impulse control." A review of R2's clinical record revealed the following history of falls: 2/24/25 – R2 sustained a fall in her room next to the bed. 3/12/25 – R2 sustained an unwitnessed fall in the lounge. 4/26/25 – R2 was found sitting on the floor of her room. 4/30/25 – R2 was found sitting on the floor next to her bed. 5/16/25 – R2 was found sitting on the floor next to her bed. 6/2/25 – R2 fell while walking unassisted out of the dining room. 6/14/25 – R2's quarterly fall assessment document a score of 80, indicating a high fall risk. R2's fall care plan lacked evidence of a person-centered care plan and interventions for the high fall risk.	F0689	Continued from page 15 Resident's Care Plan was updated accordingly on 07.22.25 R1 later passed away on 09/19/25. While R1 is no longer in the facility, the above actions demonstrate the facility's immediate response to the hazard and corrective measures to prevent recurrence. R2 Following the unwitnessed fall and identification of a head injury, R2 was assessed by nursing staff and sent to the Emergency Department (ED) for evaluation. R2 returned to the facility with diagnoses of a scalp laceration and subtle nondisplaced sacral fracture. The care plan was immediately updated to reflect R2's need for 1:1 supervision during toileting and transfers, and the requirement that the resident is not to be left unattended in the bathroom. Staff directly involved were re-educated on fall prevention, supervision requirements, and immediate post-fall response protocols. 2. Identification of Other Residents Potentially Affected: See Attachment: Bed Enablers Assessments completed between 10.21.25-10.24.25 by Physical Therapist DON/designee conducted a review of: Residents who use bed rails or bed enablers Residents who require staff assistance for toileting or transfers	

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F0689 SS = G	Continued from page 16 8/3/25 – R2's quarterly MDS assessment documented a BIMS score of 00, indicating the inability to complete a cognitive assessment. This assessment also documented that R2 required minimum assistance with eating and was completely dependent on staff for all other activities of daily living. 8/30/25 2:41 PM – R2's clinical record documented, "…S/P [status post] fall hit head, has a superficial laceration to the back of the right side of head that is 0.5cm…" 8/30/25 7:40 PM – A facility reported incident submitted to the Division documented, "Resident found on the floor in the bathroom of the third-floor day room…." 8/30/25 7:47 PM – E8 (LPN) documented in R2's clinical record, "At approximately 1400 [2:00 PM], staff reported an unwitnessed fall in the dining room immediately after lunch. Resident was noted on the floor in a seated/side-lying position with active bleeding from the head. This nurse arrived at 1402 [2:02 PM], activated post-fall protocol, and assessed the resident in place. Linear laceration to scalp… approximately 0.5 cm length, bleeding scant…" 8/30/25 4:50 PM – R2's clinical record documented, "On-call doctor called back, and new order received. Send to ER for evaluation…The resident was sent to the ER [emergency room.]" The facility failed to implement appropriate emergency interventions in a timely manner for R2's unwitnessed fall with obvious head injury. R2 fell at approximately 2:00 PM and was sent to the emergency room at 4:50 PM, 2 hours, 50 minutes later. 8/31/25 1:15 AM – R2 returned from the hospital with a diagnosis of a head laceration and a subtle non-displaced vertical fracture to the right of the sacrum. 10/21/25 1:30 PM – A review of the facility's post-fall investigative record revealed, "During the multidisciplinary care conference for [R2] on 9/11/25, it was brought to the attention of staff that the fall occurred in the bathroom after the resident was left unattended by the CNA [E7.] The CNA misrepresented the location and details of the incident." The facility's new investigation revealed that R1 was left unattended in the bathroom while the CNA went down the hall to obtain an incontinent brief. When she returned, R2 had	F0689	Continued from page 16 Residents with dementia or cognitive impairment Residents with a history of falls or are high fall risk Care plans were audited to ensure: Potential environmental hazards are identified Supervision requirements are clearly documented and communicated to staff ADLs and transfers are adequately monitored Any deficiencies found were corrected immediately, and staff were re-educated as needed. 3. Systemic Changes to Prevent Recurrence .A facility-wide audit of all residents utilizing bed rails or enablers was completed to ensure they are appropriate, safe, and properly care planned. A new consent form was implemented explaining the risks and benefits of enablers/bed rails, and signed consents were obtained for all applicable residents or their POAs. All residents with high fall risk or requiring staff assistance were reassessed to ensure supervision needs and safety interventions are clearly defined in the care plan, Kardex, and updated on the resident's status sheet. RN: Beth Carroll - Received a Written Disciplinary Action CNA - Monica Thompson (Terminated 09.15.25) The remaining nursing staff received the required	

