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: Milford Center **DATE SURVEY COMPLETED: September 23, 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 Annual, Complaint and Extended Survey was conducted at this facility from September 15, 2025, through September 23, 2025. The deficiencies contained in this report are based on observations, interviews, review of clinical records and other facility documentation as indicated. The facility census on the first day of the survey was eighty-eight (88). The investigative sample totaled thirty (30) residents. **Regulations for Skilled and Intermediate Care Nursing Facilities**		
3201	**Scope**		
3201.1.0 **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 September 23, 2025: F656, F677, F688, F690, F695, F791, F812, F842.	Cross Refer to Plan of Correction approved for the CMS 2567-L for survey ending on September 23, 2025 (and noting adjustment of time based on government shut-down) for F656, F677, F688, F690, F695, F791, F812, and F842	12-5-2025

Provider's Signature _____ Title NHA Date 12/5/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILFORD CENTER	700 MARVEL ROAD , MILFORD, Delaware, 19963

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000	Initial Comments In accordance with 42 CFR 483.73, an Emergency Preparedness survey was conducted by The Division of Health Care Quality, the Office of Long-Term Care Residents Protection at this facility from September 15, 2025 through September 23, 2025. Based on observations, interviews, and document review, no Emergency Preparedness deficiencies were identified.	E0000		12/05/2025
F0000	INITIAL COMMENTS An unannounced Annual, Complaint and Emergency Preparedness survey was conducted at this facility from September 15, 2025 through September 23, 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 eighty-eight (88). The survey sample size was thirty (30) residents. Due to the federal government shutdown, the posting date of this CMS-2567 differs from the survey exit date. This adjustment allows the facility the appropriate time to prepare and submit its Plan of Correction (PoC). The discrepancy between the exit date and posting date is administrative in nature and does not reflect any delay by the facility. Abbreviations/definitions used in this report are as follows: ADL- Activity of Daily Living; DON - Director of Nursing; LPN - Licensed Practical Nurse; NHA - Nursing Home Administrator; RCA - Regulatory Compliance Advisor; RN - Registered Nurse; RT - Respiratory Therapist;	F0000		12/05/2025

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 BiPAP – a machine that helps the patient breathe; Care Plan- outlines the plan of action that will be implemented during a patient's medical care; Chronic Obstructive Pulmonary Disease – (COPD) a chronic inflammatory lung disease that causes obstructed airflow from the lungs; Continence – control of bladder and bowel function; Frequently Incontinent – 7 or more episodes of urinary incontinence, but at least one episode of continent voiding during a 7 day look back period; Incentive spirometer - a handheld medical device used to help patients improve functioning of their lungs; Incontinence – loss of control of bladder &/or bowel function; Intelligent Volume Assured Pressure Support (iVAPS) - a type of machine that helps the patient to breathe; Minimum Data Set (MDS) – standardized assessment forms used in nursing homes; Nasal cannula- tube placed into nostrils to deliver oxygen; Occasional Incontinence- less than 7 episodes of urinary incontinence in 7 day look back period; Palm Protector/Guard - offer relief from curling fingers, hand contractures and cramping. The Palm Protector is put on over the thumb and around the hand, providing a cushioning pad for the fingers to curl onto, preventing the nails from digging into the palms; Pneumonia – lung inflammation caused by bacterial or viral infection; Respiratory failure- inability of the lungs to perform basic task of gas exchange; lack of oxygen and/or excess carbon dioxide (gas formed during breathing).	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a	F0656	Corrective Action of Areas Affected: The facility was unable to correct this deficit practice since R87 was discharged from the facility on 9/15/25. Other areas affected: An initial audit of current residents ordered oxygen and/or incentive spirometer	12/05/2025

