STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085004	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs Rehabilitation at Brandywine	505 Greenbank Road Wilmington, DE 19808

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 47114 Based on observation, interview and record review, it has been determined that for five (R26, R29, R62, R81 and R82) randomly observed during the survey, the facility failed to ensure each resident were treated with respect and dignity. Findings include: 1. R82's clinical record revealed: 6/5/22 - R82 was admitted to the facility. 9/24/24 - A review of R82's MDS assessment revealed, [R82] was dependent for toileting, showering/bathing and personal hygiene. 10/2/24 (last revised) - R82's care plan interventions documented, Resident has a suprapubic catheter position catheter bag and tubing below the level of the bladder and away from entrance doorway. 10/31/24 10:18 AM - Observed R82's suprapubic catheter bag and tubing was visible from the doorway. 10/31/23 10:33 AM - R82's catheter bag remained visible from the hallway. During an interview, E25 (CNA) stated, I'm [R82's] care provider this is my first time working with him, I guess I overlooked where the bag was. E25 left R82's room and was observed entering another resident's room. R82's catheter bag and tubing remained visible from the hallway. 10/31/24 10:38 AM - During an interview, E26 (LPN) stated, [R82's] catheter bag should be placed on the side of the bed that the tubing is positioned. E26 also stated, I'm not really sure what is in [R82's] care plan for his catheter. At 10:43 AM, E26 entered R82's room and stated to R82, I need to place your catheter bag away from your door you can see it from the hallway, it's a dignity issue and it should not be seen from the hallway. E26 repositioned R82's catheter bag so it was not visible from the hallway. 11/13/24 11:05 AM - Findings were confirmed with E2 (DON). 11/15/24 at 2:35 PM - Finding was reviewed with E1 (NHA), E2 (DON), E4 (LPN/QA/IP), E55 (RCC) and E27 (ADON). 32545 (continued on next page)

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 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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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. An observation by the Surveyor on 11/15/24 at 12:10 PM revealed E53 (CNA) sitting in an armchair with her legs hanging over the left armrest dangling and on her cellphone while positioned between two out of the four residents eating lunch at the table in the dining room. E53 was not facing nor assisting either resident at the time of the observation. The residents at the table were: R26, R29, R62 and R81. 11/15/24 at 12:15 PM - Finding was immediately reviewed with E54 (RN/UM). 11/15/24 at 2:35 PM - Finding was reviewed with E1 (NHA), E2 (DON), E4 (LPN/QA/IP), E55 (RCC) and E27 (ADON).

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 40264 Based on observation, interview, record review and review of other facility documentation, it was determined that for three (R20, R78 and R80) out of four sampled residents reviewed for activities, the facility failed to allow cognitively intact residents the choice to go outside on their own or alone. Findings include: 1. Cross refer F679, example 1 8/21/20 - An activity care plan was developed for R20 to participate in current preferred leisure group of his choice including . community outings, outdoors during appropriate weather months. R20's interventions included providing a program of activities that was of interest and empowers R20 by encouraging/allowing choice, self expression and responsibility . R20's preferred activities are: . community outings, outdoors during appropriate weather months. 10/28/24 1:46 PM - During an interview, R20 stated, With the new management, we are not allowed to go outside to get some fresh air. Before, we were allowed to go out - there's a courtyard that is enclosed but we can't go there whenever we want to go, unless (sic) staff would take us outside. 11/8/24 2:00 PM - During an interview, E16 (Activities Director) stated that residents are allowed to go out to the courtyard to enjoy breath of fresh air weather permitting with staff supervision for safety reasons. 2. Cross refer F679, example 2 6/21/22 - An activity care plan was developed for R80 to participate in current preferred leisure group of his choice including . community outings, outdoors during appropriate weather months. [R80's] interventions included providing a program of activities that was of interest and empowers [R80] by encouraging/allowing choice, self expression and responsibility . [R80's] preferred activities are: . community outings, outdoors during appropriate weather months. 10/28/24 1:30 PM - During an interview, R80 stated, We are not allowed to go outside to get some fresh air without (sic) staff. Most of the time there is no staff to take us out in the courtyard. 11/8/24 2:05 PM - In a follow-up interview, E16 (Activities Director) stated that the residents have to be supervised by staff everytime they go out even if it's just going out in the courtyard. 11/12/24 2:35 PM - Findings were discussed with E1 (NHA), E2 (DON) and E47 (Regional Nurse Consultant). 46134 3. Cross refer F809, example 2 Review of R78's clinical record revealed: (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/18/22 - R78 was admitted to the facility. 9/4/24 - R78's annual MDS documented that R78 had a BIMS of 15. 9/2/24 - R78's Elopement assessment documented no risk for elopement; R78's quarterly fall assessment revealed no falls in the preceding three months and that resident was independent with activities of daily living and ambulation (moving about; walking). 11/1/24 11:00 AM - During an interview, R78 stated that she is not able to go into the facility lobby, outside the facility, or into an enclosed outside courtyard as she would like because the doors out of the facility residential areas are always locked. 11/1/24 11:00 AM - During an interview, R78 reported that because of the late lunch meal lunch tray deliveries on the B hallway where her room is located, that sometimes she must choose between eating lunch or participating in a 2:00 PM activity. A review of the October activities calendar revealed that there was a daily activity that started at 2:00 PM. 11/12/24 10:30 AM - During an interview E1 (NHA) stated that [R78] is permitted to go outside of the facility, [R78] needs to ask someone, and then she needs to have staff with her when she is outside. Sometimes, there aren't staff members available to sit with residents outside in the courtyard. E1 stated that (R78) could go into the lobby at any time upon request, so that the door to the lobby could be unlocked. -Review of the facility schedule for lunch tray deliveries revealed that lunch tray deliveries are supposed to end at 1:15 PM. -A review of the facility meal tray delivery logs revealed that on 10/6/24 the lunch meal trays were delivered to B hallway at 2:15 PM; on 10/27/24, the lunch trays were delivered to the B hallway at 2:26 PM. -10/28/24 2:13 PM - An observation revealed that the lunch meal cart delivered was delivered at 2:13 PM to the B hallway. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 46134 Based on observation and interview, it was determined that the facility failed to have the survey results from the past three years available in a readily accessible area for residents, family members and legal representatives. Findings include: 10/31/24 11:10 AM - During a random observation in the facility lobby, the facility's survey results were not visible in the lobby. Upon surveyor request, E13 (receptionist) retrieved the survey results binder that was located behind the reception desk. During an interview on 11/1/24 at 8:30 AM, E13 stated that the survey results binder was always kept behind the reception desk. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32545 Based on observation and interview, it was determined that for residents rooms observed in three out of five hallways and two shower rooms, the facility failed to ensure that the necessary housekeeping and maintenance services were performed to maintain a sanitary and comfortable interior with an adequate supply of clean linens that are in good condition. Findings include: 1. Surveyor observations from 10/28/24 and 10/29/24 revealed: B hallway: - Room B1: floor in the bedroom was dirty with stains. Along the baseboard under the window was a old heating system but in disrepair where it was coming apart and dirt can be seen inside of it. The shared bathroom had a over the toilet commode with rusted legs. The bathroom door had a vent that was rusted along the top. Two plastic wash bins were sitting directly on the floor uncovered. - Room B3: floor in bedroom was dirty with stains and dust, especially the corners. In addition, there were two nails exposed on top of the windowsill and the windowsill was in disrepair as it was missing a piece of the edge. - Room B5: floor in bedroom was dirty with stains and dust. - Room B7: floors in bedroom and bathroom were dirty with stains and dust. F hallway: - Room F14: right side quarter length bed rail was laying on top of the resident's dresser as the Surveyor was told by the resident that her bed rail was knocked off . two weeks ago. On 11/7/24 from 3:42 PM to 4:10 PM - An environmental tour conducted with E17 (Regional Maintenance Director) and E18 (Environmental Services Director) revealed the following: B Hallway: - Room B1: bedroom and bathroom floors were dirty with stains and dust. The shared bathroom had an over the toilet commode with rusty legs and gray paint chipping off the legs. There were two plastic wash bins sitting directly on the floor uncovered. The bathroom door vent was rusted at the top. The old heating system (not in use anymore) along the baseboard under the window was in disrepair with dirt observed inside. - Room B3: bedroom was inaccessible during the environmental tour. Surveyor reviewed with E17 the following issues that were identified during screening on 10/29/24: two nails exposed on top of the windowsill and the windowsill was in disrepair as it was missing a piece of the edge. - Room B5: bedroom floor and fall mat were dirty with stains. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Room B7: shared bedroom and bathroom floors were dirty with stains. - Room B15: shared bathroom floor was dirty with stains and no trashcan liner was in place. E Hallway: - Room E15: bedroom and bathroom had discolored ceiling tiles and the wall against the bed had chipped paint and scratches. F Hallway: - Room F14: right side quarter length bed rail was observed still laying on top of the resident's dresser. Observations of two community shower rooms revealed: - B Hallway shower room had broken floor tile, discolored grout in the shower, the shower chair had brown substance smeared on the left side and small brown clumps were scattered on the shower floor and the ceiling light cover had evidence of insect debris. - E Hallway shower rooom floor was dirty and the ceiling light cover had evidence of insect debris. There was black debris in tile grout in many locations of the room, and it was heavier in the resident shower space, the wheelchair scale was dirty with debris, and there were shoes and wheelchair parts scattered on the floor in the toilet area. During a combined interview while on the environmental tour, E18 stated that the shower rooms get cleaned everyday. When the Surveyor asked if the facility conducts housekeeping audits, E17 and E18 were unable to provide any evidence. E17 stated that he has not been in this building for approximately one year. E17 stated that the facility has had three (3) maintenance directors over the past year and the most recent one just resigned yesterday. When asked to see the monthly maintenance audits, E17 stated that he cannot find them. E17 stated that they use an electronic system to track their work orders called Records, which has been in use for one year. All findings were confirmed during the tour. 46134 2. Surveyor observations on 10/28/24 at 2:45 PM and 10/29/24 at 3:23 PM revealed the following: C hallway room [ROOM NUMBER]: - The bathroom lacked a hand soap dispenser, and the hand sanitizing gel dispenser was empty; - Holes on the bathroom wall were present where the previous soap dispenser had been located; - The ventilation grate on the bathroom door had visible areas of rust; - The bathroom floor in bathroom appeared dirty; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The walls in the bedroom were in disrepair, with visible peeling paint. 10/30/24 8:15 AM - Observations of the E wing linen closet revealed a minimal supply of linens: - 2 fitted sheets; - 5 flat sheets; - No washcloths or towels. 10/30/24 8:20 AM - During an interview E23 (CNA) confirmed the lack of linens in the E wing linen closet. 10/30/24 2:00 PM - The observations for room C hallway room [ROOM NUMBER] were confirmed by E12 (Maintenance Director) during a tour of the C hallway room [ROOM NUMBER] bathroom and bedroom. 10/31/24 8:30 AM - Observations of the D wing linen closet revealed a minimal supply of linens: - 1 fitted sheet; - 1 bed pad; - 2 wash cloths; - No towels. 10/31/24 8:45 - During an interview, E26 (LPN) and E59 (CNA) confirmed the D wing linen closet observation and stated that in the facility, there are never enough linens, any day or at any time, and it makes it difficult to do our jobs. 10/31/24 10:09 AM - During an interview with another surveyor, E26 stated that because there were no wash cloths available to use, that E26 needed to use a towel to both wash and dry a resident while providing care to the resident. E26 stated that one side is wet and one side is dry. 10/31/24 11:17 AM - During an interview, E18 (Environmental Services Director-Housekeeping) stated that there is no overnight laundry staffing shift in place in the facility, so dirty linens do not get laundered overnight, and that affects how quickly linen closets are restocked with clean linens the next morning. The morning laundry shift must come in and get started right away to do laundry from the night before, in order to resupply the linen closets with clean linens. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47621 Based on record review and interview, it was determined that for one (R102) out of six residents reviewed for transfer/discharges, the facility failed to notify the Ombudsman of R102's 4/27/24 transfer to the hospital. Findings include: Review of R102's clinical record revealed: 8/20/23 - R102 was admitted to the facility. 4/27/24 - R102 was transferred to [hospital]. 