DELAWARE HEALTH AND SOCIAL SERVICES

Division of Health Care Quality
Office of Long Term Care Residents Protection

DHSS - DHCQ
263 Chapman Road, Suite 200, Cambridge Bldg.
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(302) 421-7400

STATE SURVEY REPORT

NAME OF FACILITY: Lodge Lane Assisted Living & Memory Care **DATE SURVEY COMPLETED: October 14, 2025**

SECTION	STATEMENT OF DEFICIENCIES SPECIFIC DEFICIENCIES	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED	Completion Date
	An unannounced Annual, Complaint and Emergency Preparedness Survey was conducted at this facility from October 7, 2025, through October 14, 2025. The deficiencies contained in this report are based on interview, record review and review of other facility documentation as indicated. The facility census on the first day of the survey was forty-six (46). The survey sample totaled fourteen (14) residents. Abbreviations/definitions used in this State Report are as follows: AC – "ante cibum", before meals; CNA – Certified Nursing Assistant; Dementia - a severe state of cognitive impairment characterized by memory loss, difficulty with abstract thinking, and disorientation; Concussion – a blow or jolt to the head that temporarily disrupts brain function; Cystitis – inflammation of urinary bladder; DON – Director of Nursing; ED – emergency Department; ER – Emergency Room; Feces – stool, bowel movement; FNP – Family Nurse Practitioner; Hematuria – blood in the urine; LPN – Licensed Practical Nurse; MAR – Medication Administration Record; MD – Medical Director;		

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	Mg – milligrams; NHA – Nursing Home Administrator; Osteoporosis – weakened bones with increased risk of breaking; OT – Occupational Therapy; PT – Physical Therapy; ROM (Range of Motion) - extent to which a joint can be moved safely; SA (Service Agreement) – allows both parties involved (the resident and the assisted living facility) to understand the types of care and services the assisted living facility provides. These include lodging, board, housekeeping, personal care, and supervision services; UAI (Uniform Assessment Instrument) – a document setting forth standardized criteria developed by the Division to assess each resident's functional, cognitive, physical, medical and psychosocial needs and status. The assisted living facility shall be required to use the UAI to evaluate each resident on both initial and ongoing basis in accordance with these regulations.		
3225.0 **3225.11.0** **3225.11.5** **S/S – D**	**Assisted Living Facilities** **Resident Assessment** **The UAI, developed by the Department, shall be used to update the resident assessment. At a minimum, regular updates must occur 30 days after admission, annually and when there is a significant change in the resident's condition.**	3225.11.5 1. The DON reviewed R4's UAI on 10/7/2025 and noted that it had already been reviewed and updated on September 18, 2025, to reflect R4's status as of that date, including fall history, pain status, mobility, and cognitive function.	October 14, 2025

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	This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R4) out of 14 total residents reviewed the facility failed to ensure that R4's UAI assessment was updated when there was a significant change. Findings include: Review of R4's clinical record revealed: 11/17/23 – R4's initial UAI (Uniform Assessment Instrument) documented that R4 was oriented to person, place and time, independent for toileting, mobility and transfers. R4 ambulated with the use of walker and rollator. R4 had negative fall risk indications and did not experience pain during the review period. 12/6/23 – R4 was admitted to the facility with diagnoses including a-fib (irregular heart rhythm) arthritis of the back, shoulder and bilateral knees. 9/17/24 – R4's significant change UAI documented that R4 was oriented to person, place but not with time. R4 was independent with toileting, mobility and transfers with cueing. R4 ambulated with the use of walker and rollator. R4's fall risk assessment indicated that R4 was confused and had actual falls in the last 31-180 days. R4 did not experience pain during the review period. 6/17/25 – A facility visit note by E23 (FNP) documented, "Chief complaint, 'my hip hurt'	R4's service plan was revised as needed to ensure appropriate interventions for fall prevention. 2. The DON, or designee, completed a 100% audit of all current residents' clinical records on 10/13/25 to verify that UAIs are up to date and accurately reflect each resident's current condition. 3. RCA: An updated UAI was not completed because the DON did not recognize that there was a significant change for the resident. The resident experienced 13 falls in 2024 and 13 falls in 2025. The resident only complained of pain to nursing once, and R4 is able to make her pain complaints known. This did not equate to a significant change in R4's status. There was no change in the residents cognitive status. R4's UAI was updated on 10/7/2025 for an annual review, to reflect that a sign was placed on R4's walker to use the walker at all times. The Wellness Assessment policy was reviewed and revised. Residents are reviewed every other week at clinical rounds (attended by the DON, Director of Dining, Admissions Director, Life Enrichment Director, and nursing staff working during the meeting time) for any "significant change" that may require an updated UAI. The NHA or designee educated the DON on the revised policy. The NHA educated the DON on the requirement to update the UAI with any significant change in resident condition. 4. The DON (or designee) will conduct audits of UAI's of residents with significant changes since 10/13/2025 daily x 3 to ensure that the UAI assessments are current, reflecting any changes in condition until 100% compliance is	