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F0656 SS = D	Continued from page 2 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: Based on interview and record review, it was determined that for one (R87) out of thirty (30) residents reviewed in the investigative sample, the facility	F0656	Continued from page 2 was completed to ensure care plans were individualized as per the needs of the resident by 9/16/25 Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 10/1/25 to determine that education on OPS416: Person-Centered Care Plan policy for licensed nurses was needed. Additionally (though not relevant for R87, but for other Residents found during audit), a focus, specifically on individualizing refusal care plans and noting the reason for the refusal will be reviewed. Education provided from the Nurse Practice Educator will be completed for licensed nurses and certified nursing assistants by 11/30/25 including Nursing Leadership who are responsible for editing a care plan for oxygen and incentive spirometry are ordered. Education given as follows (A-C) Any resident who has a BIMs of less than 10 cannot have an intervention of educating the resident. We may educate the family members only if they will be participating in the resident's care. All care plans must reflect the individual needs of that resident. Goals and Interventions should be specific for that individual resident. If they are on O2, they MUST have an O2 care plan. Same for DM, CHF etc. This includes education on refusals of these interventions by the Resident. Interventions must be updated with any new orders as appropriate by Nursing Leadership. Monitoring of Corrective Action:The Director of Nursing and/or designee will conduct audits (attachment A) to ensure accuracy and completion of care plans for oxygen and/or incentive spirometer for 10% of the resident population charts. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0656 SS = D	Continued from page 3 failed to develop a care plan to address the administration of oxygen via nasal cannula and the use of an incentive spirometer. Findings include: A review of R87's clinical record revealed: 8/29/25 - R87 was admitted to the facility with diagnoses that included but not limited to, pneumonia and respiratory failure. 9/2/25 - A physician's order for R87 documented "oxygen at 6L/min via nasal cannula continuously." 9/3/25 - A physician's order for R87 documented "incentive spirometer - encourage patient to use as often as tolerated." 9/15/25 11:07 AM - An observation of R87's bedside table revealed an incentive spirometer. R87 stated that he is using the spirometer. 9/16/25 - 2:03 PM - A review of R87's care plan lacked evidence of a care plan addressing he administration of oxygen via nasal cannula and the use of an incentive spirometer. 9/16/25 2:25 PM - During an interview E2 (quality manager) confirmed there wasn't a care plan developed for oxygen administration via nasal cannula or the use of an incentive spirometer. 9/23/25 2:45 PM - Findings were reviewed with E1 (NHA), E2 (Quality Manager) and E3 (DON) during the exit conference.	F0656		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for one (R69) out of seven residents reviewed for ADLs, the facility failed to provide nail care for a dependent resident. Findings include: Review of R69's clinical record revealed: 6/30/21 – R69 was admitted to the facility. 6/11/25 - A care plan documented that R69 required assistance and was dependent for all ADLs. 6/16/25 – An annual MDS assessment for R69 documented that the resident was severely cognitively impaired and required "substantially maximal assistance" for personal hygiene.	F0677	Corrective Action of Areas Affected: The facility corrected this deficient practice and provided nail care for R69 on 9/17/25. Other areas affected: An initial audit for residents identified as needing dependent care, had their nails assessed to ensure care was provided by 10/6/25. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 10/1/25 to determine that education on NSG200: Activities of Daily Living (ADLs) policy for licensed nurses and certified nursing assistants was needed to review how to provide adequate nail care to dependent residents. Education provided from the Nurse Practice Educator will be completed for licensed nurses and certified nursing assistants by 11/30/25. Education given as Follows: A. All residents must have their nails assessed on every shift, before and after meals. B. If nails are jagged, broken or dirty, nail care must be performed.	12/05/2025

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F0677 SS = D	Continued from page 4 9/15/25 9:15 AM - An observation of R69 revealed dark debris underneath each fingernail on the right and left hand. R69's fingernails were long and needed to be trimmed. 9/16/25 9:30 AM - An observation of R69 revealed dark debris underneath each fingernail on the right and left hand. R60's fingernails were long and needed to be trimmed. 9/17/25 1:03 PM - An observation of R69 revealed dark debris underneath each fingernail on the right and left hand. R60's fingernails were long and needed to be trimmed. 9/17/25 1:02 PM – During an interview, E5 (CNA) stated that she will trim and clean the resident's nails are trimmed and cleaned on the days the resident receives her baths. 9/17/25 1:04 PM – During an interview, E6 (LPN) confirmed that the right hand and left hand had long fingernails with dark debris under the nails. 9/17/25 1:10 PM- During an interview, E2 (Quality Manager) confirmed that R69's right and left hands had long fingernails with dark debris underneath each fingernail. E2 stated she would take care of it. 9/23/25 2:45 PM – Findings were reviewed with E1 (NHA), E2 (Quality Manager) and E3 (DON) during the exit conference.	F0677	Continued from page 4 C. It is part of the CNA job duties to perform fingernail care on all of our residents. D. CNAs: If a resident refuses, determine the reason for refusal and reapproach. If they continue to refuse, ask for assistance from your peers, If still unable to perform, notify the nurse of the refusal. Always document refusals of care within POC E. Nursing: If a CNA reports refusal of nail care, attempt to assist the CNA with nail care and provide Pt education. If the resident continues to refuse, make sure that all attempts including education are documented, family notification documented and the care plan reflects refusal of care. Remember any resident with a BIMs less than 10 cannot be educated. We can however educate the family when notified of refusals. F. Unit Managers should be notified of any refusals of care. G. Remember if you see toenails that need care, please report to the nurse to place on the podiatry list. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment B) to ensure accuracy and completion of nail care 10% of the resident population identified as being dependent with ADLs. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	
F0688 SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F0688	Corrective Action of Areas Affected: R69 received treatment/services as evidenced by donning the left palm splint on 9/17/25. Other areas affected: An initial audit for residents ordered splints were reviewed to determine that task complimented the order and splints were applied appropriately by 10/6/25. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 10/1/25 to determine that education on the Procedure: Splint Application protocol for licensed nurses, certified nursing assistants and physical and occupational therapy was needed to review the proper application and	12/05/2025