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F0689 SS = G	Continued from page 17 fallen to the floor. E7 put R2 into the wheelchair and told the supervisor that [R2] had fallen in the dining room. The facility failed to thoroughly investigate the location of the fall until 12 days after the event. 10/21/25 12:30 PM – During an interview, the Surveyor asked E8 (LPN) if she had seen or assessed R2 post fall, E8 stated, "No, I was on break, and I did not see her on the floor after the fall. The RN supervisor [E5] told me that she had fallen." 10/21/25 1:00 PM – During an interview, the Surveyor asked E5 (RN supervisor) how she was she became aware that R2 had sustained a fall. E5 stated, "The aide [E7] came to the second floor and told me that the resident had fallen. I went up to the third floor and saw [R2] sitting in the wheelchair in the common area." The Surveyor asked E5 about emergency intentions for R2's obvious head injury, E5 stated, "I started neuro checks and waited for the on-call doctor to call back." The facility failed to have R2 assessed by a registered nurse after the unwitnessed fall prior to getting back into the wheelchair 10/21/25 2:00 PM – During an interview E3 (ADON) stated, "All of the aides know that any resident who is an assist of one with transfers should not be left alone in the bathroom. It's documented on the care plan and on the resident's care sheet in the closet." The Surveyor asked E3 if the aides had access to the residents' care plans in the electronic records, E3 stated, "No, but they can ask the nurse." A review of R2's care plan and care sheet lacked evidence of documentation for staff to remain the bathroom with her to prevent falls. The facility failed to ensure that R2 had adequate supervisor to prevent falls with injuries despite the extensive history of falls. 10/24/25 12:00 PM - Findings were confirmed with E2 (DON). 10/24/25 2:30 PM – Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON). 1. Cross refer to F580, F657 example 1, F700 example 1, and F776	F0689	Continued from page 17 education, which was initiated on 10/21/25. Any nursing staff member who has not yet completed the mandatory education will complete the training prior to their next scheduled shift to ensure competency and ongoing compliance with facility policy and regulatory requirements. Education titled: Staff Education: Safe and Appropriate Use of Side Rails / Bed Enablers, includes the following: When Side Rails/Enablers May Be Used Safety Risks and Hazards Increased Injury Potential Functional Decline Risk Risk vs. Benefit Review Staff Responsibilities Nursing Staff, including RNs/LPNs/CNA's, received education and competency validation on: Fall prevention strategies and environmental safety Immediate post-fall assessment and physician notification Accurate and timely documentation of incidents and investigations The requirement never to leave dependent residents unattended in the bathroom All education completed by Tiffany Hodgdon, RN, DON and or Kyra Sedgwick, RN, ADON. F689 Root Cause 1. Inadequate Assessment and Identification of Environmental Hazards (R1)	

