STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regal Heights Healthcare & Rehab Center	6525 Lancaster Pike Hockessin, DE 19707

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47621 Based on record review and interview it was determined that for three (R15, R19, R20) out of seven residents reviewed for falls, the facility failed to meet professional standards of the Delaware Board of Nursing Scope of practice by failing to have a registered nurse (RN) complete and document an RN post- fall assessment . Findings include: Delaware State Board of Nursing - RN, LPN and NA/UAP Duties 2024 . RN (registered nurse) .post-fall assessment and documentation . 1. Review of R15's clinical record revealed: 3/31/18 - R15 was admitted to the facility with diagnoses, including but not limited to, stroke and difficulty walking. 4/28/24 5:40 AM - E12 (LPN) documented in R15's EMR (electronic medical record), While standing at the med cart, a loud thump could be heard .she [R15] could be seen laying on the floor, the supervisor was then called to the room to assess the resident. The resident was assessed and vitals were taken . 4/28/24 6:30 AM - E12 (LPN) documented in R15's EMR, left with EMS (emergency medical services). Review of R15's EMR progress notes after the 4/28/24 fall lacked evidence of any documentation by a registered nurse (RN) of the State required post-fall assessment. 2. Review of R19's clinical record revealed: 6/7/24 - R19 was admitted to the facility with diagnoses, including but not limited to, dementia and difficulty walking. 2/3/25 8:08 PM - E13 (LPN) documented in R19's EMR, . while doing night medication pass when I heard a loud noise coming from [R19]'s room. Upon arrival resident was noted on the floor close to the doorway with wheelchair behind him. Resident [R19] states 'I was trying to get into my cart (wheelchair) and I fell .' House supervisor notified. Resident assessed for pain and injuries, Vital signs taken . (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R19's EMR progress notes after the 2/3/25 fall lacked evidence of any documentation by a registered nurse (RN) of the State required post-fall assessment. 3. Review of R20's clinical record revealed: 1/7/25 - R20 was admitted to the facility with diagnoses, including but not limited to, dementia and difficulty walking. 1/20/25 1:27 PM - E3 (LPN) documented in R20's EMR, Nurse contacted nephew. He was informed that resident had a fall and was taken to the hospital. NP was also made aware that the resident was taken to the hospital. Review of R20's EMR progress notes after the 1/20/25 fall lacked evidence of any documentation by a registered nurse (RN) of the State required post-fall assessment. 2/10/25 12:03 PM - During an interview, E9 (Corporate Risk Manager) stated, The facility incident report is not part of the resident's EMR. They are an internal document. They do not appear in the resident's progress notes or chart.' 2/10/25 - 1:30 PM - During an interview, E1 (NHA) confirmed that the facility did not have documentation from an RN regarding R15's 4/28/24 fall, R19's 2/3/25 fall and R20's 1/20/25 fall. 2/10/25 2:23 PM - Findings were reviewed during exit conference with E1 (NHA), E2 (DON), E6 (ADON), E9 (Corporate Risk Manager) and E8 (Corporate IP/SP).

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review, interview and review of other related documents, it was determined that for one (R10) out of nine residents reviewed for accidents, the facility failed to provide R10 adequate supervision and assistance to prevent burns. This resulted in harm to R10 as he sustained second-degree burns over 15-20 % of his body surface area. This is being brought forward as past non-compliance with an alleged date of compliance of 10/13/24. Findings include: 2/18/19 - R10 was admitted to the facility with diagnoses, including but not limited to, Alzheimer's disease. 3/1/22 - R10's care plan documented, [R10] has impaired verbal communication R/T (related to) cognitive loss . Interventions: . Assess resident's non-verbal behaviors, such as facial expressions, body language, grimacing and increased restlessness . Face resident when communicating . 9/5/24 2:48 PM -E17 (Psych NP) documented in R10's EMR in a Psychiatric Periodic Evaluation note, XXX[AGE] year old male .[R10] is noted with severe cognitive impairment and non-verbal throughout . Mental Status Evaluation - Sensorium: alert, Orientation: person, Speech: non-verbal, Affect: dull, . 9/13/24 -R10's MDS revealed a BIMS score of 0, which is reflective of severe cognitive impairment. 10/3/24 5:05 PM - E19 (LPN) documented in R10's EMR in a health status note, Called to shower room by assigned CNA [E20], same [E20] stated 'after giving resident shower and drying him off, he noticed that resident skin (sic) became very red.' This nurse [E19] noticed redness and skin peeling on resident (sic) face, neck, forehead, chest and upper upper (sic) left shoulder, this writer immediately called supervisor on duty. Resident taken to his room. No s/s (signs/symptoms) of pain noted. Vs (vital signs) obtained 133/57, 78, 97.6, 20, 96%. NP [E16] made aware. New order obtained to send resident to ER (emergency room) for evaluation, apply (sic) cold towels and wash rags to affected area, responsible party wife [F1] made aware. resident left facility @ 5:38 PM via 911 on stretcher. 