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F0688 SS = D	Continued from page 5 §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review it was determined that for one (R69) out of seven residents reviewed for activities of daily living (ADLs), the facility failed to ensure that R69 received the treatment/services to prevent further decline in ROM. The facility lacked evidence that the palm device was applied to the left palm. Findings include: Review of R69's clinical record revealed: 6/30/25 – R69 was admitted to the facility. 5/7/25 10:15 AM - A physician's order documented that R69 was to have a left palm guard applied in the morning with AM care and removed with PM care. There was no stop date to this order. 6/11/25 - A care plan documented that R69 required assistance and was dependent for all ADLs. In addition, R69 had a care plan with a goal to maintain skin integrity and prevent contractures with interventions that include applying a palm guard at 10:00 AM to the left hand for up to 6 hours daily as tolerated after morning care. 6/16/25 - An annual MDS assessment for R69 documented that the resident was severely cognitively impaired and required "substantially maximal assistance." with all ADL's. 9/15/25 – On the following times, an observation of R69 was made without the left hand palm guard: 9:05 AM, 10:00 AM, 11:00 AM, 12:00 PM, 1:00 PM. 2:00 PM, and 3:00 PM. 9/16/25 - On the following times, an observation of R69 was made without the left hand palm guard: 10:00 AM, 11:00 AM, 12:00 PM, 1:00 PM, and 2:00 PM. 9/17/25 9:00 AM - An interview with E7 (CNA), confirmed she has never applied and has not seen the palm guard on the resident's left hand.	F0688	Continued from page 5 documentation of splints. Additionally, education provided that tasks are added to CNA point of care assignments and to check for application of splints and other devices. Education provided from the Nurse Practice Educator will be completed for licensed nurses and certified nursing assistants by 11/30/25. Education given as follows (A-B): If you are unable to find any DMEs such as splints, palm savers, heel boots and geri-sleeves after searching all areas, you must report it to the Unit Manager. No resident should go days or weeks without the proper equipment as ordered by the Providers. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment C) to ensure accuracy and completion of splint application and documentation of 10% of the resident population with active splint orders. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0688 SS = D	Continued from page 6 9/17/25 9:12 AM - An interview with E5 (CNA), confirmed she has never applied and has not seen the palm guard on the resident's left hand. 9/17/25 - On the following times, an observation of R69 was made without the left-hand palm guard: 10:00 AM, 11:00 AM, 12:00 PM, 1:00 PM, and 2:00 PM. 9/17/25 – 10:10 AM - During an interview, E2 (Quality Manager) confirming that R69 did not have a left palm guard. E2 stated that she would be addressed immediately. 9/18/25 9:16 AM – During an interview, E8 (Director of Rehab) confirming R69's order for "left palm protector" was a standard order with no stop date. E8 revealed the left hand palm guard order entered on 5/5/25 was stopped on 6/6/25 by mistake. 9/23/25 2:45 PM – Findings were reviewed with E1 (NHA), E2 and E3 (DON) during the exit conference.	F0688		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the	F0690	Corrective Action of Areas Affected: The facility provided services to restore bladder continence through assessment and care implementation for an individualized toileting program R20 on 10/28/25. Other areas affected: An initial audit for 100% of current residents was completed to determine if a change in urinary continence status existed by 11/19/25. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 10/1/25 to determine that education on the NSG211: Continence Management Policy with a specific focus on assessment of bowel/bladder decline. Education provided from the Nurse Practice Educator will be completed for licensed nurses and certified nursing assistants by 11/30/25. Education given as follows: CNA are to inform nursing of any changes of continence status i.e. bladder and bowel. The nurse must complete the Fecal and Urinary Incontinence Evaluation and complete the voiding trial if applicable.	12/05/2025