11/7/24 11:30 AM - Review of R102's electronic medical record (EMR) and April 2024 [facility] Ombudsman Transfer log lacked evidence that the Office of the State Long-Term Care Ombudsman was notified. 11/8/24 9:50 AM- During an interview, E1 (NHA) confirmed that R102 was sent to the hospital from the facility on 4/27/24. E1 also confirmed that R102's name did not appear on the April 2024 [facility] Ombudsman Transfer log nor did the facility have any documentation to prove that the Ombudsman's Office was notified of this transfer. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 40264 Based on record review and interview, it was determined that for two (R141 and R125) out of two sampled residents reviewed for PASARR, the facility failed to notify the appropriate state-designated authority when the residents' new diagnosis of mental disorder were identified. Findings include: 1. Review of R141's clinical record revealed the following: 7/11/24 - A PASARR Level I Screen Outcome revealed No Level II Required. 7/12/24 - R141 was admitted to the facility. 10/24/24 1:00 PM - An encounter note by E52 (NP) documented, Chief Complaint: Depression . Patient verbalized that he is feeling okay now and goes in and out of feeling depressed secondary to being here in the facility. 10/28/24 - R141 had a physician's order for citalopram (Lexapro) 20 mg (milligram) 1 tablet by mouth daily for depression. 10/28/24 - A nurse progress note by E54 (RN/UM) documented, . resident [R141] was started on new medication Lexapro 20 mg daily . 11/6/24 - A facility Psychiatric Evaluation revealed that R141 was diagnosed with adjustment disorder with depressed mood. 11/7/24 12:29 PM - There was a lack of evidence the state PASARR authority was made aware. 11/7/24 3:50 PM - In an interview, E1 (NHA) confirmed that the state PASARR authority was not contacted for R141 when he was diagnosed with depression and was prescribed with an antidepressant medication on 10/28/24. E1 also stated that the facility submitted a referral to the state PASARR authority . only today when it was brought to our attention by the surveyor. 47621 2. Cross refer F626 Review of R125's clinical record revealed: 7/13/23 - The [hospital] obtained R125's PASARR, which stated no Level II required. 7/25/23 - R125 admitted to the facility. 8/3/23 - E51 (NP) ordered in R125's EMR, Risperdal 0.5 mg PO (by mouth) BID (two times a day) for delusional disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At this time when R125 was diagnosed with a new psychiatric disorder and intiated on an atypical anti-psychotic medication (risperdal), the facility failed to refer R125 for a PASARR Level II screening as required. 10/31/23 - R125's quarterly Minimum Data Set (MDS) documented in Section I- Active Diagnoses YES to psychotic disorder. 10/31/23 - R125 admitted to the hospital. 1/10/24 - The [hospital] obtained a new PASARR, which stated no Level II required- No SMI (significant mental illness)/ ID (intellectual disability)/ RC (related conditions). On this PASARR application, the hospital incorrectly stated that R125 was on risperdal for major depression disorder when in fact R125 was on risperdal for delusional disorder, a reportable psychiatric disorder on the PASARR application. 3/4/24 - R125 was readmitted to the facility with an order for Risperdal 1 mg twice a day for delusional disorder. 3/10/24 - R125's admission MDS documented in Section I Psychotic disorder- YES. The facility failed to recognize the need to correct R125's PASARR application to reflect R125's diagnosis of delusional disorder that required a prescription for Risperdal, an atypical anti-psychotic medication. 11/11/24 1:35 PM - During an interview, E1 (NHA) acknowledged the need for R125 to have a PASARR level II evaluation and stated that Social Services had already put the application. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 32545 Based on observation, record review and interview, it was determined that for one (R41) out of five residents reviewed for medications and three (R14, R67 and R76) out of seven residents reviewed for side rails, the facility failed to develop and implement individualized care plans with respect to a seizure disorder and bed rail usage that included measurable objectives and timeframes. Findings include: 1. R41's clinical record revealed: 11/22/20 - R41 had a active physician's order for Levetiracem 500 mg tablet two times a day for a diagnosis of seizure disorder. 8/9/24 - The significant change MDS assessment documented that seizure disorder was an active diagnosis. Review of R41's comprehensive care plan lacked evidence of an individualized seizure disorder care plan. 11/12/24 at 10:34 AM - During a combined interview, finding was confirmed with E2 (DON) and E4 (LPN/QA/IC). 2. Cross refer F700, example 2 R14's clinical record revealed: 11/7/24 at 4:50 AM - Surveyor observed R14 receiving incontinence care in her bed with left sided quarter length (22 inches) bed rail positioned up, stationary and padded with gray styrofoam. Review of R14's comprehensive care plan revealed the absence of a person-centered care plan for the left side quarter length bed rail. 11/7/24 at 1:50 PM - During a combined interview with E2 (DON) and E47 (RCC), the Surveyor requested R14's bed rail care plan. The facility lacked evidence that a bed rail care plan was developed and implemented for R14. 3. Cross refer F700, example 4 R67's clinical record revealed: 10/31/24 at 9:52 AM - Surveyor observed R67 in bed with the bilateral grab bars (12 inches in length) positioned up and stationary, with the right side padded with gray styrofoam. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/7/24 at 1:50 PM - During a combined interview with E2 (DON) and E47 (RCC), the Surveyor requested R67's person-centered care plan for bilateral bed rails/grab bars. The facility lacked evidence that a bed rail care plan was developed and implemented for R67. 46134 4. Cross refer F700, example 6 Review of R76's clinical record revealed: 2/22/23 - R76 was admitted to the facility. 10/28/24 11:30 AM - During an observation a left sided quarter bed rail was in place in place on R76's bed. 11/7/24 - A review of R76's care plan revealed the lack of a care plan focus for the bed rail on R76's bed. 11/12/24 1:32 PM - During an interview, E3 (LPN) confirmed the lack of a care plan focus area for R76's bed rail. 11/13/24 at 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.

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Springs Rehabilitation at Brandywine	505 Greenbank Road Wilmington, DE 19808

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 32545 Based on observation, record review and interview, it was determined that for one (R67) out of three residents reviewed for activities, two (R6, and R16) out of seven residents reviewed for bed rails, and three (R18, R55 and R76) out of three residents reviewed for enhanced barrier precautions, the facility failed to review and revise each residents' comprehensive care plan. Findings include: 1. R67's clinical record revealed: 12/19/23 - R67 was admitted to the facility with a diagnosis of dementia. 12/21/23 - R67's activity care plan with an intervention that included, but was not limited to, . preferred activities are: card/board games, exercise/sports, religious services, reading, trivia, outdoors (in appropriate weather months), gardening/floral arrangements, music, manicure, special themed events. 6/18/24 at 12:27 PM - An activity note documented that R67 . refused invitations this past quarter to arts & (and) crafts, Coral Springs Cafe, bingo, religious services, exercise, word games, reading, music, women's group, and manicure . 9/10/24 at 7:27 AM - An activity note documented that R67 . refused invitations this past quarter to arts & crafts, Cafe, bingo, exercise, manicure, outdoors, (in appropriate weather months), religious services, STARS [group program for high risk fall residents] and board games . The facility failed to review and revise R67's activity care plan since admission to ensure that it is individualized and person-centered based on resident's previous lifestyle (occupation, family, hobbies). Although the care plan stated that R67 enjoys Indian music, it does not address how and when this activity was to be provided. R67's care plan does not address the resident's physical and mental capabilities to participate in the general activities as she has dementia with a BIMS of 6. The admission MDS stated that it was very important that R67 had family involvement in her care, but the care plan does not reflect participation and input by R67's family. 11/12/24 at 9:52 AM - During an interview, E16 (AD) acknowledged that R67's activity care plan was not reviewed and revised to ensure that it was person-centered. 2. Cross refer F700, example 1 R6's clinical record revealed: 10/29/24 at 7:11 AM - Surveyor observed bilateral quarter length (22 inches) bed rails positioned up while R6 was in bed sleeping. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/7/24 at 1:50 PM - During a combined interview with E2 (DON) and E47 (RCC), the Surveyor requested R6's person-centered care plan for bilateral bed rails. In response, the facility provided a care plan for potential for falls with injury with an intervention, last revised on 6/7/23, for a right side rail only for turning/transfers. The intervention also addressed to Ensure side rails are maintained with no gaps between rail and mattress and are secured properly. Assess need and safe use of rail quarterly and as needed for change in resident condition. The facility failed to review and revise R6's comprehensive care plan to reflect the current use of bilateral quarter length bed rails and ensure the bed rail care plan was person-centered with measureable outcomes and goals. 3. Cross refer F700, example 3 R16's clinical record revealed: 10/29/24 at 9:15 AM - Surveyor observed R16 in bed eating breakfast with bilateral quarter length side rails positioned up and stationary. 11/7/24 at 1:50 PM - During a combined interview with E2 (DON) and E47 (RCC), the Surveyor requested R6's individualized care plan for bilateral bed rails. In response, the facility provided a care plan for potential for injury related to falls with an intervention, last revised on 8/27/23, for bilateral rails as enabler to assist with turning and/or transfers. The intervention also addressed to Ensure side rails are maintained with no gaps between rail and mattress and are secured properly. Assess need and safe use of rail quarterly and as needed for change in resident condition. The facility failed to review and revise R16's comprehensive care plan to reflect that the bed rail care plan was person-centered with measurable outcomes and goals. 46134 4. Review of R18's clinical record revealed: 11/18/09 - R18 was admitted to the facility. 9/27/24 - R18's quarterly MDS documented that R18 had multiple current diagnoses including dysphagia (difficulty swallowing), right sided paralysis following a stroke and that R18 had a feeding tube. 11/7/24 - A review of R18's care plan lacked the infection control focus for EBP. 5. Review of R55's clinical record revealed: 12/13/17 - R55 was admitted to the facility. R55 had multiple current diagnoses including dysphagia (difficulty swallowing) and left sided paralysis following a stroke. and that R55 had a feeding tube in place. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/30/24 - R55's quarterly MDS documented that R55 had multiple current diagnoses, including dysphagia (difficulty swallowing) and left sided paralysis following a stroke. R55 had a feeding tube in place. 11/7/24 - A review of R55's care plan revealed the lack the infection control precaution focus for EBP. 6. Review of R76's clinical record revealed: 2/22/23 - R76 was admitted to the facility. 9/27/24 - R76's quarterly Minimum Data documented that R76 had multiple diagnoses, including end stage kidney disease and required dialysis (cleansing of the blood by artificial means when kidneys have failed). Review of R76's care plan revealed that R76 had a dialysis port (an opening implanted into the skin) for dialysis. 11/7/24 - A review of R76's care plan lacked the infection control precaution focus area of EBP. 11/12/24 8:15AM - During an interview, E54 (RN) confirmed that the care plans for R18, R55 and R76 failed to include the care plan focus area of EBP. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 32810 Based on record review and interview, it was determined that for five (R15, R102, R260, R310, R457) out of seven residents reviewed for assessments, the facility failed to meet the professional standards of practice by having an LPN complete assessments in violation of the State of Delaware Nursing Scope of practice. For R260, the facility failed to have an RN complete the post fall assessment. For R15, R102, R310 and R457, the facility failed to have an RN complete the Admission assessments as required by the Delaware Nursing Scope of Practice. Findings include: Delaware State Board of Nursing -RN, LPN and NA/UAP Duties 2024 . Admission Assessments* - RN .* = Once a care plan is established, the LPN may do assessments . Admission History Review - RN . The facility policy on falls, last updated 4/2024, indicated, When a resident experiences a fall, the facility will: a. assess the resident. b. complete a post fall assessment. The policy lacked evidence that the initial post fall assessment be completed by a Registered Nurse. 1. Review of R260's clinical record revealed: 11/19/23 1:45 PM - E24 (LPN) documented on a fall incident report, Called to assess [R260] post fall. Resident found laying on the floor in room .RN notified. MD contacted and no new orders at this time. The incident report contained VS, pain assessment, and neurological checks completed by E24 (LPN) as part of the initial post fall assessment. 11/4/24 1:00 PM - During an interview, E2 (DON) and E4 (QA) confirmed that the RN should be doing the [initial post fall] assessment. 11/4/24 1:22 PM - During an interview, E24 (LPN) confirmed completion of R260's initial post fall assessment on 11/19/23. E24 stated that any nurse can completed the initial post fall assessment. 47621 2. Review of R15's clinical record revealed: 9/20/23 - R15 was admitted to the facility. 9/22/24 to 9/26/24 - R15 admitted to the hospital. 9/27/24 - R15 readmitted to the facility after hospital stay. 9/27/24 - E55 (LPN) completed the following facility required Admission Assessments: A. Resident Basics/Vitals/Medical History, B. Sensory/Facility Orientation/Elopement Risk, C. Pain, D/E. Musculoskeletal/Fall/Lift/Side Rail or Grab/ Skin Integrity/Braden Scale, F. Oral/Nutrition, G. Respiratory/Smoking, H. Bowel & Bladder, and I. IV/Other. An LPN, not an RN as required by the State of Delaware regulation for the Board of Nursing Scope of Practice, completed the initial assessments. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R102's clinical record revealed: 8/20/23 - R102 was admitted to the facility. 9/20/24 to 9/22/24 - R102 admitted to the hospital. 9/22/24 - R102 readmitted to the facility after hospital stay. 9/22/24 - E60 (LPN) completed the following facility required Admission Assessments: A. Resident Basics/Vitals/Medical History, B. Sensory/Facility Orientation/Elopement Risk, C. Pain, D/E. Musculoskeletal/Fall/Lift/Side Rail or Grab/ Skin Integrity/Braden Scale, F. Oral/Nutrition, G. Respiratory/Smoking, H. Bowel & Bladder, and I. IV/Other. An LPN, not an RN as required by the State of Delaware regulation for the Board of Nursing Scope of Practice, completed the initial assessments. 4. Review of R310's clinical record revealed: 10/18/24 - R310 was admitted to the facility. 10/19/24 - E61 (LPN) completed the following facility required Admission Assessments: B. Sensory/Facility Orientation/Elopement Risk, C. Pain, F. Oral/Nutrition, G. Respiratory/Smoking, H. Bowel & Bladder, and I. IV/Other. 10/21/24 - E27 (RN/ADON) completed the following facility required Admission Assessment, A. Resident Basics/Vitals/Medical History. Of note, Section D/E. Musculoskeletal/Fall/Lift/Side Rail or Grab/Skin Integrity/Braden Scale of the facility required Admission Assessments was not completed for R310's admission. An LPN, not an RN as required by the State of Delaware regulation for the Board of Nursing Scope of Practice, completed the initial assessments. 5. Review of R457's clinical record revealed: 10/12/24 - R457 was admitted to the facility. 10/16/24 - E62 (LPN/UM) completed the following facility required Admission Assessments: A. Resident Basics/Vitals/Medical History, B. Sensory/Facility Orientation/Elopement Risk, C. Pain, D/E. Musculoskeletal/Fall/Lift/Side Rail or Grab/ Skin Integrity/Braden Scale, F. Oral/Nutrition, G. Respiratory/Smoking, H. Bowel & Bladder, and I. IV/Other. An LPN, not an RN as required by the State of Delaware regulation for the Board of Nursing Scope of Practice, completed the initial assessments. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/31/24 - During an interview, E2 (DON) stated that the facility required the following admission assessments when a resident was admitted : A. Resident Basics/Vitals/Medical History, B. Sensory/Facility Orientation/Elopement Risk, C. Pain, D/E. Musculoskeletal/Fall/Lift/Side Rail or Grab/ Skin Integrity/Braden Scale, F. Oral/Nutrition, G. Respiratory/Smoking, H. Bowel & Bladder, and I. IV/Other. E2 provided the surveyor with blank copies of each of these admission assessments. 11/4/24 3:33 PM - During an interview, E62 (LPN/UM) confirmed that she completed the facility required admission assessments for R457. E62 stated that she was not aware that admission assessments were outside of her (LPN) scope of practice. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 40264 Based on observation, interview, record review and review of other facility documentation, it was determined that for two (R20 and R80) out of four sampled residents reviewed for activities, the facility failed to provide outdoor activities during appropriate weather based on their comprehensive assessments and care plans. Findings include: 1. Cross refer F561, example 1 Review of R20's clinical records revealed: 8/12/20 - R20 was admitted to the facility with diagnoses which included acquired absence (amputation) of the left leg above the knee. 8/21/20 - An activity care plan was developed for R20 to participate in current preferred leisure group of his choice including . community outings, outdoors during appropriate weather months. R20's interventions included providing a program of activities that is of interest and empowers R20 by encouraging/allowing choice, self expression and responsibility .R20's preferred activities are: . community outings, outdoors during appropriate weather months. 5/1/24 - R20's annual MDS revealed that R20 was cognitively intact, indicated going outside to get fresh air when the weather is good as very important and self propelled with a manual wheelchair. 5/19/24 - A facility Recreation Evaluation for R20 documented that it was very important for R20 to go outside to get fresh air when the weather is good. R20 was independent with participation in activities. 10/28/24 1:46 PM - During interview, R20 stated, With the new management, we are not allowed to go outside to get some fresh air. Before, we were allowed to go out - there's a courtyard that is enclosed but we can't go there whenever we want to go, unless a staff would take us outside. 11/4/24 - A review of R20's Daily Activities Log revealed the following: - July 2024 - R20 was involved in outdoor activity in 4 out of 31 opportunities; - August 2024 - R20 was involved in outdoor activity in 4 out of 31 opportunities; - September 2024 - R20 was involved in outdoor activity in 1 out of 30 opportunities and; - October 2024 - R20 was not involved in outdoor activity in 31 opportunities. 11/8/24 2:00 PM - During an interview, E16 (Activities Director) stated that residents are allowed to go out to the courtyard to enjoy breath of fresh air weather permitting with staff supervision for safety reasons. 2. Cross refer F561, example 2 (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R80's clinical records revealed: 6/16/22 - R80 was admitted to the facility with diagnoses which included muscle weakness and lack of coordination. 6/21/22 - An activity care plan was developed for R80 to participate in current preferred leisure group of his choice including . community outings, outdoors during appropriate weather months. [R80's] interventions included providing a program of activities that is of interest and empowers [R80] by encouraging/allowing choice, self expression and responsibility .[R80's] preferred activities are: . community outings, outdoors during appropriate weather months. 7/24/24 - R80's annual MDS revealed that R80 was cognitively intact, indicated going outside to get fresh air when the weather was as very important and R80 self propelled with a manual wheelchair or ambulates with a rolling walker. 7/25/24 - A facility Recreation Evaluation documented that R80, required a roller walker for mobility and ambulation and was moderately dependent with participation in activities. [R80] will have opportunities to participate in a variety of desired leisure groups such as . community outings, outdoors in an appropriate weather months . [R80] will be encouraged to attend preferred leisure activities . it was very important for [R80] to go outside to get fresh air when the weather is good. 10/28/24 1:30 PM - During interview, R80 stated, We are not allowed to go outside to get some fresh air without (sic) staff. Most of the time there is no staff to take us out in the courtyard. 11/4/ 24 - A review of R80's Daily Activities Log revealed the following: - July 2024 - R80 was involved in outdoor activity in 4 out of 31 opportunities; - August 2024 - R80 was involved in outdoor activity in 4 out of 31 opportunities; - September 2024 - R80 was involved in outdoor activity in 2 out of 30 opportunities and - October 2024 - R80 was not involved in outdoor activity in the 31 opportunities. 11/8/24 2:05 PM - In a follow-up interview, E16 (Activities Director) stated that the residents have to be supervised by staff everytime they go out even if it's just going out in the courtyard. 11/7/24 1:55 PM - Finding was confirmed by E47 (Regional Clinical Consultant). 11/12/24 2:35 PM - Finding was discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant).

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 48409 Based on record review and interview, it was determined that for one (R159) out of seven residents reviewed for hospitalization s, the facility failed to ensure that R159 received care/treatment in accordance with professional standards of practice. The facility failed to monitor bowel movements resulting in a hospitalization requiring fecal disimpaction. Findings include: Review of R159's clinical records revealed: 9/20/23 - R159 was admitted to the facility with diagnoses including Parkinson's Disease, muscle weakness and dementia. 9/20/24 - R159's admission care plans included, [R159] has potential for constipation r/t [related to] decreased motility. The interventions included, Monitor and document bowel sounds and abdominal distention if no BM [bowel movements] after 3 days or resident refuses bowel interventions. Monitor BMs and document in CNA records. 9/20/23 - R159's physician's orders included, Docusate Sodium Oral Liquid [stool softener] - give 100 ml by mouth 2 times a day for constipation and Bowel protocol per facility policy: Give 30 ml of milk of magnesia on 3-11 if no bowel movement, 11-7 give Fleets Enema if no results from 11-7, nurse will inform physician for further orders and communicate to 7-3 nurse per facility's protocol. 9/26/23 - R159's admission MDS documented a BIMS score of 3, indicating severe cognitive impairment. Review of R159's Activities of Daily Living (ADLs) flowsheets revealed: 11/2/23 - R159's clinical records documented a large bowel movement. 11/6/23 - R159's clinical records documented a small bowel movement. 11/11/23 - R159's clinical records documented a large bowel movement. The facility failed to initiate the bowel protocol for 5 days (14 shifts.) 11/16/23 - R159's clinical records documented a large bowel movement. 11/21/23 - R159's clinical records documented a small bowel movement. The facility failed to initiate the bowel protocol for 5 days (16 shifts.) 11/24/23 10:03 AM - R159's clinical records documented, .Was notified that resident [R159] was not at baseline (normal status for R159). Neck hyper flexed (extended) and unable to relax. Normally resident would be able to stand, pivot and verbalize any concerns . not able to follow commands . spoke with NP and sent out for further evaluation. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	11/28/23 4:11 PM - R159's hospital records documented, . Large stool burden in the rectum with stool ball . measuring up to 7.5 cm [2.95 inches] . hospitalized for hypoactive (decreased bowel sounds), delirium with abdominal pain, both were improved after fecal disimpaction. [R159] was also treated MiraLax (medication for constipation), senna, glycerin [rectal] suppositories X (times) 2 with improvement in constipation . her mental status improved back to her baseline with treatment of her constipation. 11/6/24 10:00 AM - A review of R159's clinical records lacked evidence of documentation of a bowel movement from 11/16/23 through 11/24/23 for a total of 26 shifts. During an interview E21 (RN) stated, We run a daily report and anyone who has not had a bowel movement is put on the bowel protocol. The bowel protocol should have been started 3 days after she [R159] didn't have a BM. A review of R159's clinical records lacked evidence that prune juice, milk of magnesia or fleets enema were given per order or that the physician was notified of the lack of bowel movements. 11/8/24 2:30 PM - During an interview, the surveyor asked E22 and E23 (CNAs) what size of bowel movement would be considered a small one. E22 stated, Like a small smear on the brief. E23 stated, Small bowel movement does not count. That's not enough to say the resident has had an actual bowel movement. 11/12/24 12:15 PM - During an interview, E4 (LPN/QA/IP) stated, The bowel protocol should have been started. The facility failure to monitor and initiate the bowel protocol for 13 shifts, caused R159 have abdominal pain and to be hospitalized from 11/24/23 through 11/28/23. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 48409 Based on observation, interview and record review, it was determined that for one (R92) out of three residents reviewed for bladder continence, the facility failed to ensure that R92 received services and assistance to maintain bladder continence to the extent possible. Findings included: 4/20/24 - A facility document titled, Incontinence, Policy Explanation and Compliance Guidelines, documented, The facility must ensure that residents who are continent of bladder and bowel upon admission receive appropriate treatment, services, and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain . Residents who are incontinent of bladder or bowel will receive appropriate treatment . and to restore continence to the extent possible. R92's clinical records revealed: 7/24/24 - R92 was admitted to the facility with diagnoses including muscle weakness and urinary tract infection. 7/24/24 - R92's nursing admission assessment documented, Continent of bladder and bowel. 7/24/24 - R92's care plan documented, [R92] is incontinent of bowel and bladder. The interventions included, Assist to toilet as requested, apply barrier cream with each incontinent episode. 7/24/24 through 7/26/24 - R92's three-day voiding diary revealed no episodes of bladder incontinence. 7/29/24 - R92's admission BIMS documented a score of 15, indicating a cognitively intact status. 10/21/24 - R92's quarterly MDS documented, Occasionally incontinent of bladder. R92's clinical records lacked evidence of interventions to restore bladder continence. 11/8/24 12:00 PM - During an interview, E22 (CNA) stated, I don't know if he [R92] can use the toilet. I was never told to put him on the toilet. I just change the pads when I take care of him. 11/8/24 1:30 PM - During an interview, R92 stated, I came here to get better, but I don't think that is going to happen. I want to take myself to use the toilet, but I am afraid to do it by myself in case I fall. 11/8/24 2:00 PM - During an interview, E57 (RNAC) stated, We do a 3-day voiding diary on admission and make a toileting plan based on the results [if the resident is incontinent.] The surveyor asked what would happen if the resident was continent on admission and then became incontinent. E57 stated, We would do a voiding diary and then make a toileting plan. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/8/24 3:00 PM - A review of R92's bladder records from 10/11/24 through 11/8/24 revealed 12 episodes of incontinence out of 75 opportunities for continence. The ADLs flowsheets, Kardex and care plans lacked evidence of person-centered plan of care for to promote R92's bladder continence. The facility failed to provide services and assistance to maintain R92's bladder continence to the extent possible. 