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	…pain worse when she is walking, denies getting anything for pain…hip hurting has been disturbing her sleep… Left hip pain… new concern status post fall … I do advise Tylenol 650 mg Q (every) 4-6 hours prn (when needed) for pain… nursing please assess pain level when administering medications." 8/11/25 2:00 PM - A facility home visit note by E22 (MD) documented, "Chief Complaint: L shoulder pain… started after her most recent fall 7/22/25 … per PT [R4] has pain when she tries to raise her arm above 90 degrees... pain ... occurs when she tries to move her arm a lot. …Physical Exam … unsteady gait, dec (decreased) ROM (range of motion) L shoulder, + (positive) pain with left shoulder flexion… Assessment/Plan … left shoulder pain likely rotator cuff injury ... " 10/10/25 - Review of R4's July 2025 MAR (Medication Administration Record) lacked evidence that a pain assessment was completed for R4 when her medications were administered. 10/13/25 - Review of R4's facility fall incident reports revealed that R4 fell seven times in the 47 days between 6/14/25 through 7/31/25: 6/14/25 at 11:30 AM. 7/20/25 at 5:05 AM. 7/21/25 at 2:50 AM. 7/22/25 at 7:44 AM. 7/22/25 at 11:10 AM. 7/22/25 at 7:50 PM; and 7/24/25 at 11:15 PM.	achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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	The facility failed to ensure that R4's UAI was reviewed and revised when R4 had a change in condition when: R4 had left hip pain that worsened with walking since she fell on 6/14/25. R4 had a left shoulder pain that started after her fall on 7/22/25 and continued to have shoulder pain moving her arm a lot when seen and examined by E23 on 8/11/25. R4 had seven falls between 6/14/25 through 7/31/25 (47 days). 10/14/25 10:00 AM – Findings were discussed with E1 (NHA). 10/14/25 11:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.		
3225.12.0 **3225.12.1.3** **S/S – E**	**Services** **Food service complies with the Delaware Food Code** **Delaware Food Code** **Delaware Food Code** **3-501.17 Ready-to-Eat Time/Temperature Control for Safety Food, Date Marking** **(B) Except as specified in ¶¶ (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD**	**3225.12.1.3** 1. On 10/7/25, immediately following identification of the issue, the two unlabeled and undated containers were discarded by the Life Enrichment Director (LED) and NHA. An inspection of the café refrigeration unit was completed by the LED and NHA on 10/7/25 to ensure all remaining food items were labeled and dated appropriately. 2. On 10/8/25, a comprehensive audit of all facility food storage areas—including the main kitchen, nourishment refrigerators, and Country Café—was conducted by the Dietary	October 14, 2025

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	is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded. This requirement is not met by: Based on observation during initial kitchen tour, the facility failed to label and date food items stored in Country Café refrigerator. Findings include: 10/7/25 12:50 PM – Two unlabeled and undated containers of food were observed in the refrigerator in Country Café of facility. 10/7/25 12:55 PM – Finding was confirmed by E18 (LED). 10/14/25 11:30 AM- Findings were reviewed with E1(NHA) and E2(DON) during the exit conference.	Manager, and no unlabeled or out-of-date food items were discovered. 3. RCA: There was no clear responsibility of any department for the resident food items placed in the Country Café refrigerator. And there was no signage for Residents and families to label any food items placed in the Country Café refrigerator with the residents name, the date it was put into the refrigerator, and when it should be discarded. The facility's "Food Brought in from Outside Sources" information sheet and "Personal Food Storage" Policy was reviewed and revised to state the Country Café's refrigerator checks are included in the Dining staffs "Opening and Closing log" for proper food labeling, and monitored by the Dining Director or designee. Dietary staff were educated by Dining Director and Staff Development Nurse on the revised policy. 4. The Dietary Director, or designee, will perform audits of the Country Café refrigeration units daily x 3 to ensure compliance with labeling and dating requirements, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will then continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	
3225.12.3 **S/S – D**	**The assisted living shall ensure that the resident's service agreement is being properly implemented.**	**3225.12.3** 1. R4's service agreement was immediately reviewed to ensure it was appropriate for the resident's current needs. Staff responsible for completing R4's safety checks were counseled	November 25, 2025