10/3/24 5:33 PM - In R10's prehospital care report, C2 (EMT) documented, At 5:33 PM, the patient [R10] was found lying in bed alert, but mental status was unable to be performed due to patient being nonverbal at baseline . Skin- red with multiple burns. Nurse reported to EMS crew that the patient's skin was red and peeling. Upon further assessment, it was noted that the patient had multiple first-degree burns on his body along with second -degree burns. The first first-degree burns were all over his body to include the chest, abdomen and head. The second-degree burns were again found in multiple areas differentiating in size with some blisters noted both open and closed. The nurse stated that the pt (patient) came out of the shower this way, and that the aid (sic) took him into the shower to clean him up and when he got out of the shower and back in bed they noted his skin red all over with some areas peeling and blistering. She stated the water must have been to (sic) hot .The nurse was unable to tell us how this happened other than it happened in the shower when the aid (sic) took him to give a shower, and she was unable to say if he [R10] was left in there unattended or not. As baseline this patient is a full care patient and is unable to care for himself, is nonverbal and unable to follow direct commands at baseline .Med report was called to [hospital] to request forensic nurse and trauma eval (evaluation) . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	10/3/24 approx. 5:35 PM - Per the facility's abateman plan, At approximately 5:35 PM, [E4, Maintenance director] checked the temperature of the hot water. [E4] noted the temperature to be above 120 degrees and attempted an adjustment first and the temperature did not change. [E4] then immediately shut off the hot water to the building. 10/3/24 6:12 PM - C4 (hospital FNE RN) documented on R10's hospital forensic examination, pt (patient) nonverbal at baseline, unable to provide any details of events. Per wife [F1], pt with hx (history) (sic) dementia, non-ambulatory and totally dependent on facility staff for care. Areas of second degrees burns with blistering notable on exam. Unknown duration of thermal exposure. The hospital FNE nurse documented R10's burns with photographs and written descriptions as follows. DSC_0001 (face picture) was described as generalized superficial burn to head/face. DSC_0002 (left ear/cheek picture) was described as partial thickness burn with area of blisters and measured a 5 cm X 4 cm area of superficial partial thickness burn to L (left) cheek. DSC_0003 and DSC_0004 (right ear/cheek picture) were described as 2 cm X 2 cm area of superficial partial thickness burn. DSC_0005 and DSC_0006 (top of head pictures) were described as area of redness. DSC_0007, DSC_0008, DSC_0009, DSC_0010, DSC_0012, DSC_0018 (left clavicle/chest/neck pictures) were described as superficial burn generalized to neck, chest and abdomen with sparing noted to skin folds, area of 2 cm X 3 cm partial thickness burn to L chest. DSC_0011 (right inner upper arm picture) was described as superficial burn. DSC_0013, DSC_0014, DSC_0016, DSC_0019, DSC_0020, DSC_0021 (bilateral shoulders/back pictures) were described as generalized superficial burn to upper back with 4 cm X 4 Cm area of partial thickness burn to upper L back and 4 cm X 2 cm partial thickness burn to R (right) upper back. DSC_0017 and DSC_0023 (nose pictures) were described as circular partial thickness burn. DSC_0015, DSC_0022 (right/left ears pictures) were described as superficial burns behind R ear and L ear. 10/3/24 6:43 PM - In the ED (Emergency Department) Teaching Physician Record, C1 (hospital emergency room physician) documented, [AGE] year old male arriving per EMS for evaluation of second -degree burns. Patient has a history of CVA (stroke), is bedbound at baseline, nonverbal at baseline, and all his ADLs (activities of daily living) are provided by nursing home staff. Per nursing home, patient was found in the shower with reddened skin to face, chest and shoulders and upper back .roughly 15 to 20% surface area burns . However, secondary burns are very mild in nature and do not suspect he would require transfer to burn center at this time . 10/4/24 6:30 AM - E21 (LPN) documented in R10's EMR, Late entry. Resident [R10] arrived back to facility from hospital at 4:17 AM via stretcher, vital signs WNL (within normal limits) 126/73, O2 98%, HR 101, temp 97.4. Residents (sic) show no nonverbal signs of pain or discomfort, was able to take meds as needed without any issues, no new skin issues outside burns to face and shoulders. Orders to not remove bandage until follow-up with [physician] at the burn center in 1-2 days. Resident is in room resting in bed, with call bell in reach, bed in lowest position. 