11/12/24 1:30 PM - Findings were confirmed with E1 (NHA) and E2 (DON)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46134 Based on interviews, record review and review of other documents as indicated, it was determined that for one (R157) out of six residents reviewed for hospitalization , the facility failed to provide the necessary treatment consistent with professional standards of practice, to provide pain assessments and pain medication prior to the daily wound care for R157's extensive left lower leg wounds. The result of that incomplete pain assessment and medication administration resulted in harm. R157 experienced pain when her wound care was completed. Findings include: Cross refer to F655 Review of R157's clinical record revealed: 7/27/24 - The hospital records and discharge summary revealed that R157 was admitted to the facility for wound care and physical therapy directly from a seventeen-day hospital stay. The hospitalization included an admission to the intensive care unit for the treatment of septic shock (potentially deadly condition with whole-body infection) from an infection in R157's left lower leg. R157 had surgery on her left leg on 7/17/24 to debride (remove dead tissue so that healthy tissue can grow) her left leg. The surgery resulted in R157 having three separate and large wounds to her left leg. Two wounds were located on the upper left thigh, front and back and one wound was located on the lower left leg, from her knee and extending to her heel. The three wounds were extensive both in length and width and the wounds took up most of the skin space on R157's left leg. The hospital records that were sent to the facility with R157's admission documents included 7/24/24 color photographs of the three wounds on R157's left leg. A review of hospital records for the pain medications that R157 received during her hospital stay revealed the following: Tylenol 650 mg by mouth every six hours, Oxycodone (expected pain) 10 mg by mouth twice daily as needed, Oxycodone 5 mg by mouth every four hours as needed. The 7/27/24 hospital discharge summary highlighted R157's medication changes to continue Oxycodone 10 mg by mouth thirty minutes before dressing changes. 7/27/24 - R157 was admitted to the facility with multiple diagnoses, including cellulitis (skin infection with swelling), of left lower leg, open wounds to the left lower leg, infection of the skin, a fractured spine, arthritis and dementia. 7/27/24 - A physician's order was written by E3 (Medical Director) for R157 to receive Tylenol 650 mg by mouth every six hours as needed for pain. 7/28/24 - Medication orders were written by E51 (Nurse Practitioner) for the following medications: - Oxycodone 10 mg by mouth every twelve hours as needed for pain dressing change. - Gabapentin 100 mg by mouth three times a day for nerve pain. - Celebrex 200 mg by mouth twice a day for pain. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	It is significant to note that according to the hospital discharge documents, Gabapentin and Celebrex were medications that R157 was taking at home before she was hospitalized on [DATE] and had left leg surgery on 7/17/24. 7/28/24 - An encounter note, written by E3 revealed that R157's wound photographs were reviewed with F2 (R157's daughter) when E3 examined R157. E3 documented that R157 had extensive wounds encompassing the entire leg and that she does have pain with dressing changes. 7/31/24 - R157's Minimum Data Set (MDS, standardized assessment forms used in nursing homes) documented the following: - BIMS score of 6, which indicated that R157 had severe cognitive impairment. - R157 had received scheduled and as needed pain medications during the last five days. - R157 was unable to participate in the pain assessment interview at the time of the comprehensive assessment; the sections for the presence and the frequency of pain were not answered by R157 herself, but were completed with a staff assessment. - It was very important to R157 to have her family involved in discussions about her care. A review of R157's wound care orders revealed: 7/27/24 - 8/8/24 - Cleanse the wounds with Vashe wound solution (hypochlorous acid with antimicrobial properties), pat dry, apply intrasite and with oil emulsion (both promote moist wound for healing), cover with Vashe soaked gauze, ABD (absorbent gauze pads) and wrap with kerlix (bandage rolls) and ace wrap (compression bandage to reduce swelling) for all wounds to left hip and lower left leg every day. 8/8/24 - 8/14/24 -Cleanse the wounds with Dakin's (bleach, acid and baking soda mixed in water to promote with antibacterial effects), pat dry, apply hydrogel AG (gel with antimicrobial properties), cover with oil emulsion dressing, ABD pad, wrap with Kling (stretch bandages) every day shift for all wounds to lower left extremity. Notify MD of worsening or signs of infection. 8/6/24 1:44 PM - A progress note was written by E6 (LPN, wound care) that the LLE (lower left extremity) calf wound from knee to back of ankle appeared to be infected due to redness around the wound, green drainage on the wound dressings, and increased drainage from the wounds. 8/7/24 11:37 AM - An encounter note written by E52 (NP) revealed Patient is being seen today for concerns of pain in her left leg. Patient has an extensive left lower leg cellulitis with multiple wounds. The daughter is very involved in her care and is requesting the patient to be medicated with oxycodone half hour before her dressing changes. This has not always consistently been done. The patient is alert and oriented she is very pleasant she is a poor historian she is seen today lying in bed in no acute distress she does not appear to be in any pain at the present time she denies fever chills chest pain shortness of breath nausea vomiting. The daughter is concerned she is not getting her oxycodone prior to her dressing changes. Given the extent of the patient's wounds this is not an unreasonable request. I will write an order for the oxycodone to be given half hour before dressing changes. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	A review of the electronic medical record revealed that the order was never written. A review of R157's as needed pain medication that R157 was given revealed: - Acetaminophen 650 mg by mouth was given twice in July at 7/30/24 at 9:01 PM and 8/4/24 at 9:55 AM. - Oxycodone 10 mg was given four times: 7/28/24 at 12:34 PM, 7/29/24 at 11:14 AM, 8/8/24 at 5:05 PM for pain 8/10 and 8/12/24 at 12:42 AM for pain 8/10. 8/12/24 - A progress note written by E52 (NP) revealed that E52 was called to R157's bedside because F2 was going to take R157 home and F2 wanted to speak with a medical provider. E52 arrived and found R157 with a change in mental status, increased confusion, pale skin, and she was moving all over the bed. E52 explained that from a clinical point of view, R157 would not be safe to be discharged to home because there was a concern that the left leg had a significant infection, that the wound was very complex, as it started from the groin and extended down to the foot. E52 explained that a discharge to home would be against the medical advice of the facility. F2 stated that she would then call 911 herself and that she did not want the nursing staff or the nurse practitioner to be involved. 8/12/24 10:26 AM - A nurses note documented that the medication orders, face sheet and the last provider note was sent to the hospital with the resident. A review of the hospital admission records documented that R157 was hospitalized [DATE] thru 8/20/24 for treatment of a wound infection. 11/13/24 1:40 PM - During an interview, F2 stated that because of my mother's dementia she cannot tell someone when she is having pain. I am her caregiver, and I can tell when she is in pain by looking at her eye movements and her subtle body changes. She was in pain when she had dressing changes when I was present. According to the College of Psychiatric and Neurologic Pharmacists, Mental Health Clinician Identification, Assessment, and Management of pain in patients with advanced dementia, 2016: Pain in a dementia patient is a prevalent symptom that can be underrecognized because of the ability of the patient to self-report. Health care providers must anticipate this and screen for and treat potential pain. This includes obtaining a self-report, searching for potential causes for pain, observing patient behavior, gaining proxy reporting of pain, and attempting an appropriate analgesic trial. Although R157 was a a severly cognitively impaired resident, the facility documents lacked evidence that the facility used any alternative pain assessment tools, with the exception of one tool, the Pain Evaluation for Cognitively Impair and Intact assessment tool that was used on 8/11/24. R157's harm was evidenced by the following: - R157 was a vulnerable facility resident with significant cognitive impairment and who may not have been able to adequately express her pain verbally or physically. R157 was medicated for pain on an as needed basis on six shifts out of the fifty-two shifts that she was in the facility. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	- R157's wound care orders were changed on 8/8/24 to Dakin's, a bleach solution. R157 received as needed pain medication only two times after that change, and apparently not prior to dressing changes on those days. - R157 was a vulnerable eighty-eight facility year old resident because of her medically fragile state and her physical frailness. It was important to R157 that her daughter (F2) participate in her care while she was at the facility. F2 expressed concern to the facility about her mother's pain, specifically that her mother was not getting pain medication thirty minutes before her dressing changes. The facility made no further changes to R157's pain medications, or to document reasons why there were no changes made. - R157's wound deteriorated during her facility admission. R157 did not appear to be responding to the prescribed antibiotics that were started on 8/6/24. R157's pain medications continued to go unchanged as R157's wound infection progressed. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 32545 Based on observation, record review and interview, it was determined that for seven (R6, R14, R16, R60, R67, R76 and R119) out of seven residents reviewed for bed rails, the facility failed to have a system in place to ensure that each resident was assessed, risks/benefits reviewed, alternatives attempted, informed consent obtained prior to the installation of bed rails. Findings include: According to the Centers for Medicare and Medicaid Services State Operations Manual, Appendix PP - Guidance to Surveyors for Long Term Care Facilities, issued 8/8/24, under F700 Bed Rails, Definitions . 'Bed rails' are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of the bed. Examples of bed rails include, but are not limited to: - Side rails, bed side rails, and safety rails; and - Grab bars and assist bars . The facility's policy and procedures, dated 09/2024, entitled Bed rails stated the following: Policy: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails/Enabler bars. If bed rails/enabler bars are used, the facility ensures correct installation, use and maintenance of the rails. Guidelines 1. As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails/enabler bars meets those needs: a. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms b. Cognition c. Mobility (in and out of bed) d. Risk of falling 2. The resident assessment must also assess the resident's risk from using bed rails. Examples of the potential risks with the use of bed rails include: a. Accident hazards (e.g. falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails) (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Barrier to residents from safely getting out of bed. 3. If it is determined to be a restraint, the facility will follow their procedures related to physical restraints. 4. The facility will attempt to use appropriate alternatives prior to installing or using bed rails. Alternatives include, but are not limited to: a. Lowering the bed b. Concave/perimeter mattresses c. Enabler/grab bars 5. Alternatives that are attempted should be appropriate for the resident, safe and address the medical conditions, symptoms or behavioral patterns for which a bed rail was considered . 1. Cross refer to F657, example 2 R6's clinical record revealed: 11/7/17 - R6 was admitted to the facility. 10/29/24 7:11 AM - Surveyor observed bilateral quarter length (22 inches) bed rails positioned up while R6 was in bed sleeping. The bed rails cannot be lowered as they are stationary. Review of R6's clinical record lacked evidence of the following: - the specific date the bed rails were installed; - the medical need for the bed rails; - the attempt to use appropriate alternatives prior to installing the bed rails; - an assessment of R6 for risk of entrapment from bed rails prior to installation; - review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation; and - review the bed dimensions are appropriate for the resident's size and weight. 11/4/24 10:19 AM - The facility's form entitled Side Rail/Grab Bar Evaluation documented that R6 only had a left bed rail despite the Surveyor's observation of bilateral bed rails on 10/29/24. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates the residents and determines if bed rails should be ordered. E66 stated that Rehab does not specify the size of the bed rails when it is communicated to maintenance that the resident was ordered a bed rail. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. During this interview, Surveyors requested all therapy bed rail documentation for R6 and the email that was sent to the IDT team and maintenance. 11/12/24 1:30 PM - During a combined interview with E1 (NHA), E2 (DON), E4 (LPN/QA/IC) and E47 (RCC), Surveyors reviewed the information and assessments required prior to installing bed rails. Surveyors extended another opportunity to review facility evidence that would meet the Federal requirement up to the exit conference. The facility failed to provide evidence of the components specified in the Federal requirement prior to installing bilateral quarter length bed rails on R6's bed. In addition, the facility did not provide Surveyors with the email(s) referenced in E66's interview. 2. Cross refer F656, example 2 R14's clinical record revealed: 5/31/19 - R14 was admitted to the facility with a diagnosis of dementia. 7/30/24 - The quarterly MDS assessment documented that R14 had a BIMS of 3, which reflects a severe cognitive impairment. 10/28/24 1:01 PM - The facility's form Side Rail/Grab Bar Evaluation by E54 (RN, UM) documented, that R14 was educated on the risks associated with side rail/grab bar use despite having a severe cognitive impairment. 