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	This requirement was not met as evidenced by: Based on record review and interview, it was determined that for one (R4) out of 14 total residents reviewed the facility failed to ensure that R4's service agreement was properly implemented. Findings include: Review of R4's clinical record revealed: 9/17/24 – R4's significant change Service Agreement documented independent for transfer, toileting, monitor for safety and to inform nurse of any changes in ambulation. R4 was monitored for safety and on every 2 hours safety checks. Review of R4's July 2025 Resident Checks lacked evidence that R4's safety checks every 2 hours were completed by the 3-11 shift on 7/21/25 and 7/27/25. Review of R4's August 2025 Resident Checks lacked evidence that R4's safety checks every 2 hours were completed by the 7-3 shift on 8/14/25, 8/21/25 and 8/28/25. 10/14/25 10:00 AM – Findings were discussed with E1 (NHA). 10/14/25 11:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	and educated on the importance of the completion and documentation of safety checks. 2. The DON or designee completed an audit of residents' service agreements requiring safety checks or supervision to ensure safety checks were completed as per the Resident Service Agreement. 3. RCA: The Wellness Unit Clerk/Scheduler was responsible for checking the CNA/RA documentation daily to ensure timely documentation of following the Resident Service Agreement. The Wellness Unit Clerk/Scheduler position has been vacant, and this task was inadvertently not reassigned to another staff member in their absence. The Resident Assessment and Service Agreement Policy were reviewed and revised. A new Safety Check Tracking form was implemented to confirm completion and documentation of safety checks. The LPN Charge Nurse will review safety check tracking forms at the end of each shift to ensure completion and follow-up on any missed checks. The Staff Developer, or designee, will educate direct care staff on the policy. 4. The DON or designee will conduct audits of Safety Check Tracking forms daily x 3 to ensure all resident safety checks are performed and documented as ordered until 100% compliance is achieved. Audits will continue weekly x 3 until 100% compliance is achieved, and then monthly times 2 until 100% compliance is achieved. Audit findings will be reported to the QAPI committee monthly X 3 months to ensure compliance is obtained and maintained	

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3225.13.0 **3225.13.6** **S/S – D**	**Service Agreement** **The service agreement shall be reviewed when the needs of the resident have changed and, minimally, in conjunction with each UAI. Within 10 days of such assessment, the resident and the assisted living facility shall execute a revised service agreement, if indicated.** **This requirement was not met as evidenced by:** Based on record review and interview, it was determined that for one (R4) out of 14 total residents reviewed, the facility failed to ensure that R4's service agreement was updated to address the resident's increasing fall and to reflect the care plan changes: Review of R4's clinical record revealed: 9/17/24 – R4's significant change Service Agreement documented independent for transfer, toileting, monitor for safety and to inform nurse of any changes in ambulation. R4 was high fall risk was monitored for safety and on every 2 hours safety checks. 7/21/25 2:50 AM - A facility incident report submitted to the state agency documented that R4 was found lying on her abdomen in her bedroom noted with increased confusion. The facility's investigation summary documented "If care plan revisions were made, please describe them: [R4] was placed on hourly rounding and given a wheelchair to used (sis) instead of her rollator".	3225.13.0 1. The DON reviewed R4's Service Agreement and noted that it had already been reviewed and updated on September 18, 2025, to reflect R4's current plan of service, including every two-hour safety checks due to decreased falls since August. 2. The DON, or designee, will complete a facility-wide audit of current residents' with recent falls, significant changes, or updated UAIs for the 90 days prior to October 14, 2025, to verify that service agreements were reviewed and updated as required. Any discrepancies identified during the audit will be corrected immediately, and affected residents and/or their representatives will be provided with revised agreements. 3. RCA: An updated Resident Service Agreement (RSA) was not completed because the DON did not recognize that there was a significant change for the resident. The resident experienced 13 falls in 2024 and 13 falls in 2025. The DON's intention was to place the resident on hourly rounding during the first 72 hours after the fall and resume every 2-hour rounding after that, so no change was made to the service agreement, as this was not going to be a long-term change in the residents service plan. R4's UAI and RSA were updated on 10/7/2025 for an annual review. No change was made to the every 2-hour rounding in those documents, as R4 was back to every 2-hour rounding at that time. Residents are reviewed every other week at clinical rounds (attended by the DON, Director of Dining, Admissions Director, Life Enrich-	November 25, 2025