2/6/25 2:39 PM - During an interview, E19 (LPN) stated, There were two CNAs who showered [R10]. [E20 (CNA)] was orienting [E22 (CNA)], who was a new hire. They were with him the hole time. I was not in the shower room during the shower. I was called into the shower room to perform a skin check. His [R10] skin was red in the face and even his arm. His chest and shoulder was peeling . [R10] was in a reclining shower chair with the seat having a hole so the water drained. I think the water was malfunctioning, going hot then cold. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	2/7/25 10:38 AM - During a telephone interview, F1 stated, . I never said it was intentional .maybe negligent but not intentional . My husband is able to move his head back and forth and he does very occasionally moan or groan but you don't know why he is doing it. He would not be able to groan when hot water hit him. 2/7/25 11:25 AM - During a telephone interview, E20 (CNA) stated, . It was me and another aide [E22] that I was orienting. She [E22] was there the whole time. I checked the temperature of the water twice once with my gloved hand and then on my bare wrist. The water was fine when we started the shower. We started with his head to wash his hair. He was in a reclining shampoo chair so we could tilt him back and just wash his head first. He uses a special shampoo. So I wet his hair, then I put the shower head the grab bar and the wall spraying the wall, while I lathered up his hair. I washed the shampoo out of his hair. I don't remember if I checked the water temp again before washing the shampoo out. I noticed the redness when I was drying him. So I sent [E22] to get the nurse to do a skin check. Once he was back in bed, [E19 LPN] was busy putting cool towels on him so I left the room. 2/7/25 12:49 PM - During an interview, E4 (Maintenance Director) stated, We don't know the actual temperature of the hot water when the mixing valve was defective, because the thermometer on the thermostat only goes to 120 degrees. All I can say is it was greater than 120 degrees. E4 also clarified that the temperatures were in degrees Fahrenheit. The facility did the following as a result of this incident: - 10/3/24 at approximately 5:15 PM - E2 (DON) put all showers/baths on hold within the facility. - 10/3/24 at 5:35 PM- E4 (Maintenance Director) checked the hot water temperature and once confirmed it was out of range, E4 shut down the hot water supply in the facility. - 10/3/24 6:00 PM - E4 replaced the problematic mixing valve to the hot water heating system. - 10/3/24 during 3 - 11 PM shift, E2 (DON) started educating the direct care staff regarding testing the water temperature prior to patient care and the risk factors of the elderly for receiving burns. Education of the entire direct staff continued until 10/13/24, when all staff had been educated. - 10/4 24 at 12:01 PM - E5 (Corporate facilities manager) and [plumbing contractor] technician were on site to check the operation of the facility water mixing valve. No issues were found with the water temperature. The old mixing valve cartridge was examined and found to have sediment stuck in the valve body/spring, which affected its function. This service call lasted 3 hours. -10/4/24 2 PM - A risk management meeting was conducted with the Medical Director regarding this incident. - The facility installed water temperature safety gauges on all shower heads in the facility that notify the resident and the care provider by the color of gauge light whether the water temperature is in a safe temperature range. - Additionally, E1 (NHA) and E4 (maintenance director) monitored the facility's water temperature daily on all units for 2 consecutive weeks, then weekly for 3 weeks and then monthly to confirm 100% compliance with the water temperatures being less than 110 degrees F. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- These audit logs were presented at the QAPI steering committee meetings. The date of abatement completion was 10/13/24 at 3:30 PM. The surveyor confirmed these interventions were completed during the survey with review of trainings logs,document review and interview. 2/10/25 2:23 PM - Findings were reviewed during exit conference with E1 (NHA), E2 (DON), E6 (ADON), E9 (Corporate Risk Manager) and E8 (Corporate IP/SP).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46134 Based on record review, interview and review of other facility documents as indicated, it was determined that the facility failed to ensure that one (R14) out of one resident was provided respiratory care consistent with physician's orders. Findings include: 6/6/22 - R14 was admitted to the facility with multiple diagnoses, including Chronic Obstructive Pulmonary Disease (COPD), and dysphonia (difficult speech). R14's admission MDS documented R14's speech clarity as being no speech, absence of spoken words. On 6/7/24 the following progress notes were written: 10:37 AM - E14 (LPN) wrote that at 10:30 AM R14 wrote a note was complaining of having a hard time breathing and that E14 and E15 (RN) assessed [R14's] oxygen level to be in the low 70's, with an elevated heart rate of 104. We got her to calm down so she could control her breathing which worked her 02 started increasing to low 80's, reached out to NP to obtain a stat chest x-ray and some oxygen. 