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	05/23/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, it was determined that for two (R136 and R163) out of four residents reviewed for dignity, the facility failed to ensure that staff treat each resident with respect and dignity. Findings include: 1. 5/16/25 9:00 AM - During a medication pass observation, E16 (LPN) was seen administering medications to R163 who was lying in bed, via PEG/feeding tube (a tube that is passed into a patient's stomach through the abdominal wall). R163's bedroom door was left opened and she was visible from the hallway by visitors and staff walking by. R163's bed curtain was not pulled out to cover her and provide privacy. 5/16/25 9:20 AM - Finding was discussed with E16 who confirmed that she should have shut the door or pulled the curtain for privacy as a way to treat R163 with dignity and respect while administering her medications. 5/22/25 5:00 PM - Finding was discussed with E1 (NHA) and E2 (DON). 2. Review of R136's clinical record revealed: 12/1/23 - R136 was admitted to the facility with diagnosis of dementia. Observations of R136 during the survey include: - 5/14/25 4:32 PM - R136 was sitting on a blue-colored sling in her wheelchair in the B-Wing dining/activity room. - 5/20/25 11:40 AM - R136 was sitting on a blue-colored sling in her wheelchair outside the Social Worker's office after having participated in an activity. - 5/20/25 1:02 PM - R136 was sitting on a blue-colored sling in her wheelchair and seated at the table in the B-Wing dining room while lunch was being served. 5/20/25 1:13 PM - During an interview, E39 (LPN/UM) confirmed that the resident's sling is not to remain under the resident when sitting in the wheelchair during the day. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to provide R136, a dependent resident, with dignity as evidenced by multiple observations where a blue sling, used for mechanical lift transfers, was left under her while she sat in her wheelchair. 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, it was determined that for one (R167) out of six (6) residents reviewed for abuse, the facility failed to ensure that R167 was protected from verbal abuse. Findings include: Review of R167's clinical records revealed: 11/12/24 - R167 was admitted to the facility with diagnoses including end stage renal failure, heart failure and morbid obesity. 2/11/25 - R167's quarterly MDS documented a BIMS score of 15, indicating a cognitively intact status. The MDS also documented that R167 was independent with activities of daily living. 4/2/25 8:00 PM - The facility's investigation documented that R167 wanted to take a shower but there were used towels on the bathroom floor. He requested that the bathroom be cleaned. E6 (CNA) told R167, If you don't think I am doing my job, then speak to the supervisor. Approximately one hour later, E6 overheard R167 telling his significant other on the phone about the dirty towels in the shower. E6 stated, Why are you still talking about it? It was a mistake. E6 began to yell profanities at him. Both E6 and R167 then yelled profanities towards each other. This event was witnessed on the phone video by R167's significant other. 4/3/25 9:21 AM - A facility report to the Division documented, Staff member [E6] CNA got into a verbal confrontation with resident [R167]. Staff member was suspended pending outcome of investigation. 5/19/25 11:13 AM - During an interview E6 stated, He started cursing and snapping at me, so I cursed back at him. The Surveyor asked E6 whether she had received any training at the facility on abuse, dementia, and resident rights. E6 stated, We had a lot of training. But it was not like he [R167] had dementia or anything. E6 was terminated from employment at the facility. The facility failed to protect R167 from verbal abuse from a staff member. 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on interview, record review and review of other documentation as indicated, it was determined that for one (R70) out of six residents reviewed for abuse, the facility failed to assure that a physical restraint was used to treat R70's medical symptoms and was not being used for staff convenience. Findings include: R70, a resident with dementia, had two gowns on during the evening shift of 3/31/25. The first gown was on in the correct position. The second gown was oversized and the gown material was gathered and tied in a knot below R70's knees and behind her neck to prevent R70 from exposing herself. R70's oversized gown was not untied and R70 remained in the same position through the evening and night shifts without opportunities for repositioning, incontinence care or release of the knotted oversized gown for mobility. The inability to reposition or straighten one's legs would result in psychosocial harm to a reasonable person. Due to the facility's corrective measures completed on 4/10/25, the facility was notified that R70's incident was a harm past non-compliance. The facility policy titled, Use of Restraints (2001) documented, Policy Statement . Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the preventions of falls . Policy Interpretation and Implementation . 1. 'Physical Restraints - . any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom or restricts normal access to one's body . Cross refer F677 Review of R70's clinical records revealed: 9/24/19 - R70 was admitted to the facility with diagnoses including dementia, bipolar, anxiety and insomnia. 9/25/19 (revised 6/1/22) - R70 had a care plan for potential for falls related to poor safety awareness with interventions including, but not limited to, allowing R70 to sit in doorway of room when up when possible to experience increased stimulus from other people in the hallway. 9/25/19 (revised 5/1/20) - R70's ADL care plan stated, [R70] was unable to do own ADLs (Activities of Daily Living) without assist related to cognitive loss and interventions included . assist resident to pick out own clothes. 10/21/19 - R70 had a care plan for repetitive statements related to anxiety and memory loss. Interventions included: assessing for unmet needs. 10/21/19 - R70 had a care plan for making sexual comments and/or touches others inappropriately. Interventions included getting involved in activities of choice. 5/7/20 - R70 was care planned for removing clothes over and over in inappropriate places related to cognitive level. Interventions for R70 included approaching in a calm manner and not being judgmental. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	8/9/22 - R70 had impaired verbal communication care plan developed related to cognitive loss. R70's interventions included anticipating R70's needs and approaching R70 in a gentle, calm, friendly, relaxed manner with a smile on the face. 9/27/23 - R70 was care planned for alteration in thought process related to progressive dementia with interventions including allowing R70's choices when appropriate and assisting resident to activities of choice. 2/21/25 - R70's quarterly MDS (Minimum Data Sets) assessment indicated that R70's cognition was severely impaired with short and long term memory problems and had verbal behavioral symptoms occurring 1- 3 days during the review period. R70 was dependent with toileting hygiene and upper/lower body dressing. In addition, R70 was dependent with the following mobility performance: roll left and right, sit to lying to, lying to sitting on side of bed and sit to stand. R70 was always incontinent of urine and bowel. 3/31/25 - R70's CNA Kardex Report for Activities indicated that R70 required assistance in developing/providing a program of activities that was meaningful and of interest including to encourage and provide opportunities for exercises and physical activity. 4/1/25 7:30 AM - A nurse progress note by E13 (LPN) documented, CNA [E14] reported this morning that the resident's gown was tied up very tightly on the patient. Upon assessment the gown was bunched up and tied up very tightly by the neck and left thigh. It took a considerable amount of force in order to untie the knots, to the point where the gown was torn some . patient [R70] could not lay down straight when I observed how she was laying. 4/1/25 11:57 AM - A facility incident report submitted to the State reporting agency documented that on 4/1/25 at 7:30 AM, . Resident observed in bed with two gowns. One fitted appropriately, second gown oversized and tied incorrectly. 4/1/25 12:01 PM - A skin evaluation note by E13 documented, . [R70] had gown tied too tightly (sic) no injuries to skin, no red marks, no skin tears present . 4/1/25 - A written statement by E18 (7-3 shift RN, UM) documented, Made aware by 7-3 charge nurse [E13] . [R70] was observed in bed with two gowns on. The first gown was on in the correct position. The second gown was oversized and placed on over the first knotted at the right [left when clarified] thigh. [R70] was unable to straighten herself out and was observed in a semi fetal position . 4/1/25 - A documented phone interview of E12 (11-7 LPN) by E18 revealed that she was made aware of [R70] having on two gowns and gowns being knotted in passing by the day shift nurse as she was leaving. [E12] stated that she did not notice during her shift. 4/1/25 - A documented statement by E14 (CNA) revealed that E14 came in to provide care to R70 who was observed in a semi fetal position with two gowns on, one knotted at the right thigh. E14 immediately notified the nurse [E13]. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	4/1/25 - In a joint phone interview with E2 (DON) and E18, E10, the CNA assigned to provide care to R70 in the evening shift (3-11), confirmed Yes and that she put two gowns on R70. E10 stated that while R70 was out to bed, R70 kept lifting her gown up in the hallway. Because R70 kept exposing herself, E10 obtained a second gown and put on R70 and tied the gown just below R70's knees to keep her from exposing herself. 4/1/25 - In a separate statement documentation, a clarification phone interview by E2 and E37 (Admin/Office) revealed that E10 was not aware that putting on two gowns and preventing resident from lifting up the gown by criss-crossing it at the bottom is considered a form of restraint. 4/1/25 - A documented phone interview by E18 with E11, the CNA assigned to provide care to R70 during the night shift (11-7 on 3/31/25 going into 4/1/25) revealed that E11 did not put two gowns on R70. E11 stated that she was unaware if R70 had on two gowns while providing care and from what she can recall the gown was not tied at all during her time of providing care for R70. 4/8/25 - The facility's 5 Day follow up summary documented, . [R70] with a past history of dementia, bipolar disorder, anxiety and insomnia . with severe cognitive impairment . note (sic) occasional impulsivity with poor safety awareness and mild agitation . In an attempt to limit resident exposing herself and protect her dignity an oversized gown was placed on resident incorrectly. The gown was oversized and the gown material was gathered and tied in a knot below her knees and behind her neck. [R70] was able to move freely in her gown but was unable to pull up gown exposing herself. During movement in her sleep resident pulled her legs up and they got caught in (sic) gown. 4/10/25 - A psych physician assistant follow up note by P1 (PA) documented, . Chief Complaint/Nature of Presenting Problem: F/u (follow up) dementia, recent med adjustment, recent worsening mood lability/compulsions . Seen today at request of facility staff due to report of recent increased agitation and restlessness over the past week . restless and engaging in repetitive movements globally and appears mildly irritable . 5/20/25 9:00 AM - In an interview, P1 stated that he saw R70 and had read the nurse's notes about the inappropriate way of tying the oversized gown on R70. P1 stated that it was not the right way to address R70s' increasing behavior of raising her gown exposing herself and that R70 has intermittent clothing removal, repetitive behaviors. P1 stated, . [R70] has severe cognitive impairment and from the psychosocial point, there was no indication of harm. 5/20/25 1:25 PM - In an interview, E27 (PT) stated, . [R70] was pretty mobile . can move and walk at least 40 feet and she has been on the restorative nursing program for ambulation and range of motion when discharged from Physical Therapy caseload in February 2025 . 5/20/25 1:37 PM - During an interview, E13 (7-3 LPN) stated that he was the primary nurse for R70 on 4/1/25. Responding to E14's (CNA) call, he went to R70's room. E11 further stated, . I saw [R70] almost on her left side in a fetal position. E14 pulled down the outer gown but the knot around the neck was tied very tight that E14 had to use a pair of scissors to cut it off. I also untied the knot in the bottom of her gown. The hem or bottom of the gown was below the knee and tied around the legs, with the knot on the left side of R70's leg. The knot was tied very tight that it took an amount of time and strength for me to untie the knot. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	5/20/25 1:50 PM - During interview, E14 stated, . I went to R70's room on 4/1/25 around 7:30 AM. I saw her gown tied up in a knot and she was in a fetal position. It did not looked right to me so I called [E13]. R70 had on 2 gowns. 1 smaller gown she had on underneath with snaps on the shoulders . The inner gown had ties tied very tightly on her back. She had another oversized gown over the smaller gown. The top part of the outer gown was loose enough to be gathered around the neck and formed a knot. The knot on the right side of the neck was very tight I had to use a pair of scissors to cut it. I checked her incontinence brief and she was soaked in urine and was very soiled. 5/20/25 3:30 PM - In a follow up interview, E13 demonstrated to Surveyor how R70 was found with the double gowns. The following were observed with the Surveyor as the model resident for demonstration purpose: The top part of the outer gown was gathered and tied in a knot on the right side of the model's neck. The lower hem or bottom of the model's outer gown was wrapped around the model's legs and tied in a knot on the left side of the leg. Both knots on the right side of the model's neck and on the left side of the leg were tied so tight that it was very difficult to untie them. 