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F0689 SS = G	Continued from page 18 Review of R1's clinical record revealed: 3/7/23 – R1 was care planned for "left bed enabler for assistance to change position while in bed." Interventions included: -"Document that the enabler is being used to help assist resident to change position in bed; -Ensure a valid consent is on chart prior to initiating enabler; and -Obtain order for enabler." 10/26/23 – A physician's order stated, "TRANSFER STATUS: resident is a Hoyer lift with 2 staff assist with transfers BED MOBILITY: resident is a 1 assist with bed mobility." 7/3/24 – A physician's order stated, "May use a left sided bed enabler to assist with turn and repositioning." 5/1/25 3:19 PM – R1's side rail assessment documented by C1 (contracted PT): 1. Has Resident expressed a desire to have side rails raised while in bed for their own safety and/or comfort? "Yes… rolling and positioning." 2. Does the resident have fluctuations in levels of consciousness or a cognitive deficit? "Yes… dementia." 3. Does the resident have any visual deficits? "Yes… glaucoma, legally blind." 4. Is the resident able to get in/out of bed safely? "Yes."… 7. Is the resident having problems with balance or poor trunk control? "Yes… enabler for sitting balance." 8. Does the resident use the side rails for positioning or support? "Yes" 9. Does the side rail help the resident rise from a supine position to a sitting/standing position? "Yes"… 14. Is there a risk to the resident if side rails are used? "No"	F0689	Continued from page 18 The facility did not have a reliable process to ensure routine evaluation of bed rails/enablers for safety and appropriateness. Specific failures included: The bed enabler was not reassessed after R1 experienced functional decline and became more dependent with dementia. The care plan did not identify the bed enabler as a potential hazard, even though R1's condition required increased supervision and environmental risk mitigation. 2. Failure to Provide Adequate Supervision During High-Risk Care Activities (R2) Staff did not follow accepted standards and facility expectations for supervision of dependent, cognitively impaired residents during toileting. Contributing issues: The CNA left R2 unattended in the bathroom, despite the resident's severe cognitive impairment and dependence for mobility. The care plan did not clearly specify the level of supervision required, resulting in inconsistent staff understanding of expectations. 3. Insufficient Staff Training and Accountability Across both incidents, the facility identified gaps in: Staff understanding of environmental safety risks associated with bed enablers. Supervision requirements for dependent, high-risk residents. Accurate, timely, and factual documentation of incidents.	

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F0689 SS = G	Continued from page 19 16. Is the resident alert and oriented? "Yes" 17. Is the resident currently using a side rail for positioning or support? "Yes" 18. Would a side rail improve independence for transfers in/out of bed? "Yes" 18b. Side Rail Type and Location: "Left side enabler".... 5/17/25 – The quarterly MDS assessment documented that R1's vision was severely impaired; BIMS score of 3/15 (cognitively impaired); functional limitation in range of motion revealed no impairments of upper and lower extremities; was dependent for toileting hygiene/upper body dressing/roll left and right/sit to lying/lying to sitting on side of bed/chair to bed transfer/shower transfer; always incontinent of bowel and bladder; no pain presence in the last 5 days; and used bed rail daily. This assessment documented that only the resident participated in the assessment process, and not R1's POA. 7/16/25 11:00 AM – R1's Multidisciplinary Care Conference form documented that R1 was alert and oriented x1, able to communicate her needs, incontinent of bowel and bladder, dependent on staff for all ADLs (activities of daily living), required Hoyer lift for transfers, wheelchair bound, legally blind, and complaining of pain often… and to schedule Tylenol for pain management. R1's POA attended by phone on 7/17/25. 7/17/25 – A physician's order was entered to administer Tylenol two times a day for pain. R1 received her first dose at 8 PM on 7/17/25. 7/17/25 and 7/18/25 – The CNA Documentation Survey Report revealed that R1 was dependent for rolling left and right, incontinent of bowel and bladder and turned and repositioned every two hours. 7/18/25 1:29 AM – A nursing note documented that R1 had no complaint of "bodily (sic) pain at present…". 7/18/25 12:48 PM – A nursing note documented, "Resident noted with increased pain in L [left] elbow and decreased range of motion to LUE [left upper	F0689	Continued from page 19 4. Monitoring and Quality Assurance The DON or designee will perform weekly audits for 4 weeks to ensure 100% compliance then monthly for 3 months to ensure 100% compliance, of: Residents using bed rails or enablers (checking for safety, care plan inclusion, and consent) Fall incident reports for timely intervention, physician notification, and post-fall investigation accuracy Audit findings will be reviewed during monthly QAPI meetings to identify trends and ensure sustained compliance.	