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F0690 SS = D	Continued from page 7 extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review it was determined that for one (R20) out of one resident reviewed for bowel and bladder, the facility failed to provide services to maintain or restore bladder continence. Findings include: Review of R20's clinical record revealed: 3/21/21 - R20 was admitted to the facility. 8/18/22 - A care plan documented that R20 was incontinent of urine and was unable to cognitively or physically participate in retraining with the following interventions: assist with perineal care as needed, monitor for signs and symptoms of infection, and provide privacy and comfort. 1/10/25 - A post voiding diary follow up assessment documented that R20 was assessed for urinary and fecal incontinence and the outcome determined R20 was a candidate for prompted voiding. The assessment lacked documentation regarding a toileting plan or update for the care plan. 5/15/25 - A quarterly MDS documented R20 had a BIMS score of 15 indicating the resident was cognitively intact. The MDS documented that R20 required supervision or minimal assistance for toileting and was occasionally incontinent of urine. Additionally, the MDS documented R20 was not on a toileting program. May 2025 - The CNA documentation record revealed that R20 was incontinent of urine 9 times out of 111 opportunities. June 2025 - The CNA documentation record revealed that R20 was incontinent of urine 27 times out of 117	F0690	Continued from page 7 Nursing will also need to start a CIC and update the care plan. CNA will be responsible to accurately document all resident's continence status at all times. Nursing will complete the follow up Fecal and Urinary Incontinence Evaluation and report findings to the Unit Manager or ADON. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment D) to ensure accuracy and completion of bowel/bladder continence assessment for identification of a decline in status and implementation of a toileting program, as appropriate for 10% of the resident population. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0690 SS = D	Continued from page 8 opportunities. July 2025 - The CNA documentation record revealed that R20 was incontinent of urine 29 times out of 113 opportunities. August 2025 - The CNA documentation record revealed that R20 was incontinent of urine 44 times out of 112 opportunities. 8/14/25 - A quarterly MDS documented that R20 had a BIMS score of 12 indicating the resident was moderately impaired. The MDS documented that R20 required supervision or minimal assistance for toileting and was frequently incontinent of urine. Additionally, the MDS documented R20 was not on a toileting program. September 2025 - The CNA documentation record revealed that R20 was incontinent of urine 20 times out of 59 opportunities. The CNA documentation and task list lacked evidence of frequency of toileting and any approaches individualized to R20. The CNA documentation combined urinary continence and bowel continence and provides an unclear determination of continence status. 9/15/25 11:02 AM - During an interview, R20 stated she was able to take herself to the bathroom and was continent. 9/22/25 10:06 AM - During an interview, E14 CNA stated that R20 was an assist of one with toileting and stated R20 can verbalize the need for toileting. E14 stated that R20 was not on a toileting program currently. E14 also stated R20 had an increase in incontinence and required staff assistance for toileting hygiene. 9/22/25 10:11 AM - During an interview, E15 (LPN) stated that R20 was able to toilet herself but required assistance from staff for hygiene care. E15 stated that R20 is not on a toileting program currently and staff takes R20 to the toilet every two hours. E15 did confirm that R20 was having increased incontinent episodes and stated R20's behaviors made it difficult for staff to complete toileting hygiene.	F0690		