11/7/24 4:50 AM - Surveyor observed R14 receiving incontinence care in her bed with left sided quarter length bed rail positioned up. The bed rail cannot be lowered as it was stationary. Review of R14's clinical record lacked evidence of the following: - the specific date the bed rails were installed; - the medical need for the bed rails; - the attempt to use appropriate alternatives prior to installing the bed rails; - an assessment of R14 for risk of entrapment from bed rails prior to installation; - review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation; and - review the bed dimensions are appropriate for the resident's size and weight. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates the residents and determines if bed rails should be ordered. E66 stated that Rehab does not specify the size of the bed rails when it is communicated to maintenance that the resident was ordered a bed rail. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. During this interview, Surveyors requested all therapy bed rail documentation for R14 and the email that was sent to the IDT team and maintenance. No further information was received from the facility. 3. R16's clinical record revealed: 9/3/20 - R16 was admitted to the facility. 8/13/24 - The quarterly MDS assessment documented that R16 was cognitively intact, had a diagnosis of a stroke with right sided hemiplegia and had a functional limitation in range of motion on the right arm and leg. 10/29/24 9:15 AM - Surveyor observed R16 in bed eating breakfast with bilateral quarter side rails positioned up. The bilateral quarter length (22 inches) side rails are stationary and unable to be lowered. Review of R16's clinical record lacked evidence of the following: - the specific date the bed rails were installed; - the medical need for the bed rails; - the attempt to use appropriate alternatives prior to installing the bed rails; - an assessment of R16 for risk of entrapment from bed rails prior to installation; - review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation; and - review the bed dimensions are appropriate for the resident's size and weight. 11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates the residents and determines if bed rails should be ordered. E66 stated that Rehab does not specify the size of the bed rails when it is communicated to maintenance that the resident was ordered a bed rail. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. During this interview, Surveyors requested all therapy bed rail documentation for R16 and the email that was sent to the IDT team and maintenance. No further information was received from the facility. 4. Cross refer to F656, example 3 R67's clinical record revealed: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/19/23 - R67 was admitted to the facility with a diagnosis of dementia. 10/31/24 9:52 AM - Surveyor observed R67 in bed with the bilateral grab bars (12 inches in length) positioned up and stationary. 9/2/24 10:55 AM - The facility's form entitled Side Rail/Grab Bar Evaluation completed by E54 (RN, UM) documented that R67 had bilateral half side rails despite the Surveyor's observation on 10/31/24 of bilateral grab bars. The form had grab bars as an option, but only half side rails were checked by E54. Review of R67's clinical record lacked evidence of the following: - the specific date the bed rails were installed; - the medical need for the bed rails; - the attempt to use appropriate alternatives prior to installing the bed rails; - an assessment of R67 for risk of entrapment from bed rails prior to installation; - review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation; and - review that the bed dimensions are appropriate for the resident's size and weight. 11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates the residents and determines if bed rails should be ordered. E66 stated that Rehab does not specify the size of the bed rails when it is communicated to maintenance that the resident was ordered a bed rail. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. During this interview, Surveyors requested all therapy bed rail documentation for R67 and the email that was sent to the IDT team and maintenance. No further information was received from the facility. 46134 5. Review of R60's clinical record revealed: 3/31/17 - R60 was admitted to the facility. 8/1/24 - R60's MDS documented that R60 had a BIMS of 10, indicating moderate cognitive impairment, and had diagnoses of high blood pressure and arthritis. 10/28/24 9:05 AM - An observation revealed a quarter length (22 inches) side rail on the right side of R60's bed. Review of R60's clinical record lacked evidence of the following: (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-the date that the bed rail was installed; -the attempt to use appropriate alternatives prior to installing the bed rail; -an assessment of R60 for the risk of entrapment from the bed rail prior to installation; -the presence of the informed consent for the use of a bed rail -review that the bed dimensions are appropriate for the resident's size and weight. 10/18/24 1:02 PM - The facility's form Side Rail/Grab Bar Evaluation by E21 (RN, UM) documented that R60 was educated on the risks associated with side rail/grab bar use, despite having moderate cognitive impairment. 11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates residents and determines if bed rails should be ordered. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. E66 stated that Rehab does not specify the size of the bed rail when it is communicated to maintenance that the resident was ordered a bed rail. During this interview, a request was made for R66 to send the surveyor all therapy bed rail documentation for R60, and the email that was sent to the IDT team and maintenance in reference to R60's bed rail. No further information was received from the facility. 6. Cross refer F656 example 4. Review of R76's clinical record revealed: 2/23/23 - R76 was admitted to the facility. 10/8/24 - R76's MDS documented that R60 had a BIMS of 11, indicating moderate cognitive impairment, and that R76 had diagnoses of renal disease and coronary artery disease. 10/28/24 9:45 AM - An observation revealed a quarter length (22 inches) side rail on the left side of R76's bed. Review of R76's clinical record lacked evidence of the following: -the date that the bed rail was installed; -the medical need for the bed rail; -the attempt to use appropriate alternatives prior to installing the bed rail; -an assessment of R76 for the risk of entrapment from the bed rail prior to installation; -the presence of the informed consent for the use of a bed rail -review that the bed dimensions are appropriate for the resident's size and weight. (continued on next page)

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Springs Rehabilitation at Brandywine	505 Greenbank Road Wilmington, DE 19808

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/7/24 at 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates residents and determines if bed rails should be ordered. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. E66 stated that Rehab does not specify the size of the bed rail when it is communicated to maintenance that the resident was ordered a bed rail. During this interview, a request was made for R66 to send the surveyor all therapy bed rail documentation for R76, and the email that was sent to the IDT team and maintenance in reference to R76's bed rail. No further information was received from the facility. 7. Review of R119's clinical record revealed: 1/18/24 - R119 was admitted to the facility. 10/2/24 - R119's MDS documented that R119 had a BIMS of 10, indicating moderate cognitive impairment, and that R119 had a diagnosis of dementia. 10/28/24 10:13 AM - An observation revealed a quarter length (22 inches) side rail on the right side of R119's bed. Review of R119's clinical record lacked evidence of the following: -the date that the bed rail was installed; -the attempt to use appropriate alternatives prior to installing the bed rail; -an assessment of R119 for the risk of entrapment from the bed rail prior to installation; -the presence of the informed consent for the use of a bed rail -review that the bed dimensions are appropriate for the resident's size and weight. 11/7/24 1:30 PM - During an interview, E66 (Rehab Director) stated that rehabilitation evaluates residents and determines if bed rails should be ordered. E66 stated that he would send an email to the interdisciplinary team and maintenance staff. E66 stated that Rehab does not specify the size of the bed rail when it is communicated to maintenance that the resident was ordered a bed rail. During this interview, a request was made for R66 to send the surveyor all therapy bed rail documentation for R119 and the email that was sent to the IDT team and maintenance in reference to R119's bed rail. No further information was received from the facility. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 40264 Based on observation, interview and review of facility records, it was determined that the facility failed to ensure that a qualified person in charge was present during hours of Kitchen operation. Additionally, the facility failed to ensure that breakfast trays were provided to residents within 45 minutes of the facility's scheduled time for meals. Findings include: 1. 10/28/24 11:20 AM - In an interview, E33 (Regional Dietary Consultant) stated she was not sure if a food service member was present during hours of kitchen operation whenever E8 (Dietary Supervisor) takes off from work schedule. 11/1/24 8:45 AM - A review of the facility's dietary time cards from September 2024 through October 2024 revealed no members in the facility's food service department possessed valid Food Protection Manager certificates from an Accredited Food Safety Program on the following dates: - 9/7/24; - 9/8/24; - 9/21/24; - 9/22/24; - 10/5/24; - 10/10/24; - 10/24/24; and - 10/27/24. 11/1/24 10:21 AM - Findings were confirmed by E33 and E8. 11/12/24 2:35 PM - Findings were discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant). 2. 10/28/24 10:14 AM - An observation during breakfast on the B unit revealed that the meal delivery truck arrived after 10:00 AM. 10/29/24 10:24 AM - An observation during breakfast on the B unit revealed that the meal delivery truck arrived after 10:00 AM. 10/31/24 9:25 AM - In an interview, E63 (CNA) confirmed that the resident in the B unit were not getting their breakfast meals on time. E63 further stated, They are getting brunch and sometimes they get their breakfast meals very close to lunch time. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11/1/24 10:10 AM - Review of the facility's scheduled meal times for the residents in the B Unit, it was documented that the dinner meal was served beginning at 6:15 PM and the breakfast meal the following day was served beginning at 8:40 AM. 11/1/24 10:15 PM - Review of the facility Meal Truck Delivery Log for the B Unit from September 2024 through October 2024 revealed the following: - on 9/4/24, dinner was delivered at 5:40 PM. The following day, 9/5/24, breakfast was delivered at 10:09 AM; - on 9/14/24, no documentation of dinner delivery time. The following day, 9/15/24, breakfast was delivered at 10:36 AM; - on 10/17/24, dinner was delivered at 5:52 PM. The following day, 10/18/24, breakfast was delivered at 10:09 AM; - on 10/18/24, dinner was delivered at 5:50 PM. The following day, 10/19/24, breakfast was delivered at 10:14 AM; - on 10/19/24, dinner was delivered at 6:27 PM. The following day, 10/20/24, breakfast was delivered at 10:48 AM; - on 10/27/24, dinner was delivered at 5:14 PM. The following day, 10/28/24, breakfast was delivered at 10:15 AM and; - on 10/28/24, dinner was delivered at 6:07 PM. The following day, 10/29/24, breakfast was delivered at 10:29 AM. 11/1/24 11:21 AM - In an interview, E8 (Dietary Supervisor) confirmed that there were delays in the meal delivery times and that, . The kitchen staff need to be more efficient with time management starting at the tray line. 11/12/24 2:35 PM - Findings were discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant). 46134 2. 11/4/24 9:00 AM - During an interview, R78 stated that the lunch and dinner meals on Sunday 11/3/24 were both late in delivery and did not have reasonable portions or selection of foods. 11/4/24 3:15 PM - An email request was made to E1 (NHA) to provide the kitchen staff time cards for 11/2/24 and 11/3/24. 11/4/24 - A review of the facility dietary time cards for 11/3/24 revealed that no member in the facility's food service department possessed a valid Food Protection Manager certificate from an Accredited Food Safety Program on 11/3/24 during dinner preparation and service, between the hours 3:52 PM - 6:14 PM. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11/13/24 - During an interview, E1 (NHA) confirmed that E70 (kitchen cook), who was the cook in the kitchen during dinner preparation, did not possess a valid Food Protection Manager certificate from an Accredited Food Safety Program. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 40264 Based on observation, interview and record review, it was determined that for one (R141) out of 13 residents reviewed for food, the facility failed to ensure that R141's food was prepared and appropriate to meet R141's needs and according to his care plan. Findings include: Review of R141's clinical record revealed the following: 7/12/24 - R141 was admitted to the facility. 7/15/24 - R141 had a care plan developed for nutrition/hydration risk related to poor food intake by mouth and for potential for weight changes. R141's interventions included but not limited to monitor and to report to the physician . refusing to eat, appears concerned during meals and to provide and serve diet as ordered . 9/23/24 - R141 had a physician's order for regular diet regular texture, regular (thin) consistency diet for comfort feeding. 10/28/24 1:30 PM - An observation of R141's lunch tray revealed a plate with ground fried chicken with country gravy, buttered mashed potatoes, seasoned spinach, buttered dinner roll and diced pears. R141's meal ticket documented mechanical soft (texture). 10/28/24 1:31 PM - During an interview, R141 stated that he had been telling the nursing staff that he wanted to eat regular texture food, yet he continued to receive chopped and grounded baby food on his food tray. 10/28/24 1:35 PM - In an interview, E56 (LPN) stated that she was not aware if R141 was allowed to eat regular texture food. E56 confirmed that R141 had a mechanical soft texture meal served on [R141's] lunch tray. The facility failed to ensure that R141 received the prescribed and appropriate regular texture food during meals. 11/07/24 1:55 PM - Finding was confirmed by E47 (Regional Clinical Consultant). 11/12/24 2:35 PM - Finding was discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant).