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). 5/22/25 5:15 PM - E1 submitted to the Surveyor documentation of the abatement/corrective action plan with correction completed 4/10/25 at 1:00 PM. Corrective Actions: 4/1/25 - R70's gowns were removed and skin check was performed with no noted areas of concern. - Investigation was initiated and statements were obtained. - Staff directly involved were interviewed and suspended pending investigation. - Incident reported to Division of Healthcare Quality (DHCQ) - Through investigation and interviews it was found that in an attempt to limit [R70] from exposing herself and to protect her dignity, an oversized gown was placed on [R70] incorrectly. The oversized gown gathered and tied in a knot below her knees and behind her neck. [R70] was able to move freely in her gown but was unable to pull up her gown to expose herself. During movement in her sleep it appears [R70] pulled her legs up and they got caught in the gown causing her to be unable to straighten out her legs. This is how she [R70] was found during routine rounding on 4/1/25 7-3 shift. - No other residents were found with gowns tied. - Facility reviewed incident during high risk meeting with Medical Director present. Discussed with Medical Director the events reported and staff statements obtained at that time. - Facility reviewed incident with the Corporate Regional Nurse. 4/10/25 (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	- Facility initiated nursing staff education to promote resident dignity, proper use of a gown and reporting anything found to be out of the ordinary. All nursing staff will be educated prior to next scheduled shift. - Facility initiated audits of residents who are dependent on staff for care to ensure dignity is being observed an gowns are being used properly. - Audits will continue three times a week until 100% successful audits over three consecutive evaluations, then continue monitoring once a week until 100% successful over three consecutive evaluations. Audits will continue another month after that time, if 100% success is noted then compliance is achieved. Results of the audits and evaluations will be brought to the QAPI steering committee for further evaluation or recommendation. - CNAs [E10] and [E11] were terminated for inconsiderate care of a resident. No immediate action required related to facility correction and no further occurrences after the incident on 4/1/25. This was verified by interviews with staff about promoting resident dignity and abuse with use of physical restraints, education, spot inspection for residents wearing gowns and inspection of the facility abuse incident reports. 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). 5/23/25 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the Exit Conference.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that for two (R6 and R22) of six residents reviewed for abuse, the facility failed to report an allegation of abuse within two hours. Findings include: 1. Review fo R22's clinical record revealed: 5/3/25 8:30 AM - A facility incident report documented, . [R22] presents wit (sic) 2 bruises on the the inner side of the left arm above the elbow. Main bruise is 13.0 x 10.5 and smaller bruise above it is 2.5 x 3.0. [R22] did not know how it occurred. . RCA (Root Cause Analysis) Summary: . bruises appear that they may have been caused by a hand that may have been facilitating a transfer . [R22] also noted to have been transported to the dentist by family on 4/30/25 .also noted to be on aspirin therapy . 5/20/25 3:00 PM - Review of the state incident report database lacked evidence that the facility reported the incident to the state incident reporting center. 5/22/25 - A written statement by E2 (DON) documented, I have observed family both daughter and son, have difficulty putting him in car. They seem to have most difficulty with getting him out of his wheelchair when putting him into car. When the son has him alone, he often will hold on to his upper arms and or wrap his arms around him to assist him into and out of the car . 5/22/25 5:00 PM - Finding was discussed with E1 (NHA) and E2 (DON). 2. Review of R6's clinical record revealed: 3/27/23 - R6 was admitted to the facility with diagnoses including. but was not limited to bipolar disorder. 4/2/25 - R6 was hospitalized with a mental status change and was diagnosed with a urinary tract infection (UTI). 4/12/25 - R6 returned to the facility from the hospital. 5/20/25 10:10 AM - A review of R6's hospital records revealed documentation of R6's allegation to hospital staff regarding this alleged incident and the hospital's subsequent report to the state agency. 