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F0690 SS = D	Continued from page 9 The facility failed to develop an infividulized toileting program to improve or maintain bladder continence. 9/23/25 2:45 PM – Findings were reviewed with E1 (NHA), E2 (Quality Manager) and E3 (DON) during the exit conference.	F0690		
F0695 SS = E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, it was determined that for five (R4, R12, R38, R66 and R87) out of six residents reviewed for respiratory care, the facility failed to ensure residents' respiratory equipment (Bi-PAP mask and IVAPS mask) were stored in a protective plastic bag, the oxygen tubing was labeled and the filter on the oxygen concentrator was cleaned. Findings include: 1. A review of R4's clinical record revealed: 12/16/22 – R4 was admitted to the facility. 7/8/24 – A physician's order for R4 documented to use IVAPS (Intelligent Volume-Assured Pressure Support) every night shift for bedtime and as needed for when napping. 8/1/25 – A quarterly MDS assessment documented that R4 received oxygen therapy and used a non-invasive mechanical ventilator. 8/8/25 – A care plan documented R4 as a risk for respiratory complications related to chronic respiratory failure with an intervention to use the IVAP at bedtime. 9/15/25 9:50 AM – An observation revealed that R4's IVAPS mask was sitting on top of the bedside table with	F0695	Corrective Action of Areas Affected: The facility placed the respiratory equipment (BIPAP mask and tubing) in a protective bag for R4, R12 and R38 on 9/15/25. All filters for the oxygen concentrators were cleaned for R4, R12 and R66 on 9/15/25. For R87, the nasal cannula was changed and tubing was labeled and dated on 9/15/25. Other areas affected: An initial audit for residents ordered oxygen via nasal cannula and BIPAP/CPAP were reviewed to determine that (1) BIPAP masks and tubing were stored properly when not in use (2) the filter for the oxygen concentrator was clean and changed weekly (3) oxygen tubing was changed, labeled and dated weekly by 11/17/25. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 10/1/25 to determine that education on the following procedures: (1) Procedure: Bi-level Positive Airway Pressure (BiPAP)/Continuous Positive Airway Pressure (CPAP) (2) Procedure: Oxygen Concentrator (3) Procedure: Oxygen: Nasal Cannula Education provided from the Nurse Practice Educator will be completed for licensed nurses, certified nursing assistants and respiratory therapy by 11/30/25. Education given as follows (A-D): All O2 tubing must be changed and filters must be cleaned every week Scheduled on Tuesdays, day shift (approximately 7AM to 3PM) by Respiratory Therapy. It will be the responsibility of the Nursing staff to complete if RT is not available. Nebulizers and O2 tubing must be labeled with date, with additional labels if space is too small on tubing. CPAPs and BiPAPS masks should be cleaned daily with	12/05/2025

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F0695 SS = E	Continued from page 10 no protective bag available. 9/15/25 10:28 AM – During an interview, E6 (LPN) confirmed that R4's IVAPS mask should be stored in a protective bag. E6 mentioned that it is usually in a bag and promptly retrieved a protective bag to place R4's IVAPS mask inside. 2. A review of R12's clinical record revealed: 2/12/25 – R12 was admitted to the facility. 2/28/25 – A physician's order for R12 documented to use Bi-PAP at bedtime and as needed. 7/9/25 – A quarterly MDS assessment documented that R12 received oxygen therapy and used a non-invasive mechanical ventilator. 7/19/25 – A care plan documented R12 as a risk for respiratory complications related to COPD and acute and chronic respiratory failure, with interventions including using a Bi-PAP at bedtime and as needed. 9/9/25 – A physician's order for R12 documented to clean the external filter on the oxygen concentrator every Tuesday on the night shift and as needed. 9/15/25 9:24 AM - An observation revealed that R4's Bi-PAP mask was sitting on top of the bedside table with no protective bag available. The external filter on the oxygen concentrator was completely full of dark gray dust. 9/15/25 9:36 AM - During an interview, E13 (LPN) confirmed that R12's Bi-PAP mask should be stored in a protective bag. E13 stated that the external filter needed to be cleaned and immediately cleaned the filter and replaced it. 3. Review of R38's clinical record revealed: 7/23/25 - R38 was admitted to the facility with diagnoses including but not limited to obstructive sleep apnea and congestive heart failure. 9/15/25 9:11 AM - An observation revealed R38's BiPap mask and tubing sitting on the nightstand and not enclosed in protective bagging. 9/15/25 12:20 PM - During an observation E10 (RCA)	F0695	Continued from page 10 soft cloth of soap and water and stored in a breathable bag. Resident's O2 concentrators should be kept in their room. An O2 concentrator should be made available in the dining room so that residents who need continuous O2 can be transferred to the concentrator to prevent O2 running out during activities or meal time. These concentrators must be wiped down with Caviwipe (or similar cleaning agent) in between each resident's use Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachments E1, E2, E3) to ensure accuracy and completion of the cleaning procedures for 1.) BIPAP/CPAP devices, 2.) oxygen concentrator(s), and 3.) nasal cannulas among 10% of the resident population with active oxygen orders for the use of BiPAP/CPAP or nasal cannula. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0695 SS = E	Continued from page 11 confirmed R38's BiPap equipment was not in protective bagging. E10 stated, "I'll take care of that now." 9/23/25 2:45 PM – Findings were reviewed with E1 (NHA), E2 (Quality Manager) and E3 (DON) during the exit conference. 4. Review of R66's clinical record revealed: 1/7/21 - R66 was admitted to the facility. 9/22/24 - A physician's order for R66 documented oxygen via nasal cannula at 3L/min continuous every shift. 9/22/24 11:12 AM - A physician's order for R66 documented "clean external filter on oxygen concentrator every Tuesday dayshift, RT (respiratory therapy) to complete." 9/15/25 1:30 PM - An observation of R66's oxygen concentrator filter noted with dusty thick gray particles. 9/16/25 9:16 AM - An observation of R66's oxygen concentrator filter noted with dusty thick gray particles. 9/16/25 1:16 PM - During an interview, R66 stated "the nurse cleaned the filter this morning and they don't normally do that." 9/16/25 1:40 PM - During an interview, E16 (LPN) confirmed the oxygen concentrator was covered in thick gray particles when it was cleaned this morning. E16 confirmed that it was signed off on the MAR on 9/9/25 but E16 stated it did not appear it was cleaned. 9/23/25 2:45 PM – Findings were reviewed with E1 (NHA), E2 (Quality Manager) and E3 (DON) during the exit conference. 5. Review of R87's clinical record revealed: 9/2/25 - R87 was admitted to the facility with diagnoses that included but not limited to, pneumonia and respiratory failure. 9/2/25 - A physician's order for R87 documented " change oxygen tubing weekly every night shift, every	F0695		