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 40264 Based on observation, interview and record review, it was determined that for two (R141 and R78) out of 13 residents reviewed for food, the facility failed to accommodate a food preference. Findings include: 1. 10/28/24 1:15 PM - During an interview, R141 stated that a facility staff (not identified) came to see him that morning and showed him the day's lunch menu. R141 also stated that he told the staff that he did not want the primary menu which was fried chicken with gravy, mashed potatoes, seasoned spinach and dinner roll. R141 stated that he told the staff that for his lunch, he wanted to order the alternative tuna sandwich instead. 10/28/24 1:30 PM - An observation of R141's lunch tray revealed a plate with ground fried chicken with country gravy, buttered mashed potatoes, seasoned spinach, buttered dinner roll and diced pears. 10/28/24 1:35 PM - In an interview, E56 (LPN) stated that she was not aware that R141 had spoken to a facility staff earlier and had requested for the alternative tuna sandwich instead of the primary lunch menu. E56 confirmed that R141 had the following on his lunch tray: ground fried chicken with country gravy, buttered mashed potatoes, seasoned spinach, buttered dinner roll and diced pears. E56 further stated that she called the kitchen to request for R141's tuna sandwich. 11/1/24 10:21 AM - In an interview E8 (Dietary Supervisor) stated, . Sometimes alternative menus or other food requests are not done because they don't get to us or they (nursing/activity staff) don't drop the paper into the bin hung outside by the kitchen door. 11/1/24 11:15 AM - In an interview, E37 (Activities Staff) stated that every morning Activities staff give out packets to the residents with information including the day's breakfast, lunch and dinner menus. E37 further stated, If they don't like what's on the menu, they can refer to the Always Available Menu page with a list of alternative sandwiches, soups and salads. Sometimes we make the changes for them if they don't want what's on the list. We take the paper to the kitchen and drop it on the bin outside the kitchen by the door. 11/1/24 2:56 PM - During an interview, E31 (RD) stated that it's the Food Service Director's or Dietary Supervisor's responsibility to ask residents of their meal preference, or ask for alternative food in case residents don't want the primary menu. 11/12/24 2:35 PM - Findings were discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant). 46134 2. 11/1/24 11:00 AM - R78 reported that the facility breakfast meal is always determined by the kitchen, and that there are no alternative meal choices for breakfast. Additionally, there are no breakfast items on the always available menu. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/12/24 8:30 AM - During an interview, E28 (Food Service Director) confirmed that the facility does not have an alternative breakfast menu and that there are no breakfast items on the always available menu food list. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 32545 Based on observation, interview and record review, it was determined that for 10 (R6, R11, R14, R52, R69, R78, R99, R103, R105 and R106) out of 13 residents reviewed for food, the facility failed to provide each resident with drinks consistent with each residents' needs and preferences. Findings include: 1. R6's clinical record revealed: 10/29/24 10:50 AM - During an interview, R6 stated that fluids are not always offered during the day. R6 stated that I have to ask. Review of the facility form entitled Brandywine 3 C.N.A. assignment, revised 5/8/23, stated, . ALL ASSIGNMENTS PASS OUT YOUR OWN WATER . 11/6/24 12:16 PM - Surveyor observed R6 in bed with a white Styrofoam cup dated 11/5/24 7-3 PM sitting on her bedside table. During an interview, the Surveyor asked R6 if she was offered fresh water since the date and shift on the Styrofoam cup. R6 said No. The facility failed to offer water to R6 on the two prior shifts. 11/12/24 1:30 PM - Finding was reviewed with E1 (NHA), E2 (DON), E4 (LPN/QA/IC) and E47 (RCC). 40264 2. 10/31/24 - An observation on the B unit from 9:07 AM through 9:55 AM revealed the following residents' meal trays which did not include coffee or tea beverages contrary to what was indicated in their breakfast meal tickets: R14 - no coffee or hot tea; R106 - no coffee or hot tea; R105 - no coffee or hot tea; R52 - no unsweetened coffee or hot tea; R103 - no coffee or hot tea; R78 - no unsweetened coffee or hot tea; R99 - no coffee or hot tea; R11 - no coffee or hot tea; and (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R69 - no coffee or hot tea. 10/31/24 9:13 AM - During an interview, E65 (CNA) confirmed that R14, R106 and R105 did not have coffee nor tea on their meal trays. 10/31/24 9:23 AM - In an interview, E64 (CNA) confirmed that R52, R103, R78, R99, R11 and R69 did not have coffee nor tea on their meal trays. 10/31/24 9:40 AM - In a follow up interview, E64 also stated, It happens all the time that the residents on this (B) unit are not getting their coffee or tea. If the resident requests for it, then we go to the kitchen and ask. 11/1/24 10:21 AM - In an interview, E8 (Dietary Supervisor) stated that she was not aware that some residents in the B unit did not receive their hot coffee or hot tea beverages in their meal trays. E8 further confirmed that it was a breakdown in the kitchen system and that she will need to educate the kitchen staff on the use of the coffee machine. 11/6/24 3:50 PM - During interview, E34 (Regional Dietary Consultant) stated that if a resident's meal ticket indicated coffee or tea, then the resident should have coffee or tea in his/her meal tray. In nine (9) out of 27 residents on the B unit, the facility failed to ensure that other liquids, such as coffee or tea, were provided with their breakfast meal trays to encourage fluid intake. 11/12/24 2:35 PM - Finding was discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant).

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. 40264 Based on review of the facility's scheduled meal times and interview, it was determined that for two (R23 and R78) out of 13 residents reviewed for food, the facility failed to ensure that R23 and R78 received their evening snacks. Findings include: 1. Review of R23's clinical record revealed: 8/3/21 - R23 was admitted to the facility. 10/28/24 12:38 PM - In an interview, R23 told surveyor that she was not getting her bedtime or evening snacks. She further stated, You have to call the girls (nursing staff) and ask for food. I am a big girl, I always get hungry at night . When I asked from the girls, they told me that the kitchen people told them that there were no more snacks. 10/28/24 2:00 PM - Review of R23's CNA flowsheet from September 2024 through October 2024 revealed a lack of evidence that R23 was provided evening snacks. 11/1/24 4:05 PM - During interview, E42 (CNA) stated, . A few weeks ago . 2-3 times in a week there were no evening snacks . Sometimes we keep our back up oatmeal cookies or fudge in the Unit Manager's office but she (Unit Manager) locks the room after 3:00 PM. We were not able to access the back up snacks. Kitchen won't give us enough snacks to be distributed to the residents. 11/1/24 4:14 PM - In an interview, E43 (CNA) stated that they give out evening snacks but there were nights when the snacks were not enough. E41 confirmed and stated, . Sometimes we don't have anything to give at all . Other times we want to get the back up snacks in the Unit Manager's room but we can't go in because the room is locked. 46134 2. Cross refer F561 and F802, example 2 11/1/24 11:00 AM - During an interview, R78 stated that the facility does not always provide evening snacks. R78 stated that because the timing of each meal is unpredictable, and that bedtime snacks are sometimes not provided, she was aware that many of the residents in the facility stored food in their rooms. R78 stated that they cannot depend on the facility to provide their food or bedtime snacks timely. 11/13/24 3:00 PM - Findings were reviewed with E1 (NHA), E2 (DON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman's office.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40264 Based on observation and interview, it was determined that the facility failed to ensure food/items were stored and/or prepared under sanitary conditions. Findings include: 1. During the initial tour of the kitchen on 10/28/24 beginning at 9:00 AM, the following observations were made: - The walk-in freezer contained bread, ice cream, and debris on the floor; - The standard refrigerator near the entrance had a pink and orange substance spilled inside at the base; - The dry food storage room revealed three bags of onions, a bag of potatoes, and a container of icing stored on the floor; - A pan with meat that was to be seasoned was located on a table uncovered and unattended; - A prepared salad located inside the refrigerator without a date; - In the ware washing room, the table in the dish area where the clean dishes come out of the ware washing machine was covered in food debris; - In the ware washing room, clean plastic mugs were stored inside the room placing them at risk of exposure to splash and in a wet location. The plastic mugs had visible white spots on them; and - Paper towels were not available at the hand washing sink. A follow-up visit to the kitchen on 10/30/24 at 11:30 AM found: - The walk-in freezer with small containers of ice cream and muffins turned over on the floor; - A box of muffins was left partially uncovered; and - In the ware washing room, the table in the dish area where the clean dishes come out of the ware washing machine contained visible food debris. 2. 11/1/24 11:20 AM - An observation on the snack/nourishment refrigerator serving B, C, D and E units revealed a personal lunch bag and food items with no date and no label in Styrofoam inside an undated and unlabeled plastic bag. 11/1/24 11:23 AM - Findings were confirmed by E40 (RN). 11/12/24 2:35 PM - Findings were discussed with E1 (NHA), E2 (DON) and E47 (Regional Clinical Consultant).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47621 Based on record review and interview, it was determined that for eleven (R16, R18, R33, R38, R43, R55, R94, R113, R310, R456 and R457) out of forty-two residents reviewed for resident records, the facility failed to maintain complete, accurate and readily accessible resident medical records. Findings include: 1. Review of R38's clinical record revealed: 4/19/24 - R38 was admitted to the facility. 10/22/24 1:39 PM - R38's urine culture specimen that was ordered by E3 (MD) was received at the laboratory. 10/24/24 4:05 PM - R38's urine culture results were received at the facility stating 1 Organism growth. 10/24/24 11:21 PM -E52 (NP) documented in R38's EMR that the urine culture was reviewed. 11/12/24 12:53 PM - During an interview, E4 (LPN/IP) confirmed that [contracted laboratory] does not upload final culture results to the residents' EMR. The facility gets the final results and then sends the results in an email group to all the providers but it is not in the resident's records. 11/13/24 10:30 AM - The facility provided the surveyor with a copy of R38's 10/22/24 urine culture final microbiology report with sensitivity. 2. Cross refer F881, example 1 Review of R43's clinical record revealed: 9/20/24 - R43 was admitted to the facility. 10/10/24 1:00 PM - R43's urine culture specimen that was ordered by E3 (MD) was received at the laboratory. 10/12/24 3:20 PM - R43's urine culture results were received at the facility stating 1 Organism growth. 10/14/24 11:36 AM - E51 (NP) documented in R43's EMR that the urine culture was reviewed. 11/12/24 - The facility was not able to produce evidence of R43's 10/10/24 urine culture final microbiology report with sensitivity for the surveyor to review. 3. Review of R113's clinical record revealed: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/25/22 - R113 was admitted to the facility. 10/4/24 1:53 PM - R113's urine culture specimen that was ordered by E3 (MD) was received at the laboratory. 10/6/24 3:48 PM - R113's urine culture results were received at the facility stating 1 Organism growth. 10/14/24 11:36 AM - E21 (RN/UM) documented in R113's EMR that the urine culture was reviewed. 11/12/24 12:53 PM - During an interview, E4 (LPN/IP) confirmed that [contracted laboratory] does not upload final culture results to the residents' EMR. The facility gets the final results and then sends the results in an email group to all the providers but it is not in the resident's records. 11/13/24 10:30 AM - The facility provided the surveyor with a copy of R113's 10/4/24 urine culture final microbiology report with sensitivity. 4. Review of R33's clinical record revealed: 9/30/24 - R33 was admitted to the facility with diagnoses, including but not limited to, heart failure, morbid obesity and chronic atrial fibrillation (Afib). 9/30/24 - E3 (MD) ordered in R33's electronic medical record (EMR), Rivaroxaban oral tablet 20 mg (milligrams)- give one tablet by mouth one time a day for anticoagulant. Atrial fibrillation placed R33 at risk of having her blood clot. The goal of prescribing rivaroxaban was to prevent R33's blood from clotting or to place R33 in a state of anticoagulation. Anticoagulation is not a medical diagnosis; it is a physiologic state. However, R33's medical history included a diagnosis that was a medical indication for the drug rivaroxaban, Afib. Therefore, atrial fibrillation was the medical diagnosis for R33 requiring the drug, rivaroxaban. Anticoagulant was not an adequate indication/ medical diagnosis for the order for R33's rivaroxaban. 