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F0689 SS = G	Continued from page 20 extremity]. No obvious swelling or deformity noted at this time. NP [Nurse Practitioner] & [and] POA made aware. X-ray of L elbow ordered." 7/18/25 – A physician's order stated, "Elbow X-ray: Including the humerus, radius, and ulna, for fractures, dislocations, or deformities R/T [related to] increased pain and decreased movement. STAT for Increased pain and decreased movement of LEFT arm." 7/18/25 5:49 PM – A nursing note documented, "X-ray of left arm completed. Awaiting results to come back." The following nursing notes revealed: 7/19/25 3:32 AM - "No complaints of pain this shift. Still waiting for xray (sic) results of left arm." 7/19/25 10:05 AM - "LATE ENTRY. This RN called [name of x-ray company] at 1000 [10 AM], and was told that the X-ray results still pending. They stated that they are running late, once they get the results, and they'll fax the results to the facility. Family made aware." 7/19/25 3:48 PM - PRN Tylenol administered for pain level of 10/10…. 7/19/25 8:57 PM - "Resident still continues with pain to L arm, slightly swollen. Pain relieved with Tylenol, given around 1545 [3:45 PM] and 2045 [8:45 PM]. Xray results still pending as of this time." 7/20/25 1:34 AM - "… Xray of left arm results still pending." 7/20/25 9:45 AM - "The nurse called [name of x-ray company] at 0945 [9:45 AM], and they stated that the X-ray result is not available yet. They will let us know in 2 to 3 hours." 7/20/25 4:22 PM - "This RN got a phone call from [name of x-ray company] at 1610 [4:10 PM], and was told that the X-ray results are still not available. They stated that they hoped to get the result by 9 PM today." 7/20/25 6:40 PM – A nursing note documented, "The resident's [name of POA] came in to see the resident this afternoon… was very upset to know the X-ray results still pending… was so concerned… asked to send the resident to ER to get the X-ray. MD made aware. New	F0689		

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F0689 SS = G	Continued from page 21 MD order received at 1650 [4:50 PM]. Send to ER for evaluation and treatment for left elbow pain and decreased range of motion to LUE [left upper extremity]. The resident was sent to ER by ambulance at 1710 [5:10 PM]...". 7/20/25 8:20 PM – While R1 was in the ER, the mobile x-ray results were faxed to the facility and documented "acute nondisplaced fracture of the left humeral neck" and "no acute abnormality at the elbow." According to the facility's investigation, when the ER called to report that R1 was going to return and there was no elbow fracture, the facility informed the ER about the fracture identified in the mobile x-ray results. The ER cancelled R1's transfer back to the facility and conducted further x-rays, which revealed a fracture. 7/21/25 12:20 AM – The ER's x-ray of R1's left humerus revealed that there was an "impacted fracture of the surgical neck of the humerus." 7/25/25 – The facility's five-day follow-up to the State Agency documented that "...based on the review of staff statements, timing, and the location/pattern of the injury, it is feasible that the resident sustained the injury as an accidental contact with the bed enabler during care...". 10/22/25 12:58 PM – During an interview, E9 (LPN) stated that staff have to move/roll the resident in bed. E9 stated that R1 would always have her left elbow bent and would rest her left hand on her stomach. E9 stated that R1 would ask for Tylenol for knee pain or body aches and never complained about her left arm before the fracture. E9 confirmed that R1 was unable to get out of bed independently. 10/22/25 3:30 PM – During an interview, E10 (CNA) stated that she was assigned to provide care for R1 on 7/18/25 day shift. E10 stated that when she touched R1's left arm, the resident screamed and told her that it hurts. E10 stated that she immediately knew something was wrong as this was an unusual response of R1. E10 stated that she immediately reported this complaint of pain to the assigned nurse.	F0689		