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	7/22/25 7:50 PM – A facility incident report submitted to the state agency documented that R4 was found sitting upright on the floor. The facility's investigation summary documented" "If care plan revisions were made, please describe them: [R4] was placed on hourly rounding". A review of R4's July and August 2025 Resident Checks revealed that R4 was on every 2 hours safety checks. 9/18/25 – R4's annual Service Agreement documented independent for transfer, toileting, monitor for safety and to inform nurse of any changes in ambulation. R4 was high fall risk was monitored for safety and on every 2 hours safety checks. 10/13/25 11:52 AM – During an interview, E5 (CNA) stated that she is familiar with R4 and that R4 was always on every 2-hour safety check and that R4's safety monitoring was not changed to every hourly check. 10/13/25 12:50 PM – A review of R4's September 2025 fall incident reports revealed that R4 continued to fall on the following days: 9/1/25 6:30 AM 9/1/25 2:25 PM 9/20/25 5:45 AM The facility failed to update R4's service agreement to increase R4's safety check monitoring into hourly from every two hours	ment Director, and nursing staff working during the meeting time) for any "significant change" that may require an updated RSA. The "Resident Assessment and Service Agreement" and the "Post-Fall Assessment" policies were revised. Staff Development Nurse, or designee, will educate the DON on the revised policies. 4. The DON, or designee, will conduct audits of Resident Service Agreements of residents with significant changes daily x 3 to ensure that the Resident Service Agreements are current, reflecting any changes in condition until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

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	check to address R4's identified increasing falls on 7/21/25 and 7/22/25. 10/14/25 10:00 AM – Findings were discussed with E1 (NHA). 10/14/25 11:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.		
3225.16.0 **3225.16.2**	**Staffing** **A staff of persons sufficient in number and adequately trained, certified or licensed to meet the requirements of the residents shall be employed and shall comply with applicable state laws and regulations.** **Per the State of Delaware Board of Nursing's Scope of Practice document entitled "RN, LPN, and NA/UAP Duties 2024", last revised 4/10/24, only a Registered Nurse (RN) can perform post fall assessment and documentation.** **This requirement was not met as evidenced by:** A facility policy titled, "Post – Fall Assessment" revised 1/2025, documented," … Residents will have an initial assessment performed by a Registered Nurse after a fall. The Registered Nurse will document their findings in the resident's medical record". A review of R4's facility incident reports revealed the following: 2/9/25 11:50 AM – R4 had an actual fall.	**3225.16.2** 1. Unable to correct in the past. 2. The DON, or designee, will complete audits of current resident fall incidents occurring after October 14, 2025, by November 25, 2025, to ensure that each had a documented Registered Nurse (RN) post-fall assessment. -Any fall lacking RN documentation will immediately be reviewed by an RN, and a current assessment will be completed with entry in the Resident's medical record. 3. RCA: Although full-time licensed nursing staff were aware of the recent enforcement of the Nurse Practice Act r/t RN completing Initial Assessment after a fall, there was a knowledge gap with the PRN staff. The Post Fall Assessment Policy did not explicitly state that an RN had to do the Initial Assessment or what to do when an RN was not in the building. The Post-Fall Assessment Form was updated to include instructions for initial assessment to be performed by an RN. A Post-Fall Checklist was developed and added to the incident report packet to confirm RN assessment and signature completion occurs. A Post-Fall Assessment Binder (PFB) was created to include instructions to follow after a	November 25, 2025