5. Review of R94's clinical record revealed: 6/6/24 - R94 was admitted to the facility with diagnoses, including but not limited to, chronic Afib, peripheral vascular disease and rheumatic mitral stenosis. 10/8/24 - E52 (NP) ordered in R94's EMR, Warfarin Sodium oral tablet 2 mg - give one tablet by mouth one time a day every Monday, Tuesday, Wednesday, Thursday for anticoagulation. E52 also ordered in R94's EMR Warfarin Sodium oral tablet 3 mg- give one tablet by mouth one time a day every Friday, Saturday, Sunday for blood thinner. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Atrial fibrillation placed R94 at risk of having her blood clot. The goal of prescribing warfarin was to prevent R94's blood from clotting or to place R94 in a state of anticoagulation. Anticoagulation is not a medical diagnosis; it is a physiologic state. However, R94's medical history of Afib was a medical indication for the drug warfarin. Therefore, atrial fibrillation was the medical diagnosis for R94 requiring the drug, warfarin. Anticoagulation and blood thinner were not adequate indications/ medical diagnoses for the order for R94's warfarin. 6. Review of R310's clinical record revealed: 10/18/24 - R310 was admitted to the facility with diagnoses, including but not limited to, chronic obstructive pulmonary disease (COPD) and history of pulmonary embolism (PE). 10/18/24 - E3 (MD) ordered in R310's EMR, Rivaroxaban oral tablet 20 mg - give one tablet by mouth one time a day for anticoagulant. A known history of PE placed R310 at risk of having her blood clot. The goal of prescribing rivaroxaban was to prevent R310's blood from clotting or to place R310 in a state of anticoagulation. Anticoagulation is not a medical diagnosis; it is a physiologic state. However, R310's medical history included a diagnosis that was a medical indication for the drug rivaroxaban, pulmonary embolism. Therefore, history of PE was the medical diagnosis for R310 requiring the drug, rivaroxaban. Anticoagulant was not an adequate indication/ medical diagnosis for the order for R310's rivaroxaban. 7. Review of R456's clinical record revealed: 10/27/24 - R456 was admitted to the facility with diagnoses, including but not limited to, chronic embolism and thrombosis and hyperlipidemia. 10/327/24 - E3 (MD) ordered in R456's EMR, Eliquis oral tablet 5 mg (apixaban)- give one tablet by mouth two times a day for anticoagulant therapy. The diagnoses of chronic embolism and thrombosis placed R456 at risk of having her blood clot. The goal of prescribing apixaban was to prevent R456's blood from clotting or to place R456 in a state of anticoagulation. Anticoagulation is not a medical diagnosis; it is a physiologic state. However, R456's medical history of chronic embolism and thrombosis was a medical indication for the drug apixaban. Therefore, chronic embolism and thrombosis was the medical diagnosis for R3456 requiring the drug, apixaban. Anticoagulant therapy was not an adequate indication/ medical diagnosis for the order for R456's apixaban. 8. Review of R457 s clinical record revealed: 10/12/24 - R457 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation and stroke. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/12/24 - E3 (MD) ordered in R457's EMR, Apixaban oral tablet 2.5 mg (apixaban) - give one tablet by mouth two times a day for anticoagulation. Atrial fibrillation placed R457 at risk of having his blood clot. The goal of prescribing apixaban was to prevent R457's blood from clotting or to place R457 in a state of anticoagulation. Anticoagulation is not a medical diagnosis; it is a physiologic state. However, R457's medical history included a diagnosis that was a medical indication for the drug apixaban, atrial fibrillation. Therefore, Afib was the medical diagnosis for R457 requiring the drug, apixaban. Anticoagulation was not an adequate indication/ medical diagnosis for the order for R457's apixaban. 11/1/24 3:36 PM - During a telephone interview, C1 (consultant Pharmacist) confirmed that anticoagulation, anticoagulant therapy, anticoagulant and/or blood thinner were not medical diagnoses that can be used as an indication for warfarin, rivaroxaban, apixaban or any other novel anticoagulants. 46134 9. Review of R18's clinical record revealed: 11/18/09 - R18 was admitted to the facility. 9/27/24 - R18's MDS documented that R18 had multiple diagnoses including dysphagia (difficulty swallowing), right sided paralysis following a stroke, and had had a feeding tube in place. 10/14/24 - A physician's order was written by E3 (Medical Director) for enteral feed overnight, with a continuous water flush of 52 mls every hour, while the enteral feed was running, for a total of 624 mls every 24 hours. A review of the November 2024 medication administration record revealed that the enteral feed water flush total amounts for 11/7/24 thru 11/12/24 were not documented. 11/12/24 10:12 AM - During an interview, E15 (RN) confirmed that for R18's enteral feed, the total amount of water flushes on the dates 11/7-11/12 24 inclusive were not recorded. 10. Review of R55's record revealed: 12/13/17 - R55 was admitted to the facility. 9/30/24 - R55's quarterly MDS documented that R55 had multiple diagnoses including dysphagia (difficulty swallowing), left sided paralysis following a stroke and had a feeding tube in place. 10/29/24 - A physician's order was written by E3 (Medical Director) for a 50 ml water flush to be given with the enteral feed, for a total of 1000 mls every 24 hours. A review of the November 2024 medication administration record revealed that the hourly 50 ml water flush was inaccurately documented on the following dates and shifts: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/1/24 11-7 shift - 400 ml was documented in each hourly water flush column at 1:00 AM and 2:00 AM, instead of the ordered 50 ml per hour 11/1/24 3-11 shift - 400 ml was documented in each hourly water flush column for 4:00 PM thru 10:00 PM, instead of the ordered 50 ml per hour. 11/2/24 3-11 shift - 400 ml was documented in each hourly water flush column for 4:00 PM thru 6:00 PM instead of the ordered 50 ml per hour. 11/6/24 1:30 PM - During an interview, E4 (LPN) confirmed the incorrect hourly documentation of 50 ml hourly water flushes above. 32545 11. R16's clinical record revealed: 11/5/20 (last reviewed on 6/10/24) - R16 was care planned for potential for skin impairment with an intervention to have nursing staff assist with incontinence care every 2 hours and as needed. 8/13/24 - The quarterly MDS assessment documented that R16 was cognitively intact with a BIMS of 12, frequently incontinent of bladder and required substantial/maximal assistance for toileting hygiene. 11/6/24 at 12:18 PM - During an interview with R16, the resident told the Surveyor that she should receive incontinence care every 2 hours, but this was not being done. Review of the CNA Kardex, as of 11/1/24, documented that R16 was on a Toileting Program 0500-0600 [5:00-6:00 AM], 0800-0900 [8:00-9:00 AM], 1400-1500 [2:00-3:00 PM], 2100-2200 [9:00-10:00 PM]. While R16's comprehensive care plan documented that the resident was to receive incontinence care every 2 hours, the CNA Kardex stated that R16 was on a toileting program. There was no evidence in R16's comprehensive care plan about a toileting program. The facility failed to ensure R16's CNA Kardex accurately reflected R16's incontinence care needs. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 47621 Based on record review and interview, it was determined that for seven (R14, R25, R92, R102, R120, R314 and R456) out of thirteen residents reviewed for infection control, the facility failed to maintain an infection control program that included enhanced barrier precautions for residents who met the criteria. In addition for R25, high-contact suprapubic care was provided on 10/31/24 without the staff wearing the appropriate PPE. Direct care was provided to R14 on 11/7/24 without the staff wearing appropriate PPE. An environmental tour confirmed several observations of infection control issues. Findings include: Facility's Infection Prevention and Control Program Policy: This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections as per accepted national standards and guidelines. (revised 1/2024) Facility's Enhanced Barrier Precautions Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multi-drug-resistant organisms (MDRO) .Policy Explanation and Compliance Guidelines: 2. Initiation of Enhanced Barrier Precautions- a. Nursing staff may place residents with certain conditions or devices on enhanced barrier precautions empirically while awaiting physician orders. B. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. wounds . and/or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO . 4. High-contact resident care activities include: . g. device care . 6. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals or indwelling medical device is removed. 1. Review of R25's clinical record revealed: 7/9/24- R25 was admitted to the facility with diagnoses, including but not limited to obstructive and reflux uropathy and suprapubic catheter in situ (in place). 7/9/24- E3 (MD) ordered in R25's electronic medical record (EMR), Cleanse suprapubic catheter site with NSS (normal saline solution), pat dry. Apply 4x4 gauze daily one time a day. 8/22/24 - E3 (MD) ordered in R25's EMR, Enhanced Barrier Precautions: related to suprapubic cath. 1. Gown. 2. Mask 3. Face shield (if splattering expected to occur) 4. Gloves every shift. 11/4/24 10:35 AM - Review of R25's order recap report lacked evidence of an order for enhanced barrier precautions during R25's admission from 7/9/24 until 8/22/24 despite R25 meeting criteria for enhanced barrier precautions by having an indwelling medical device. The facility failed to order and implement enhanced barrier precautions with R25 spending 46 days in the facility with an indwelling device (suprapubic catheter) without staff practicing enhanced barrier precautions during high-contact care activities for R25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/31/24 10:09 AM - Surveyor observed E26 (LPN) change the dressing on R25's suprapubic catheter without donning a gown. R25's suprapubic catheter care is a high-contact resident care activity and a gown should have been worn during this care. 2. Review of R92's clinical record revealed: 7/24/24 - R92 admitted to the facility with diagnoses, including but not limited to, calculus (stone) of the bile duct with acute cholecystitis with obstruction. 7/24/24 - E51 (NP) ordered in R92's EMR, Change the cholecystostomy tube drain dressing with gauze and tape every 5 days and PRN as needed if dressing is soiled or wet AND one time a day every 5 days. 7/28/24 - E52 (NP) ordered in R92's EMR, Flush cholecystostomy drain with 10 mls (milliliters) NS (normal saline) daily one time a day for cholecystitis. 11/4/24 9:46 AM - Review of R92's order recap report lacked evidence of an order for enhanced barrier precautions since R92 's admission on 7/24/24. The facility failed to order and implement enhanced barrier precautions for R92 spending 103 days in the facility with an indwelling device (cholecystostomy tube) without staff practicing enhanced barrier precautions during high-contact care activities. 3. Review of R102's clinical record revealed: 8/30/23 - R102 admitted to the facility with diagnoses, including but not limited to, end stage renal disease with dependence on hemodialysis. 12/27/23 - E3 (MD) ordered in R102's EMR, Type of access for dialysis and location: Hemodialysis right chest wall . 4/1/24 - Centers for Medicare & Medicaid Services (CMS) Enhanced Barriers in Nursing Homes regulation becomes effective. 4/27/24 - E3 (MD) placed R102's order, Type of access for dialysis and location: Hemodialysis right chest wall . on hold in the EMR. 4/27/24 to 5/21/24 - R102 was hospitalized . 5/21/24 - R102 readmitted to the facility. 8/27/24 to 9/14/24 - R102 was hospitalized . 9/17/24 - E3 (MD) ordered in R102's EMR, Type of access for dialysis and location: Hemodialysis right chest wall . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9/20/24 to 9/22/24 - R102 was admitted to the hospital. 9/22/24 - R102 was readmitted back to the facility. 11/7/24 12:59 PM - Review of R102's order recap report lacked evidence of an order for enhanced barrier precautions since 4/1/24. 4. Review of R120's clinical record revealed: 5/31/24 - R120 was admitted to the facility with diagnoses, including but not limited to, heart failure and rectal cancer. 5/31/24 - E51 (NP) ordered in R120's EMR, PICC (peripherally inserted central catheter) . flush with 5-10 ml (milliliters) . R120's PICC line was an indwelling medical device and enhanced barrier precautions should have been initiated. 6/22/24 - R120 was discharged from the facility to home. 11/7/24 4:22 PM - Review of R120's order recap report lacked evidence of an order for enhanced barrier precautions during R120's 5/31/24 to 6/22/24 admission. 5. Cross refer F881, example 3 Review of R314's clinical record revealed: 10/23/24 - R314 admitted to the facility with diagnoses including but not limited to, stroke and chronic osteomyelitis. 10/23/24 - E51 (NP) ordered in R314's EMR, Foley cath (catheter) care q (every) shift . R314's foley catheter qualified as an indwelling medical device and R314 should have been placed on enhanced barrier precautions. 10/25/24 - E3 (MD) documented in R314's admission history and physical, .He [R314] does have a left foot wound that he is being treated for osteomyelitis from podiatry .He is now on meropenem through November 7 . He does have a foley catheter placed . 11/11/24 4:41 PM - Review of R314's order recap report lacked evidence of an order for enhanced barrier precautions since R314's admission on 10/23/24. 