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F0689 SS = G	Continued from page 22 10/24/25 11:00 AM – During an interview, E11 (CNA) stated that R1 could not turn in bed. E11 stated that R1 always kept her hands together and left elbow bent. The facility failed to identify R1's right sided bed rail as a potential accident hazard. 10/24/25 2:30 PM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0689		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and review of clinical records and facility documentation, it was determined that for three (R1, R4 and R5) out of seven residents reviewed for bed rails, the facility failed to ensure that each residents' bed rail was used appropriately with ongoing monitoring. Additionally, the facility lacked evidence that preventive maintenance/safety checks were being done for bed rails being used in the	F0700	1. Corrective Action Taken for Residents Affected R1 (Deceased September 2025) R1's bed enabler had been removed prior to death, 07.22.25 by The Maintenance Director Chart reviewed for completeness and accuracy. No further resident-specific actions required. R4 Right bed enabler immediately discontinued after survey findings on 10.23.25 - Right Side Enabler Removed by Maintenance Director Provider notified; new orders received. Updated care plan to reflect resident's actual functional status and removal of bed rail. PT performed a new bed mobility/bed safety assessment. R5 Bilateral bed rails lowered immediately; left rail removed, leaving only the ordered right bed enabler on 10.23.25 by Maintenance Director	11/21/2025

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F0700 SS = D	Continued from page 23 facility. Findings include: The facility's policy and procedure entitled Bed Enabler, last updated 10/28/23, stated, "Objective: 1. To assist with bed mobility. 2. To assist with transfer from bed to chair. Procedure: 1. Physical therapy will determine the potential benefit of bed enabler use for bed mobility and/or transfers. 2. Obtain an order for bed enablers from the physician. 3. Obtain informed consent from the resident and/or resident representative. 4. The Maintenance Department will be asked to install a bed enabler on the side/sides of the bed as specified by the physician order in Point Click Care. 5. Update the care plan. 6. The resident will be reassessed at least every six months for continued bed enabler use by physical therapy. 7. If the bed enabler is discontinued, the bed enabler will be removed from the bed, cleaned with disinfectant, dry thoroughly and placed in a designated storage area by the Maintenance department." 1. Cross refer to F689, example 1 Review of R1's clinical record revealed: 3/7/23 – R1 was care planned for "left bed enabler for assistance to change position while in bed." Interventions included: -"Document that the enabler is being used to help assist resident to change position in bed; -Ensure a valid consent is on chart prior to initiating enabler; and -Obtain order for enabler." 7/3/24 – A physician's order stated, "May use a left sided bed enabler to assist with turn and repositioning."	F0700	Continued from page 23 Provider notified; orders updated. Care plan corrected to reflect appropriate use of bed enabler and required two-person assistance for turning. PT reassessed resident for safe use of bed enabler. 2. Identification of Other Residents The DON and PT Department completed a house-wide audit of all residents using bed enablers or any type of bed rail. Audit included: Verification of physician order Informed consent PT bed rail assessment Care plan accuracy Verification that rail is used as ordered Functionality and safety checks Appropriateness based on current mobility needs Any discrepancies were corrected immediately; providers were notified as needed. No additional residents were identified with issues comparable to the cited findings. The timing of a resident's bed rail assessment prior to initiation of bed rails.	