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F0695 SS = E	Continued from page 12 Tuesday. label each component with date and initials. 9/15/25 11:07 AM - An observation of R87's oxygen tubing revealed no label. 9/15/25 11:10 AM - During an interview, E177 (RN) confirmed there was no label on the oxygen tubing. 9/23/25 2:45 PM - Findings were reviewed with E1 (NHA), E2 (Quality Manager) and E3 (DON) during the exit conference.	F0695		
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they	F0791	Corrective Action of Areas Affected: R10 was offered dental services on 9/20/25. Other areas affected: An initial audit for 100% of current residents was completed to ensure that dental services were offered by 11/7/25. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 10/1/25 to determine that education on OPS160: Dental Services policy, to offer dental services screening at least annually and as reported by staff, even if care / services are refused, as discovered with R10. Education includes that if Resident(s) request(s) dental care, any staff need to report it to Nursing leadership. Nursing leadership along with Social Services will coordinate dental services, as needed and by accessibility. Education provided from the Nurse Practice Educator will be completed for the Licensed Nursing Home Administrator, the Director of Nursing, Social Services and licensed nurses by 11/30/25. Monitoring of Corrective Action: The Director of Social Services and/or designee will conduct audits (attachment F) of all newly admitted residents and a look back for any mouth pain suggestive of a dental needs assessment for the past year to ensure that dental services were offered. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	12/05/2025

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F0791 SS = D	Continued from page 13 did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, it was determined that for one (R10) out of three residents sampled for dental services, the facility failed to assist R10 in obtaining routine dental services. Findings include: Review of R10's clinical record revealed: 7/23/23 - R10 was admitted to the facility. 6/27/25 - An annual MDS documented that R10 had no broken or loosely fitting dentures, no natural teeth or tooth fragments, no abnormal mouth tissue, and no obvious broken teeth. 9/15/25 9:57 AM - An observation of R10 revealed loosely fitting dentures. 9/15/25 10:13 AM - An interview with FM1 (Guardian) revealed that R10 had not seen a dentist. 9/17/25 11:11 AM - An interview with E12 (Scheduler) confirmed that a dentist comes to the facility and residents also can go to outside dental providers. E12 stated, "residents will request to see the dentist and will get added to the list." 9/17/25 11:44 AM - An interview with E10 (Regulatory Compliance Advisor) confirmed that R10 had not been seen by the dentist. 9/23/25 2:45 PM - Findings were reviewed with E1 (NHA), E2 (Quality Manager) and E3 (DON) during the exit conference.	F0791		

