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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. Based on record review and interview, it was determined for one (R95) out of three residents reviewed for participation in care planning, the facility failed to ensure the correct resident representative was invited to participate in R95's care planning conferences. Findings include: Review of R95's clinical record revealed: 11/19/20 - A durable power of attorney (DPOA) financial only document appointing P6 was signed and notarized by R95. 7/1/21 - R95 was admitted to the facility for long-term care. 7/8/21 - The facility's form entitled Preferred Intensity of Medical Care and Treatment was signed by F3 (R95's family member). 7/1/24 8:29 AM - A care conference review documented the following: - R95 had severe cognitive impairment. - R95's resident representative was P6 (R95's DPOA-financial only). P6 was invited, but did not attend. The documented stated, No RSVP. - Does Resident and or Resident/Representative agree with Plan of Care established? YES. - Under the social work section, it was documented that . Nursing reported fall on 6/12/24 and [R95] was sent to the hospital. [F3, family member] was informed . - Code Status Reviewed? Yes, No changes required. 9/19/24 6:17 PM - A care conference review documented the following: - R95 had severe cognitive impairment. - R95's resident representative was P6 (DPOA-financial only). P6 was invited, but did not attend. The documented stated, No RSVP. - Does Resident and or Resident/Representative agree with Plan of Care established? YES. - Code Status Reviewed? Yes, No changes required. 12/16/24 10:56 AM - A care conference review documented the following: - R95 had cognitive impairment. - R95's resident representative was P6 (DPOA-financial only). P6 was invited, but did not attend. The documented stated, No RSVP. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Does Resident and or Resident/Representative agree with Plan of Care established? YES. - Code Status Reviewed? Yes, No changes required. 3/7/25 10:43 AM - A care conference review documented the following: - R95 had cognitive impairment. - R95's resident representative was P6 (DPOA-financial only). P6 was invited, but did not attend. The documented stated, No RSVP. - Does Resident and or Resident/Representative agree with Plan of Care established? YES. - Code Status Reviewed? Yes, No changes required. 5/22/25 at 4:41 PM - During an interview, E20 (BOM) confirmed that R95's profile had P6 (DPOA-financial) incorrectly listed as the facility's first point of contact/resident representative. As a result, R95's care conference invitation letters were incorrectly and repeatedly sent to P6 and not to F3 (R95's family member). The facility failed to ensure that the correct Resident Representative, F3, was able to excerise the resident's rights on behalf of R95 with respect to medical care and treatment. 5/23/25 2:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on record review and interview, it was determined that for one (R87) out of four (4) residents reviewed for personal property, the facility failed to provide the family with a written explanation of why R87 moved rooms at the facility's request on 1/23/25. Findings include: 2/23/22 - R87 was admitted to the facility on the C wing with diagnoses including, but was not limited to, dementia. 2/23/22 - 1/23/25, R87 resided on the C wing of the facility. 1/23/25 - R87's room was changed, and she was moved to the A wing of the facility. 5/15/25 2:56 PM - During an interview, F1 (R87's husband) stated, They (the facility staff) told me on a Thursday around 11:30 AM that they were going to move my wife's room. It was [E20] (admission office) who told me. When I asked why, my wife has been on C wing for 3 years, we went to the office (admissions) and . the DON (E2) came in and said it was because she (R87) was hollering. But she has been hollering for years. I had built relationships with the staff on C wing, and they knew my wife. By 2 PM, a lady with a clipboard came in (my wife's room) and they started moving her. I thought it would happen in a few days. I did not get any paperwork or sign anything . 5/15/25 3:30 PM - A review of R87's progress notes revealed no documentation regarding the 1/23/25 room change. 5/16/25 10:30 AM - A review of the Notice of Room Change document provided by the facility regarding R87's move did not demonstrate the required explanation in writing of why the move was required. 