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F0700 SS = D	Continued from page 24 5/1/25 3:19 PM – R1's side rail assessment documented by C1 (contracted PT): 1. Has Resident expressed a desire to have side rails raised while in bed for their own safety and/or comfort? "Yes… rolling and positioning." 2. Does the resident have fluctuations in levels of consciousness or a cognitive deficit? "Yes… dementia." 3. Does the resident have any visual deficits? "Yes… glaucoma, legally blind." 4. Is the resident able to get in/out of bed safely? "Yes."… 7. Is the resident having problems with balance or poor trunk control? "Yes… enabler for sitting balance." 8. Does the resident use the side rails for positioning or support? "Yes" 9. Does the side rail help the resident rise from a supine position to a sitting/standing position? "Yes"… 14. Is there a risk to the resident if side rails are used? "No" 16. Is the resident alert and oriented? "Yes" 17. Is the resident currently using a side rail for positioning or support? "Yes" 18. Would a side rail improve independence for transfers in/out of bed? "Yes" 18b. Side Rail Type and Location: "Left side enabler"…. Despite the 5/1/25 Side Rail Assessment, R1's 5/17/25 quarterly MDS assessment documented that R1 was dependent for toileting hygiene/rolling left and right/sitting to lying/lying to sitting on side bed/chair to bed transfers. 7/16/25 11:00 AM – The Multidisciplinary Care Conference form documented that R1 was dependent on staff for all ADLs and required a Hoyer lift for transfers. There was no evidence that R1's bed rail was reviewed to ensure it was still appropriate for the resident.	F0700	Continued from page 24 Physical Therapy will assess the resident to determine whether a bed enabler is clinically appropriate to promote independence with bed mobility and/or transfers. A physician order for bed enabler use must be obtained prior to installation. The resident and/or resident representative must be provided with a clear explanation of the risks, benefits, and purpose of the bed enabler. Written informed consent must be obtained before implementation. Documentation of the risk/benefit discussion and confirmation of informed consent must be completed in PointClickCare prior to initiating bed enabler use. A copy of the signed consent form will be placed in the resident's chart. The Maintenance Department will install the bed enabler on the side(s) of the bed as specified in the physician order. Update the resident's care plan to reflect bed enabler use, supervision needs, and identification of potential environmental hazards. The resident's ability to safely utilize the bed enabler will be reassessed by physical therapy at least every six months or sooner if a change in condition, functional improvement, or decline occurs. If a resident is no longer able to safely or effectively use the bed enabler, it must be discontinued, and the physician notified as needed. The care plan and documentation will be updated to reflect the change. 3. Systemic Changes to Prevent Recurrence	

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F0700 SS = D	Continued from page 25 2. Review of R4's clinical record revealed: 8/19/24 – A physician's order stated, "May use right side bed enabler to assist with turn and repositioning." 8/23/24 – A physician's order stated, "… Bed Mobility: resident is an assist of 1 with bed mobility." 9/21/25 – The quarterly MDS assessment documented that R4 had a BIMS of 15/15 (cognitively intact); was dependent for toileting hygiene/upper body dressing/roll left and right/sit to lying/lying to sitting on side of the bed/sit to stand/chair to bed transfer/shower transfer; and daily use of bed rail. Review of the October 1-21, 2025 CNA Documentation Survey Report revealed that for 56 out 63 shifts, staff documented that R4 was dependent for rolling left and right in bed. 10/23/25 1:15 PM – An observation during care revealed that R4 had a right sided bed rail in the up position. E10 (CNA) was observed removing the therapy carrot device from R4's left contracted hand. During incontinent care, R4 required two staff assist for rolling left and right in bed. R4 was observed and the resident stated that he was not able to grab the right bed rail with his left contracted hand to roll in bed. Immediately after the observation, E10 confirmed that R4 required staff assistance for turning in bed. 3. Review of R5's clinical record revealed: 7/3/24 – A physician's order stated, "May use right side bed enabler to assist with turn and repositioning." 10/23/25 7:20 AM – Despite having a physician's order for only one bed rail, an observation of R5 in bed revealed bilateral bed rails in the up position and head of bed elevated approximately 30 degrees. R5 was sleeping with the right elbow bent and laying on top of the right sided bed rail and right hand under his head.	F0700	Continued from page 25 The root cause of the deficient practice was a facility-wide failure in the assessment, monitoring, and oversight systems governing the safe use of bed rails and bed enablers, which resulted in inappropriate and unsafe use for R1, R4, and R5. 1. Insufficient Staff Training on Bed Rail Risk, Monitoring, and Documentation Nursing staff lacked full competency in: Person-centered care planning requirements Identifying and communicating risks related to bed rail/enabler use Monitoring changes in mobility or cognition that affect bed rail safety 2. Absence of a Preventive Maintenance and Safety Check System The facility did not have an implemented or enforced process to ensure routine safety checks or maintenance inspections were conducted on bed rails. 3. Inadequate Oversight and Monitoring Systems The facility did not have a structured audit or monitoring system to ensure: Consent and risk-benefit discussions were documented Rails were clinically appropriate Preventive maintenance was performed monthly Policy Review and Revision The "Bed Enabler" policy (10/28/23) was reviewed and updated to include: Required PT reassessment every 6 months or with any	