10:51AM - E14 wrote that R14 was still having a hard time breathing, after taking a listen to her he (sic) is wheezing and her 02 is still in the 70's . She is being sent out to the hospital, due to respiratory distress. 2/6/25 10:15 AM - A review of the Electronic medical record (EMR) for R14's medication orders revealed the following respiratory medications were ordered for R14 on 6/7/22: -Trelegy Ellipta, inhale by mouth daily one time a day for COPD; -albuterol sulfate, 1 puff inhale orally every 6 hours as needed for SOB (shortness of breath). 2/6/25 10:20 AM - A review of R14's EMR June 2024 medication administration record (MAR) revealed that on 6/7/24, the day that R14 experienced respiratory distress, R14 was never administered the as needed for shortness of breath medication abuterol during the time she experienced respiratory distress. The albuterol medication was never administered to R14 prior to the time that she was sent to the hospital emergently for respiratory distress. 2/6/25 2:45 PM - During an interview, E14 confirmed that Albuterol was not administered to R14 during the time that R14 experienced respiratory distress on 6/7/24 2/10/25 2:23 PM - Findings were reviewed during the exit conference with E1(NHA), E2 (DON), E6 (ADON), E9 (Corporate Risk Manager) and E8 (Corporate IP/SP).

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F 0697 Level of Harm - Minimal harm or potential for 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** 51357 Based on interview and record review, it was determined that for one (R12) out of one residents sampled for pain management, the facility failed to monitor the resident's pain to the extent possible in accordance with the comprehensive assessment and care plan, and current professional standards of practice. Findings include: 4/4/22 - R12 admitted to the facility with a diagnosis of dementia. 2/5/25 - a review of R12's care plan dated 4/4/22 reveals that staff should assess for verbal or non-verbal signs and symptoms of pain. A review of R12's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS)could not be conducted because the resident is rarely/never understood. The same MDS identifies R12's Speech Clarity: Unclear speech - slurred or mumbled words; Ability to express ideas and wants: Rarely/never understood; Ability to Understand others: Rarely/never understands. 8/29/24 - R12 admitted to hospice. 9/22/24 - At approximately 7:20 PM, nurse aides providing care reported to the charge nurse swelling and bruising to resident's right knee as well as a skin tear. The charge nurse reported this to the nursing supervisor. R12 was administered 650 milligrams of as needed Tylenol. 9/22/24 9:47 PM and 10:41 PM - resident's pain level was assessed utilizing a numerical pain scale and documented as 4/10, moderate pain, even though R12's speech clarity was rated as Unclear and her ability to understand others was Rarely/never understands. A numerical pain scale requires the ability to self-report their pain. 9/23/24 - 7:17 AM Record review revealed R12 continues (sic) monitoring for a skin tear to left lower leg. Resident is in bed with her eyes closed with no apparent distress at this time. Vital signs recorded: blood pressure 123/74, temperature 97.8, and pulse 69. 9/23/24 11:13 AM - Resident's pain was assessed and rated at 8/10 (severe pain) and 5 milligrams of morphine sulfate was administered orally, even though there is no evidence that a non-verbal assessment of pain was performed. 9/23/24 - An x-ray was obtained at approximately 11:23 AM that revealed a distal femur fracture. Family, hospice, and provider informed, and resident was transferred to a higher level of care. 2/7/25 1:45 PM - An interview with E2 (DON) confirmed that when there is an injury of unknown origin, a full assessment must be performed. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A full assessment would include a pain assessment utilizing tools appropriate for assessing a resident with severe cognitive deficits who has difficulty understanding and being understood verbally. R12 was care planned for the potential for impaired verbal communication, but the facility failed to utilize a pain monitoring instrument (such as the PAINAD scale, which is a pain measurement tool for people with advanced dementia) that aligned with the communication deficits that were identified in the care plan and the MDS. 2/10/25 2:23 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E6 (ADON), E7 (Corporate Risk Manager) and E8 (Corporate IP/SP).