6. Review of R456's clinical record revealed: 10/27/24 - R456 was admitted to the facility. 10/28/24 - E3 (MD) ordered in R456's EMR, Change suprapubic catheter . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R456's suprapubic catheter was an indwelling medical device and enhanced barrier precautions should have been initiated. 11/4/24 10:04 AM - During an interview, R456 confirmed that she had a suprapubic catheter. 11/4/24 9:40 AM - Review of R456's order recap report lacked evidence of an order for enhanced barrier precautions during R456's admission. 11/12/24 3:15 PM - During an interview, E4 (LPN/IP) stated, Just trying to be transparent, we did miss ordering EBP (enhanced barrier precautions) for R102, R456 and R92 . 32545 7. Review of R14's clinical record revealed: 9/5/24 at 2:17 PM - A progress note by E51 (NP) documented that R14 had a wound to the left lower extremity and returned from the hospital with sutures. Review of R14's EHR revealed that there was no enhanced barrier precaution (EBP) physician's order for the significant wound. However, there was an active EBP physician's order, dated 12/12/23, for ESBL in the urine. 11/6/24 - Review of the CNA Kardex for R14 lacked evidence to use EBP when providing R14 direct care. 11/7/24 at 4:50 AM - Surveyor observation of R14's nameplate outside her room indicated an orange sticker next to her name. Surveyor observed incontinence care provided by E67 (CNA) at this time. R14 still had the wound. E67 did not apply a gown prior to providing incontinence care to R14. Surveyor also observed that no PPE (gown, mask) were placed in the resident's room for staff to don before providing direct care. 11/7/24 at 5:40 AM - During an interview, Surveyor asked E69 (RN, Night shift Supervisor) standing outside R14's room what the orange sticker next to her name represented. E69 replied, I am going to check and walked away from the Surveyor back to the nurse's station. 11/7/24 at 5:41 AM - During a combined interview with E67 (CNA) and E68 (CNA), Surveyor asked each CNA what the orange sticker next to R14's name represented. E68 stated it is for precautions and PPE is behind the door. E67 stated that she did not know. 11/7/24 at 5:45 AM - During a follow-up interview, E69 returned to the Surveyor, who was still standing outside R14's room in the hallway. E69 stated that the orange sticker was for EBP. E69 stated that she was not sure if precautions were needed when providing direct care as R14's wound is covered. Immediately confirmed with E69 that there was no PPE available in R14's room for staff to use. 11/7/24 at 8:21 AM - Surveyor observed R14's scheduled shower with E9 (LPN) and E71 (CNA). E9 removed R14's wound dressing and was wearing appropriate PPE. However, E71 only wore gloves and showered R14. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/7/24 at approximately 8:45 AM - Findings were reviewed with E4 (LPN/QA/IC). 8. On 11/7/24 from 3:42 PM to 4:10 PM, an environmental tour was conducted with E17 (Regional Maintenance Director) and E18 (Environmental Services Director). The following were reviewed and confirmed. - R14's bed frame and left sided quarter bed rail was covered with a gray styrofoam that could not be cleaned properly. - R41's shared bathroom had two uncovered plastic wash bins sitting directly on the stained and dusty floor. - Surveyor reviewed with E17 as R67's room was inaccessible at the time that the resident also had gray styrofoam padding on the right sided grab bar too. E17 acknowledged this finding and would take care of it. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 47621 Based on record review and interview, it was determined that for three (R147, R307 and F606) out of twenty-one residents reviewed for antibiotic stewardship, the facility failed to ensure that antibiotics were prescribed in accordance with recognized standards. For R606 the facility also failed to ensure the antibiotic was placed on the line list. Findings include: Facility's Infection Prevention and Control Program Policy: . 3. Surveillance: a. A system of surveillance for prevention, identifying, reporting, investigating and controlling infections and communicable diseases for all residents . based on national standards . 6. Antibiotic Stewardship: b. Antibiotic use protocols and a system to monitor antibiotics use will be implemented as part of the antibiotic stewardship program. (revised 1/2024) McGeer's Criteria for Infection Surveillance: Syndrome - UTI with indwelling catheter Criteria- Must fulfill both 1 and 2. 1. At least one of the following sign or symptom: - fever, rigors, or new onset hypotension, with no alternate site of infection - either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis - new-onset suprapubic pain or costovertebral angle pain or tenderness - purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate 2. Urinary catheter specimen culture with > or = 105 cfu/ml of any organism(s) 1. Review of R147's clinical record revealed: 9/10/24 - R147 was admitted to the facility with diagnoses, including but not limited to, bladder cancer. 9/27/24 - E3 (MD) ordered in R147's EMR, 20-24 French Coude catheter for obstructive uropathy . 10/16/24 - E52 (NP) ordered in R147's EMR, Cephalexin oral capsule 500 mg (milligrams) - give 1 capsule by mouth two times a day for UTI until 10/23/24. Administer x 7 days. 10/18/24 2:05 PM - E52 discontinued the cephalexin order in R147's EMR. 10/18/24 - E52 (NP) ordered in R147's EMR, Levaquin oral tablet 500 mg (levofloxacin)- give 1 tablet by mouth one time a day for (sic) administer X 7 days until 10/26/24. (continued on next page)

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	085004	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs Rehabilitation at Brandywine	505 Greenbank Road Wilmington, DE 19808

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/11/24 2:35 PM - Review of R147's EMR lacked evidence of a urine culture specimen order or results for R147 at any time around 10/14 to 10/26/24. 11/12/24 3:15 PM - During an interview, E4 (LPN/IP) stated, Just trying to be transparent . for [R147], I have no idea why the NP (nurse practitioner) put him on cephalexin and Levaquin. We don't have a urine. I asked several times and never got a response. 2. Review of R307's clinical records revealed: 10/24/24 - R307 readmitted to the facility from the hospital. R307's Interagency Discharge Orders documented R307 as being admitted to the hospital for a catheter-associated urinary tract infection and also stated that R307 has a chronic indwelling foley catheter. 10/30/24 1:48 PM - During an interview, E4 confirmed that he was the facility's Infection Preventionist. He stated that the facility utilized the McGeer Criteria for Infection Surveillance to promote antibiotic stewardship. 11/6/24 - E52 (NP) ordered in R307's EMR, UA (urinalysis) and C&S (culture & sensitivities) . for infection . 11/8/24 1:43 PM - R307's urine culture results were received at the facility stating 1 Organism growth. 11/8/24 - E52 (NP) ordered in R307's EMR, Cipro oral tablet 500 mg- give 1 tablet by mouth every 12 hours for infection until 11/16/24. 11/12/24 - The facility was not able to produce evidence of R307's 11/6/24 urine culture final microbiology report with sensitivity for the surveyor to review because they were awaiting final culture read. Without the final microbiology culture read with the cfu/ml numbers, R307 did not meet McGeer's Criteria for Infection Surveillance for UTI with indwelling catheter. 39058 3. Review of R606's record revealed: 1/25/24 11:58 AM - A physician progress note documented R606 as having Recent fever History Of Present Illness: . here for long-term care was to be discharged to assisted living yesterday [on 1/24/24]. Resident [R606] developed fever and shaking. Resident was given 1 g Rocephin [antibiotic]. Resident seen this morning sitting in his wheelchair no acute distress. Resident appears back to baseline. Resident reports he is slightly anxious. 1/25/2024 11:15 AM - A physicians order for R606 to inject 1 gram of CefTRIAXone Sodium Solution an antibiotic intramuscularly one time for COPD exacerbation for one day. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/7/24 11:55 AM - Review of the January line list lacked evidence of R606's antibiotic and what infection R606 was being treated for with Rocephin 1 gram. Also, the facility lacked evidence of laboratory or radiology reports to confirm what infection. 11/08/24 10:17 AM - A brief interview with E3 (MD) revealed that sometimes a one time dose of IM CefTRIAXone (antibiotics) is given if a resident is sick enough. It was further revealed the length of time it takes to get the lab test or a chest xray for confirmation it could be later at night or the next day. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interview, it was determined that for four (R15, R33, R102 and R138) out of eight residents reviewed for vaccines, the facility failed to have evidence in each resident's medical record the administration of the influenza and/or pneumococcal vaccines. Findings include: Facility's Infection Prevention and Control Program- . 7. Influenza and Pneumococcal Immunization: . b. Residents will be offered the pneumococcal vaccines recommended by the CDC (Center for Disease Control) upon admission, unless contraindicated or received the vaccines elsewhere . e. Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations. (revised 1/2024) 1. Review of R15's clinical record revealed: 9/20/23 - R15, aged [AGE] years, was admitted to the facility. 9/20/23 - E3 (MD) documented an order to give pneumococcal vaccine IM (intramuscularly). 10/30/24 10:35 AM - Review of R15's electronic medical record (EMR) revealed that no pneumococcal vaccine was offered to R15. The facility failed to offer R15 the pneumococcal vaccine. 2. Review of R33's clinical record revealed: 9/30/24 - R33, aged [AGE] years, was admitted to the facility. 10/30/24 10:35 AM - Review of R33's EMR lacked evidence that the pneumococcal vaccine was up-to-dated or offered. 10/30/24 11:00 AM - Review of the DELVAX website, the State of Delaware public immunization portal, revealed R33 as having received PPV23 on 5/21/16, PCV13 on 1/23/19 and PCV20 on 6/17/22. This series of vaccines reflected a complete pneumococcal vaccine schedule; however, R33's EMR failed to include the documentation of R33's pneumococcal immunization status. 3. Review of R102's clinical record revealed: 8/30/23 - R102, aged [AGE] years, admitted to the facility. 10/30/24 10:35 AM - Review of R102's EMR revealed that no pneumococcal vaccine was documented for R102. 10/30/24 11:00 AM - Review of the DELVAX website revealed R102 as having received PCV20 on 10/5/23. R102's EMR failed to include the documentation of R102's pneumococcal immunization status. 4. Review of R138's clinical record: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/1/24 - R138, aged [AGE] years, was admitted to the facility. 10/30/24 10:35 AM - Review of R138's EMR revealed no pneumococcal vaccine for R138 or that she had refused the vaccine. 10/30/24 11:00 AM - Review of the DELVAX website revealed R138 as having received PCV13 on 4/2/18. Per the CDC adult Pneumococcal vaccine schedule, R138 was due for PCV20 upon admission to the facility. The facility was not able to provide evidence of R138's declination of the pneumococcal vaccine. 10/31/24 11:40 AM - During an interview, E4 (Infection Preventionist) confirmed that the facility had not held a vaccine clinic last year. The last IP (Infection Preventionist) had not kept up with it but we are trying to get back on track. E4 confirmed that R15 had not had a pneumococcal vaccine but her family consented to give it to her at the upcoming vaccine clinic. E4 confirmed that R33, R102 and R138 all had pneumococcal vaccines documented in DELVAX but not in the facility's EMR. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interview, it was determined that for two (R25 and R33) out of eight residents reviewed for vaccines, the facility failed to record R25 and R33's COVID vaccines in their medical records. Findings include: Facility's Infection Prevention and Control program- . COVID-19 Immunization: . f. Documentation will reflect the education provided and details regarding whether or not the resident or staff received the vaccine. (revised 1/2024) 1. Review of R25's clinical record revealed: 7/9/24 - R25, aged [AGE] years, was admitted to the facility. 10/30/24 10:35 AM - Review of R25's electronic medical record (EMR) revealed no COVID-19 vaccines were documented as administered to R25. 10/30/24 11:00 AM - Review of the DELVAX website, the State of Delaware public immunization portal, revealed R25 as having received the COVID-19 vaccine on the following dates: 2/17/21, 3/17/21, 12/15/21 and 8/15/22. The facility was unable to provide evidence of R25's education and declination of the COVID vaccine. 2. Review of R33's clinical record revealed: 10/30/24 10:35 AM - Review of R33's EMR revealed no COVID-19 vaccines were documented as administered to R33. 10/30/24 11:00 AM - Review of the DELVAX website revealed R33 as having received the COVID-19 vaccine on the following dates: 11/19/21, 10/4/22 and 10/13/23. The facility was unable to provide evidence of R33's education and declination of the COVID vaccine. 10/31/24 11:40 AM - During an interview, E4 (Infection Preventionist) confirmed that the facility had not held a vaccine clinic last year. The last IP (Infection Preventionist) had not kept up with it but we are trying to get back on track. E4 confirmed that R25 and R33 had received COVID-19 vaccines that were documented in DELVAX but not in the facility's EMR. 11/13/24 1:30 PM - Findings were reviewed with E1 (NHA), E2 (DON), E27 (ADON), E47 (RCC), E58 (RDO) and a representative from the Ombudsman office.