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F0700 SS = D	Continued from page 26 The left hand was in a fist and laying on his chest. 10/23/25 11:05 AM – During an interview, E12 (ES) confirmed that the facility did not have evidence of preventive maintenance/safety checks of the bed rails that are currently being used in the facility. E12 provided the manufacturer's guidelines for the bed rails being used. 10/23/25 11:38 AM – An observation during incontinent care revealed that R5 had bilateral bed rails in the up position. R5 was observed in bed with the right elbow bent and laying on top of the right-sided bed rail. During incontinent care, R5 required two staff assist. R5 was observed grabbing and holding onto the left bed rail with his right hand during incontinent care. However, R5 was not able to use the right sided bed rail for turning during care with his left hand and required two staff assist for turning and repositioning. The facility failed to ensure each residents' bed rail(s) were used appropriately with ongoing monitoring. In addition, the facility lacked evidence that preventive maintenance/safety checks were being completed of all bed rails being used in the facility. 10/24/25 2:30 PM – Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).	F0700	Continued from page 26 decline/improvement. Prohibition of using rails for residents who cannot safely utilize them. Clear documentation requirements in PointClickCare for use, risk assessment, and consent. Preventive Maintenance Program Implemented Maintenance developed and implemented a monthly Bed Rail Safety & Functionality Checklist, including: Hardware stability Proper fitting Absence of entrapment zones Correct model per manufacturer guidelines Logs will be maintained and reviewed by NHA or designee. Staff Re-Education (See Attached 700 Enabler Education) All nursing, therapy, and maintenance staff were re-educated on: Proper and safe use of bed enablers Requirement for reassessment when resident mobility changes Obtaining and maintaining physician orders & consents Documentation of rail usage in care plans Safety and monitoring requirements	

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F0700 SS = D		F0700	Continued from page 27 Prohibition of using rails not ordered or safe for the resident Required maintenance checks Attendance logs retained. 4. Monitoring and Quality Assurance The DON or designee will perform weekly audits for 4 weeks until 100% compliance is achieved, then monthly for 3 months until 100% compliance is achieved to ensure: Residents using bed rails or enablers (checking for safety, care plan inclusion, and consent) ' Physician order present ' Consent on file ' PT bed enabler assessment current ' Care plan accuracy ' Proper installation ' Rail being used ONLY as ordered ' Maintenance safety check completed ' Resident function matches rail justification Audit findings will be reviewed during monthly QAPI meetings to identify trends and ensure sustained compliance. Cross-referenced monitoring under F689 Accident Hazards is incorporated into this process.	
F0776 SS = D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii)	F0776	1. Immediate Corrective Action for the Affected Resident	11/21/2025