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F0791 ~~F0812~~ SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure food and beverages were stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 9/15/25 8:29 AM - The corners of numerous ceiling tiles in the dry food stoage room had a variety of different sized black and gray circular areas, which appeared to be mold. 9/15/25 9:17 AM - The clear plastic tubing that connected the kitchen juice machine to the beverage dispenser contained several areas of a blackish gray substance that appeared to be mold. 9/23/25 2:45 PM – Findings were reviewed with E1 (NHA), E2 (Quality Manager) and E3 (DON) during the exit conference.	F0791 F0812	Corrective Action of Areas Affected: The facility replaced the ceiling tiles in the dry food storage room of the kitchen on 9/15/25. The facility replaced the clear plastic tubing that connected the kitchen juice machine to the beverage dispenser on 9/15/25. Other areas affected: An initial audit to inspect the integrity of 100% of ceiling tiles in the kitchen and review the condition of the juice machine's clear plastic tubing was completed by 9/22/25. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 10/1/25 to determine that education for maintaining cleanliness protocols in the kitchen, as per HCSG028: Environment policy required access to electronic preventative maintenance software (TELS) for reporting by Food Service Director; and then to add tubing and tile inspections as a required PM task for facility maintenance staff. Education provided that all food service staff can report issues in the PM system through the food service director, maintenance staff, or request through the front desk, additionally letting food service know that maintenance staff will be tracking all work orders to assure Administration maintains a sound environment. Education provided from the Nurse Practice Educator will be completed for the Licensed Nursing Home Administrator, Director of Dietary Services and the kitchen staff by 11/30/25. Monitoring of Corrective Action: The Licensed Home Administrator and/or designee will conduct audits (attachment G) to review the integrity of the ceiling tiles and the juice machine's clear plastic tubing. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	12/05/2025
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F0842	Corrective Action of Areas Affected: Documentation for R2 was corrected via addendum reflecting care provided during the time in and out of the community, during the shift, for the accuracy of care on 11/19/25.	12/05/2025

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F0842 SS = D	Continued from page 15 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F0842	Continued from page 15 Other areas affected: An initial audit of 100% of current residents task records were reviewed for the accuracy of documentation of care on 11/19/25. Systemic Changes to Prevent Future Occurrences: The root cause analysis was conducted on 10/1/25 to determine that education was needed for the timely documentation of resident care. Education provided from the Nurse Practice Educator will be completed for the licensed nurses and certified nursing assistants by 11/30/25. Education given as follows (A-D): Situation: Resident was sent to the ER around 1:00pm, however the documentation reflected that the resident was not available all shift Issue: Staff member admitted to not seeing this resident from 7 am to 1 pm in writing within POC. That was 6 hours of an 8 hour shift that this resident was neglected. Solution: Always document all care you have provided as you go along on your shift. Do not wait until the end of the shift. If a resident leaves the facility during your shift, you are still responsible for documenting the care you give up until the time they leave the facility. All residents should have eyes on at least hourly with care offered every two hours and PRN. Monitoring of Corrective Action: The Director of Nursing and/or designee will conduct audits (attachment H) for 20% of the resident population to determine that documentation of care was accurate. The audit will occur daily until 100% compliance is achieved on 3 consecutive reviews, then weekly until 100% compliance is achieved on 3 consecutive reviews, then monthly until 100% compliance is achieved on 3 consecutive reviews. Results will be reviewed by the Quality Assurance Performance Committee monthly for review and recommendations.	

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F0842 SS = D	Continued from page 16 §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, it was determined that for one (R2) out of thirty sampled residents, the facility failed to ensure the clinical record contained accurate documentation. Findings include: Review of R2's clinical record revealed: 11/28/23 - R2 was admitted to the facility. 9/10/25 - A review of a facility investigation documented that R2 was involved in a resident to resident altercation with R53. 9/10/25 11:06 AM- A physician's order documented that R2 was to be sent to ER for treatment and evaluation. 9/10/25 - A review of the CNA documentation record revealed that R2 was "not available" for all ADL tasks on the 7:00 AM to 3:00 PM shift.	F0842		

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F0842 SS = D	Continued from page 17 9/22/25 10:20 AM - An interview with E7 (CNA) confirmed that R2 was in the facility on the date of 9/10/25 at approximately 12:15 PM and the documentation of "not available" was inaccurate. 9/23/25 9:00 AM - An interview with E10 (Regulatory Compliance Advisor) confirmed that R2 was sent to the ER at 12:15 PM and confirmed the documentation should reflect receiving care prior to R2 leaving the facility. 9/23/25 2:45 PM - Findings were reviewed with E1 (NHA), E2 (Quality Manager) and E3 (DON) during the exit conference.	F0842		