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51357 Based on interview and record review, it was determined that for one (R1) out of seven residents reviewed for falls, the facility failed to have complete, readily accessible medical records regarding the required post-fall assessment. Findings include: Review of R1's clinical record revealed: 12/10/07 - R1 admitted to facility for CAD (coronary artery disease), HTN (hypertension), PVD (peripheral vascular disease), and right-sided hemiplegia. 10/2/24 - Progress note entered by E11 (RN, charge nurse) at approximately 8:45 PM revealed R1 was found on the floor of his room. He explained to staff that he was removing the footrests from his wheelchair in preparation for going to bed as he does every night. He leaned forward too far and fell out of his chair and onto the floor. R1 has a BIMS of 15 (indicating a resident is cognitively intact), according to his MDS dated [DATE]. 10/2/24 8:56 PM - Progress note entered by E11 (RN, charge nurse) states Resident assessed with small skin tear to right lower leg .resident denies pain. 2/7/25 - Record review revealed no comprehensive assessment (vital signs, focused assessment, or range of motion) documented in R1's chart. 2/10/25 - Findings were confirmed with E2 (DON). 2/10/25 2:23 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E6 (ADON), E9 (Corporate Risk Manager) and E8 (Corporate IP/SP).

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interview, it was determined that for one (R10) out of twenty-eight residents reviewed for environment, the facility failed to maintain the water supply/patient care equipment was in safe operating condition. Findings include: Facility 's Safety of Water Temperatures policy- Domestic water in the facility shall be kept within a temperature range of 95-110 degrees to prevent scalding of residents and to maintain temps (temperatures) for infection control and good handwashing practices . 2. Mixing valves are to be set at 110 degrees to ensure domestic water temperatures are provided to resident rooms, bathroom common area fixtures and shower/tub rooms . 3. Maintenance staff are responsible for checking thermostats, mixing valves and temperature controls in the facility. 4. Maintenance staff shall conduct daily water temperature checks and record the water temperature in a water temperature log . 6. Recordings will be taken on each wing or floor, the date, time and location is to be recorded by an employee.7. If at any time water temperature feel excessive to the touch .staff will report this finding to the immediate supervisor, Maintenance director and NHA. 8. If at any time water temperatures are above 110 degrees, water source/fixture will be shut down immediately . 10. The length of exposure to warm or hot water, the amount of skin exposed, and the resident's current condition affect whether or not exposure to certain temperatures will cause scalding or burns. Therefore, ongoing resident observation and assessment during prolonged exposure to warm or hot water will help to determine the safety of the situation .12. If a resident is scalded or burned, nursing staff shall follow pertinent first aid and physician notification protocols and report the injury to his or her direct supervisor. Revision date: December 2009 10/4/24 - The appointment summary/ work order (service call ID 241004-0018) from [plumbing/HVAC/R contractor] stated, Hot water mixing valve- Symmons MN 7-900NW. Checked over operation of mixing valve that contact [E4, Maintenance director] had recently replaced cartridge in after mixing valve had spike in temperature . Note: At contact's [E4] request, checked old cartridge to determine why it failed, appears sediment had been stuck in valve body/spring. 2/7/25 12:30 PM - During an interview, E1 (NHA) stated the recordings [of water temperatures) on each floor was not being done prior to 10/3/24. 2/7/25 12:49 PM - During an interview, E4 stated that the maintenance team checks the water temperatures daily in the morning. On October 3, 2024 during the daily water temperature checks, hot water was in the correct range based on area checked. 1. Mixing valve 109 degrees F (Fahrenheit), C wing hydration room [ROOM NUMBER] degrees F, Water heater 152 degrees F, and Pot sink 105 degrees F. E4 also stated that prior to this incident the mixing valve was checked every three months. Of note, R10 was showered in a different wing's shower room, not C wing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085006	A. Building B. Wing	02/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regal Heights Healthcare & Rehab Center	6525 Lancaster Pike Hockessin, DE 19707

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the manufacturer's Parts Breakdown (7-9000) manual, page 10 stated Maintenance- the cartridge unit contains the entire valve control mechanism. For non-interrupted service, keep a spare cartridge on hand. Temp Control Valve control mechanism must be kept clean and free from deposits and any foreign matter build-up that will be present in many water systems . If inspection determines that your water system causes deposits and foreign matter build-up monthly, then valve should be cleaned monthly . The facility was lacked evidence of the monthly mixing valve cartridge inspections prior to 10/3/24. 2/10/25 2:23 PM - Findings were reviewed during exit conference with E1 (NHA), E2 (DON), E6 (ADON), E9 (Corporate Risk Manager) and E8 (Corporate IP/SP).