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	6/14/25 11:30 AM – R4 had an actual fall. 9/20/25 5:45 AM – R4 had an actual fall. The facility failed to ensure that a Registered Nurse documented and completed R4's post fall assessments on 2/9/25, 6/14/25 and 9/20/25. 10/10/24 12:45 AM – In an interview, E2 (DON) confirmed that the dates identified did not have the Registered Nurse's post fall assessments. 10/14/25 10:00 AM – Findings were discussed with E1 (NHA). 10/14/25 11:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	resident fall, all necessary RN documentation needed to be completed (the Post-Fall Assessment form and Post Fall Checklist).The PFB will be located in the Wellness Center. The LPN Charge Nurse will bring the PFB from the Wellness Center to the location of the resident's fall, after ensuring a call has been placed to a facility RN, or the RN Supervisor at Kutz Rehabilitation and Nursing (KRN). The Post-Fall Assessment policy was reviewed and revised on 10/16/2025 to include the components of the PFB. The Staff Developer will educate all licensed nursing staff in person, via Zoom, or over the telephone by 11/30/2525 regarding: * The Delaware Board of Nursing Scope of Practice requirements. * Facility expectations for immediate RN involvement and documentation after all falls. * Procedures for any fall occurring during non-RN coverage hours. * Procedure if there is no RN in the facility and the KRN RN is unavailable to perform the initial assessment. Those educated by telephone will be required to send an email that they received and understood the information, and all questions were answered. 4. The DON (or designee) will conduct audits of all fall incident reports daily x 3 to verify that an RN assessment and documentation were completed for each fall, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	November 25, 2025

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3225.19.0 **3225.19.1** **S/S – D**	**Records and Reports** **The assisted living facility shall be responsible for maintaining appropriate records for each resident. These records shall document the implementation of the service agreement for each resident.** **This requirement was not met as evidenced by:** Based on record review and interview it was determined that for one (R4) out of 14 residents reviewed the facility failed to maintain appropriate records. Findings include: 10/14/25 9:00 AM - Review of R4's July 2025 Resident Checks lacked evidence that R4's safety checks every 2 hours were completed by the 3-11 shift on 7/21/25 and 7/27/25. 10/14/25 9:10 AM - Review of R4's August 2025 Resident Checks lacked evidence that R4's safety checks every 2 hours were completed by the 7-3 shift on 8/14/25, 8/21/25 and 8/28/25. 10/14/25 9:20 AM - Review of R4's September 2025 Resident Checks lacked evidence that R4's safety checks every 2 hours were completed by the 3-11 shift on 9/25/25 and 9/29/25. 10/14/25 9:30 AM - Review of R4's October 1 - 11, 2025 Resident Checks lacked evidence that R4's safety checks every 2 hours were completed by the 7-3 shift on 10/9/25. Additionally, R4's safety checks every 2 hours	**3225.19.1** **Cross Refer to 3225.12.3** 1. Unable to correct in the past. 2. The DON or designee completed an audit of residents' service agreements requiring safety checks or supervision to ensure safety checks were documented in accordance with the Resident Service Agreement. 3. RCA: The Wellness Unit Clerk/Scheduler was responsible for checking the CNA/RA documentation daily to ensure timely documentation of following the Resident Service Agreement. The Wellness Unit Clerk/Scheduler position has been vacant, and this task was inadvertently not reassigned to another staff member in their absence. The Resident Assessment and Service Agreement Policy were reviewed and revised. A new Safety Check Log was implemented to confirm documentation of safety checks. The LPN Charge Nurse will review safety check logs at the end of each shift to ensure documentation is completed and follow-up on any missed checks. The Staff Developer, or designee, will educate direct care staff on the policy. 4. The DON or designee will conduct audits of Safety Check Tracking Sheets daily x 3 to ensure all resident safety checks are performed and documented as ordered until 100% compliance is achieved. Audits will continue weekly x 3 until 100% compliance is achieved, and then monthly times 2 until 100% compliance is achieved.	