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F0776 SS = D	Continued from page 28 §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is NOT MET as evidenced by: Based on interview and review of clinical records and facility documentation, it was determined that for one (R1) out of three residents reviewed for accidents, the facility failed to meet the acute medical needs of R1 with regard to obtaining the timeliness of STAT x-ray results on 7/18/25. Findings include: Review of R1's clinical record revealed: 7/18/25 – A physician's order stated, "Elbow X-ray: Including the humerus, radius, and ulna, for fractures, dislocations, or deformities R/T [related to] increased pain and decreased movement. STAT for Increased pain and decreased movement of LEFT arm." 7/20/25 8:20 PM – Approximately 48 hours later, R1's mobile x-ray results were faxed to the facility and documented an "acute nondisplaced fracture of the left humeral neck." 10/23/25 12:18 PM – During an interview, C2 (Representative with X-ray company) stated that STAT x-ray results are usually completed in two hours on the same day ordered. C2 confirmed that on the weekend of 7/18/25 through 7/20/25, the company had limited staff coverage for reading x-rays. C2 stated that the x-ray company notified the facility on 7/20/25 at 2:28 PM that the next available reading would be on 7/20/25 approximately 8:30 PM. 10/24/25 2:30 PM – Finding was reviewed during the exit	F0776	Continued from page 28 The resident was evaluated in the ED and diagnosed with a left humeral neck fracture The resident returned to the facility with updated treatment orders, which were implemented promptly (pain management, activity modification, and monitoring for pain. R1 passed away in September 2025. A retrospective review of all documentation relating to the delayed STAT x-ray was completed. The review identified areas where follow-up on STAT imaging results did not meet facility expectations. 2. Identification of Other Residents Potentially at Risk The facility conducted a 30-day review of all STAT diagnostic orders (x-rays, labs, imaging). The review confirmed whether: STAT orders were communicated correctly, Follow-up occurred timely, No additional residents were identified as being adversely affected. 3. Systemic Changes Implemented to Prevent Recurrence The facility will no longer order STAT x-rays or STAT imaging studies. All residents requiring urgent or emergent evaluation will be sent immediately to the Emergency Department (ED) for assessment and management.	

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F0776 SS = D	Continued from page 29 conference with E1 (NHA) and E2 (DON).	F0776	Continued from page 29 Staff Education: Licensed nursing staff were re-educated on the facility's "Timing of Clinical Results" policy Education will be added to new employee orientation. F776 Root Cause The root cause of the deficient practice was a breakdown in the facility's process for timely management of urgent diagnostic needs, specifically STAT x-rays, which prevented prompt physician evaluation and intervention. Contributing factors included: 1. Lack of a Standardized Process for STAT Diagnostics The facility previously did not have a clear protocol for situations when STAT diagnostic results were delayed. As a result: Nursing staff were unsure of the appropriate steps to notify the physician immediately when results were not available within expected timeframes. STAT x-rays were performed in-house without a defined monitoring or escalation procedure for delayed results. 2. Insufficient Oversight and Tracking Mechanisms There was no reliable system to: Track STAT diagnostic orders and ensure results are received and reviewed promptly. Escalate delays to the physician or supervisory staff. Ensure consistent documentation of communications and interventions. 4. Monitoring and Quality Assurance: The DON/designee will audit all residents sent to the ED for urgent concerns weekly for four weeks until 100% compliance is achieved, then monthly for two	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 08A020	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEWARK MANOR NURSING HOME	254 WEST MAIN STREET , NEWARK, Delaware, 19711

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F0776 SS = D		F0776	Continued from page 30 monthsuntil 100% compliance is achieved, to ensure compliance with the new procedure. Audits will include: Documentation of ED transfer for urgent care Timeliness of recognition and response to urgent medical needs Staff adherence to the updated protocol Findings will be reviewed by the Quality Assurance/Performance Improvement (QAPI) committee to ensure ongoing compliance.	