5/20/25 11:35 AM - A review of the facility personnel lists revealed no staff by the name of [name] work at the facility. A review of the staff assignments on the day of the alleged incident revealed there were no Caucasian staff providing care on that wing on that date. 5/20/25 1:52 PM - During an interview, E1 (NHA) stated, We did not know about the allegation when she was at the hospital. She has made multiple allegations (prior to the 4/2/25 hospitalization) and the story changed several times. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/21/25 11:09 AM - During an interview, E36 (RNAC) stated, I was the one that [R6] reported the alleged abuse to. I was doing a pain assessment for her quarterly MDS in late March. Her roommate [R126] was there shaking her head the entire time saying 'No, that did not happen.' I reported it to leadership within two hours. I thought it was reported to the state agency because there was a big investigation. 5/21/25 12:04 PM - During an interview, E2 (DON) stated, We investigated it twice. We did not think it was anything and we knew [hospital] had reported it so I did not report it. 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 2. Cross refer to F641, example 2 Review of R14's clinical record revealed: 8/19/24 - R14 was admitted to the facility with a diagnosis of diabetes. Review of R14's comprehensive care plan lacked evidence of an individualized care plan with approaches for R14's diabetes diagnosis and use of insulin. 5/22/25 12:55 PM - During an interview, E39 (LPN/UM) confirmed the finding. 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON). Based on record review and interview, it was determined that for two (R22 and R14) out of 35 sampled residents, the facility failed to develop a person centered care plan to address an identified need for R22. For R14, the facility failed to initiate a care plan for R14's diagnosis and treatment of diabetes. Findings include: 1. Review of R22's clinical record revealed: 12/13/22 - R22 was admitted to the facility with diagnoses including peripheral vascular disease with a need for assistance with personal care and a non - pressure ulcer of the left ankle. 12/13/22 - A care plan was developed for R22's risk for skin breakdown related to decreased mobility and fragile skin.R8's interventions included: encourage [R22] to wear long pants to prevent injury. 5/21/25 - R22's CNA Kardex (a CNA plan of care for individual resident) documented. . for safety in resident's dressing, encourage [R22] to wear long pants to prevent injury . 5/21/25 12:00 PM - R22 was observed in the hallway sitting on his wheelchair wearing short pants. E17 (CNA) approached R22 and began to maneuver R22's wheelchair and started wheeling R22 into the dining room. 5/21/25 12:00 PM - When asked if R22 was to wear short pants while having lunch in the dining room, E17 responded, Yes, he can wear short pants. 5/22/25 8:50 AM - R22 was observed in his room sitting on his wheelchair and wearing the same short pants he wore the day before. Long pants were folded on his bed and a pair of pants lying on the floor. 5/22/25 9:00 AM - When asked whether he wanted to wear short pants or long pants, R22 responded, I don't know. This is all I can wear (pointing down on his short pants). (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/22/25 9:30 AM - In an interview, E29 (LPN) stated, [R22] has a non compliance behavior with the care we provide. Sometimes he wants to dress for the weather with just short pants on like what is wearing know. We know we need to encourage him to wear long pants as he has no safety awareness and he could easily hit himself and bump against anything and could get a skin tear . Follow up review of R22's comprehensive care plan lacked evidence of an individualized care plan with approaches for R22's non compliance with wearing long pants. 5/22/25 5:00 PM - Finding was discussed with E1 (NHA) and E2 (DON).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, it was determined that for one (R70) out of 35 sampled residents, the facility failed to provide incontinence care to a resident who was unable to carry out out activities of daily living. Findings include: Cross refer F604 Review of R70's records revealed: 9/24/19 - R70 was admitted to the facility. 9/25/19 (revised 5/1/20) - R70's ADL care plan stated, [R70] was unable to do own ADLs (Activities of Daily Living) without assist related to cognitive loss and interventions included . toileting schedule as resident allows . 9/25/19 (revised 10/18/23) - R70 was care planned for incontinence of bowel and bladder related to cognition and interventions included . encourage highest level of independence of toileting as possible and toilet at regular intervals if able. 2/21/25 - R70's quarterly MDS assessment indicated that R70's cognition was severely impaired with short and long term memory problems. R70 was dependent with toileting hygiene and was always incontinent of urine and bowel. 