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that for two (R14 and R110) out of four residents reviewed for assessments, the facility failed to document each residents' insulin usage. Findings include: 1. Review of R110s cinical record revealed: 5/24/22 - R110 was admitted to the facility with diagnoses including, but were not limited to, diabetes and end stage kidney disease. 12/17/24 - E5 (MD) ordered in R110's EMR, Insulin Lispro injection solution 100 unit/ml . subcutaneously before meals and at bedtime for diabetes. 2/20/25 - R110's quarterly Minimum Data Set (MDS) documented in Section N - Medications that R100 received 7 days of insulin injections in the look back period but failed to document that R100 was taking a Hypoglycemic (including insulin). The facility failed to accurately document R100's High Risk Drug classes in the 2/20/25 MDS. 5/22/25 12:47 PM - During an interview, E36 (RNAC) confirmed that hypoglycemics was not checked on R110's MDS dated [DATE]. 2. Cross refer to F656 Review of R14's clinical record revealed: Review of R14's April 2025 eMAR revealed that the resident received insulin injections two times a day from 4/10/25 through 4/16/25 for diabetes. 4/16/25 - The quarterly MDS assessment documented that R14 received seven days of insulin injections under Section N - Medications. However, the facility failed to document that R14 was taking a hypoglycemic (including insulin) under the subsection N0415. High-Risk Drug Classes: Use and Indication. 5/22/25 12:47 PM - During an interview, E36 (RNAC) confirmed the finding. 5/23/25 2:30 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).

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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. Based on record review and interview, it was determined that for one (R92) out of three residents reviewed for PASRR, the facility failed to incorporate the recommendation from the 9/10/24 PASRR level II determination in R92's care plan. Findings include: The facility's policy and procedure for Care of Visually Impaired Resident, last revised March 2021, stated, . 4. When interacting with the visually impaired resident implement the following procedures: a. Use the resident's name when speaking to him/her so he/she will know you are speaking to him/her. b. Introduce anyone else who may be with you. c. Always speak directly to the resident. d. Assist with ADLs as needed or requested. e. Let the resident know when you leave the room. f. Use large lettering on any distributed written information. 5. To help the resident orient and avoid accidents in the environment implement the following practices: a. Use nightlights to help the resident with dark adaptation problems. b. When the resident dines, describe the location of the place setting and food on the plate according to the clock face (e.g., meat at 12 o'clock, potato at 6 o'clock, etc.). c. Leave doors in the open or closed positions only. A partially closed door may be difficult for the resident to see . e. Attempt to keep the environment consistent by leaving objects in their designated locations. f. Keep lighting bright and at consistent levels. Eliminate as much glare and reflection as possible. Review of R92's clinical record revealed: 8/26/24 - R92's PASRR level I was completed and referred R92 for a level II evaluation. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/10/24 - R92's PASRR level II determined that R92 has a PASRR condition with the outcome documented that R92 was approved for nursing facility services. Specifically, the level II documented, If you are admitted to a Medicaid certified nursing facility, What services and supports are nursing facility staff required to provide for you? . Rehabilitative services: You will need to be provided the following services and/or supports: . Services or Accommodations for the Visually Impaired . Review of R92's comprehensive care plan revealed a impaired vision care plan, last revised on 11/24/21, as follows, [R92] has impaired vision related to diabetes/dense cataract's. She had a vision consult 11/22/21. She declines cataract surgery. Approaches: - arrange consultation with eye care practitioner as required (11/23/21); - she may be able to see better in a well lit room etc. (revised 11/23/21); - she may prefer to have her personal item's arranged the way she likes, in order to promote independence (11/23/21). R92's comprehensive care plan lack evidence of incorporation of her PASRR level II recommendation to provide accommodations for her visual impairment that include, but are not limited to, activities of daily living, activities, nursing care and treatments, care plan conferences and reviewing/signing any medical or financial facility documents, if necessary, as she is her own resident representative. 