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	were not completed by the 3-11 shift on 10/3/25, 10/9/25, 10/10/25 and 10/11/25. 10/14/25 10:00 AM – Findings were discussed with E1 (NHA). 10/14/25 11:30 AM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.	Audit findings will be reported to the QAPI committee monthly X 3 months to ensure compliance is obtained and maintained	November 22, 2025
16 Delaware Code, Part II, Chapter 11, Subchapter II, Right of Residents **S/S – D**	**1121 Resident's rights (b)(30) Each resident shall be free from verbal, physical or mental abuse, cruel and unusual punishment, involuntary seclusion, withholding of monetary allowance, withholding of food, and deprivation of sleep.** This requirement was not met by: Based on record review and other documentation as indicated, it was determined that for one (R10) out of three residents sampled for abuse, the facility failed to ensure that R10 was free from abuse when a staff member publicly told R10, using profanity, she smelled of feces. The facility also failed to prohibit the staff member from contact with R10 until education was completed to prevent further occurrences of abuse. Findings include: The facility policy revised 11/2024 and titled, "State Reportable Incidents" included, "…The facility will not tolerate residents to be subject to abuse, violence, neglect, mistreatment, or misappropriation of property by anyone, including: staff members…" Review of R10's clinical record revealed:	16 Del. C. Chap.11 §1121 1. Unable to correct in the past. 2. DON or designee will review grievances and incident reports related to resident abuse with profanity for 90 days before 10/14/25 to identify any similar allegations of inappropriate staff communication or verbal abuse to ensure documentation of education was performed prior to the staff's return to work. 3. RCA: The DON thought the NHA had documented the education done on 2/7/25 with the staff member regarding Resident's Rights, and the NHA thought the DON had documented the education with E12. As the education had been performed, E12 was allowed to return to work on 2/8/25. The "State Reportable Incidents" policy was revised to ensure immediate education is performed with the staff member and documented by Human Resources Manager or designee in the employee's personnel file prior to the staff member returning to work. The NHA educated the DON and HR on the revised "State Reportable Incidents" policy. The Staff Development nurse educated all employees during the Annual Critical Skills Fair in August 2025 that the use of profanity with a resident is considered abuse.	

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NAME OF FACILITY: Lodge Lane Assisted Living & Memory Care **DATE SURVEY COMPLETED: October 14, 2025**

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	6/27/23 – R10 was admitted to the facility with diagnoses including dementia and osteoporosis. 2/6/25 9:30 AM – E19 (LEA) documented in an Abuse-Complaint Statement, "I heard the nurse [E12] (LPN) ask [R10] to let staff change her. [R10] stated she did not need to be changed. The nurse [E12] stated to [E10], 'you need to because you smell like [expletive].' Another resident [R12] heard and stated, 'Oh my God, what did she just say?', when the nurse told [R10] she smelled like [expletive]. This incident occurred in front of many residents that were sitting in the living room…I believe the resident [R10] was embarrassed…As a staff member I felt bad for [R10] and the other residents." 2/6/25 - Review of facility's abuse investigation documentation revealed E12 was placed on suspension pending investigation. 2/6/25 8:20 PM – During a facility conducted abuse investigation interview, E20 (CNA) stated, "[E12] told [R10] she needed to be changed. [R10] continued to resist, so [E20][sic] said they[sic] let her be for a while." When E20 was asked during the interview if [E12] said anything else to [R10], E20 stated, "[E12] told [R10], 'she smelled like poop.'" E20 was then asked if [E12] used the word poop or [expletive]. E20 stated, "[E12] used the word [expletive]." 2/17/25 – Per the facility's abuse investigation documentation, E12 completed education on properly communicating with residents with dementia and received training	4. The DON (or designee) will review all abuse or neglect investigations daily x 3 to ensure staff involved in any investigation are not permitted to work until training is completed and documented, until 100% compliance is achieved. Audits will continue weekly x 3, until 100% compliance is achieved. Audits will continue monthly x 2 until 100% compliance is achieved. Findings of the audits will be reported to the QAPI committee monthly x 3 months to ensure compliance is obtained and maintained.	

Provider's Signature Tricia E Hall Title CEO Date November 24, 2025

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	on abuse, neglect, exploitation and mandated reporting. 10/10/25 1:45 PM – During an interview, surveyor asked E2 (DON) what was E12's employment status between 2/7/25 and when education was completed on 2/17/25. E2 stated, "[E12] was suspended for one day [2/7/25] after the investigation was completed." A review of the facility's daily timesheets revealed E12 was assigned to care for R10 on 2/8/25, 2/10/25, 2/11/25, 2/12/25, 2/13/25 and 2/14/25, a total of six shifts before post-investigation education was completed on 2/17/25. Although the facility identified and corrected the issue by providing E12 with additional abuse training, the facility failed to remove E12 from resident care until the additional abuse training was completed. 10/13/25 3:30 PM – Finding was confirmed with E1 (NHA) and E2 (DON). 10/14/25 11:30 AM- Findings were reviewed with E1 and E2 during the exit conference.		