5/20/25 1:50 PM - During interview, E14 stated, . I went to [R70's] room on 4/1/25 past 7:30 AM. I saw her gown tied up in a knot and she was in a fetal position . I checked her incontinence brief and she was soaked in urine and was very soiled. 5/20/25 2:00 PM - Review of R70's 3/31/25 going into 4/1/25 11-7 shift CNA flowsheet lacked evidence that R70's Bladder Continence and Toilet Use was completed. 5/21/25 9:22 AM - During a telephone interview, E11 (CNA) confirmed that she was the CNA assigned to provide care to R70 on 3/31/25 going into 4/1/25 11-7 shift. E11 further confirmed that she did not provide incontinence care to R70. E11 stated, I checked the back of her incontinence brief and I felt that she was dry so I did not change her. 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). 5/23/25 2:30 PM - Findings were reviewed with E1 (NHA) and E2 (DON) during the exit conference.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, it was determined that for one resident (R108) out of four (4) residents reviewed for accidents, the facility failed to ensure that R108 received adequate supervision and assistance to prevent accidents to the extent possible. R108 was left sitting on the side of the bed during care and fell to the floor. R108 sustained a large hematoma on her forehead and was sent emergently to hospital. Findings include: Review of R108's clinical records revealed: 3/22/24 - R108 was admitted to the facility with diagnoses including dementia, major mood disorder and age-related osteoporosis. 3/24/24 - R108's fall care plans included, Potential for (actual) falls r/t (related to) poor safety awareness Resident will not sustain or be injured from falls X 90 days. The interventions included, Bed in lowest position when care is not being provided. 2/24/25 - E108's annual MDS documented a BIMS score of 00, indicating a completely impaired cognitive status, and was completely dependent on staff for dressing and undressing of both lower and upper extremities. R108 required substantial/maximum to move from lying to sitting. The MDS defined substantial/maximal assistance as, Helper does more than half of the effort. Helper lifts or holds trunk or limbs and provides more than half the effort. 3/27/25 12:56 PM - A facility incident report submitted to the Division documented, Resident [R108] had an unwitnessed fall at approximately 11:05 AM. Resident was observed lying on her left side next to the bed and bedside table. Resident AOx1 [alert and oriented times 1] to self which is her baseline. Hematoma noted to left side of forehead, facial grimacing noted as well .order obtained to send resident to the ER for further evaluation. 3/27/25 4:47 PM - R108's clinical records documented, Patient was sent to the emergency room. She was evaluated and returned to Regal Heights Patient with an intact hematoma left side of her head. Her neurological status is at baseline. 3/28/25 10:39 AM - R108's clinical records documented, Left side of forehead remains swollen and bruised. 3/29/25 2:09 AM - R108's clinical records documented, Resident continues to be monitored s/p [status post] unwitnessed fall with hematoma sustained to left side of face. Swelling remains to the area with some tenderness when touched . 3/29/25 5:50 PM - R108's clinical records documented, Continues to be monitored s/p unwitnessed fall with hematoma sustained on left side of face. Hematoma noted with swelling and tender to touch. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/19/25 1:30 PM - During an interview, E7 (CNA) stated, I was helping [R108] to get dressed and I realized that I did not have a top for her. She was sitting on the side of the bed, and I went to the closet to get a top and I heard a noise. I ran over and saw that the resident had fallen to the floor. The Surveyor asked E7 how much help R108 needed to sit up in bed. E7 stated, She needed a lot of help because she was weak. The Surveyor also asked E7 if the resident was in her line of vision when she went to the closet. E7 stated, No, the curtain was pulled so I could not see her. I know now that I should not leave a resident sitting on the side of the bed. 5/19/25 2:00 PM - During an interview, E8 (CNA) stated, I only worked with the resident (R108) a couple of times. She needed total assistance because of her poor balance. 5/19/25 2:30 PM - During an interview, E9 (CNA) stated, She (R108) sometimes sits up but she is kind of weak at other times. She must be positioned correctly in wheelchair because she leans a lot. The facility failed to ensure that R108 received adequate supervision and assistance to the extent possible to prevent accidents. 5/23/25 2:30 PM - Findings were reviewed at the Exit conference with E1 (NHA), E2 (DON) and E4 (Regional nurse) in attendance.