5/20/25 11:50 AM - During an interview, E22 (SW) provided the surveyor with R92's last annual eye consultation dated 9/13/24 and stated that the resident did not want cataract surgery. At the request of the surveyor, E22 obtained a copy of R14's 9/10/24 PASRR level II from the PASRR website as this document was not readily accessible in R14's EMR. 5/22/25 1:00 PM - During an interview, the surveyor reviewed the 9/10/24 PASRR level II recommendation with E39 (LPN/UM) for accommodations for R14's vision impairment. 5/23/25 2:30 PM - Finding was 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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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 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. Based on record review and interview, it was determined that for one (R65) out of thirty-five sampled residents, the facility failed to have a comprehensive care plan in complaince with the standard of practice regarding R65's dental cleanings and risk for infective endocarditis. Findings include: Subacute Bacterial Endocarditis Prophylaxis -Infective endocarditis is an infection of the heart's endocardial surfaces involving one or more heart valves . Several risk factors can predispose patients to infective endocarditis, including structural heart disease, prosthetic heart valves, indwelling cardiovascular device . National Library of Medicine, STATPEARLS 2025, Updated February 10, 2024 [Hospital] LVAD Heartmate Discharge Binder- . Important Information Regarding Dental Procedures- Please let your dentist know that you have an artificial heart pump and will need prophylactic antibiotics for any procedure that invades the gums. This includes basic dental cleaning. There is the potential that bacteria could invade the blood stream and possibly contaminate the LVAD . 7/12/18 - R65 was admitted to the facility with diagnoses including but not limited to, stroke affecting left side and presence of a heart assist device. 12/9/24 - P4 (dentist) documented a Dental Consult note in R65's EMR, # 9 (tooth) facial and #11 (tooth) facial have fixable decay . Recommendations: I will return to clean teeth and place resin fillings where decay of on teeth #'s 9 & 11. 5/21/25 - A review of R65's orders lacked evidence of a prophylactic antibiotic order for the dental appointment in December 2024. A review of R65's care plan revealed that R65 was not care planned to receive SBE (subacute bacterial endocarditis) prophylaxis prior to dental procedures. The facility failed to meet the standard of practice for SBE antibiotic prophylaxis for dental procedures. 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 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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on record review and interview, it was determined that for one (R22) out of one sampled resident reviewed for hearing/vision, it was determined that the facility failed to ensure that R22 received proper treatment and assistive device to maintain hearing abilities. Findings include: Review of R22's clinical record revealed: 12/13/22 - Resident was admitted to the facility. 12/19/22 - R22's admission MDS indicated that R22's cognition was intact, had adequate hearing and did not use a hearing aid. 1/18/23 - R22 had a care plan developed for impaired verbal communication related to hard of hearing with interventions including to assess [R22's] hearing and vision, and if deficits are noted, refer resident for further evaluation and treatment. 3/13/23 - R22's quarterly MDS indicated that R22 had minimal difficulty with hearing and did not use a hearing aid. 1/18/23 - R22 had a care plan developed for impaired verbal communication related to hard of hearing with interventions including to asses [R22's] hearing and vision, and if deficits are noted, refer resident for further evaluation and treatment. 11/16/23 12:37 PM - A social worker progress note documented, . [R22] goes to the VA (Veterans Affairs) for any vision/dental/hearing issues . 5/3/24 - R22's quarterly MDS indicated that R22 had moderate difficulty with hearing and did not use a hearing aid. 7/29/24 - R22's quarterly MDS indicated that R22 had moderate difficulty with hearing and did not use a hearing aid. 10/3/24 - R22's annual MDS indicated that R22 had moderate difficulty with hearing and did not use a hearing aid. 1/17/25 - R22's quarterly MDS indicated that R22 had moderate difficulty with hearing and did not use a hearing aid. 1/15/25 12:09 PM - A social worker progress note documented, . [R22] is HOH (hard of hearing), no aids . 3/31/25 - R22's quarterly MDS indicated that R22 had moderate difficulty with hearing and did not use a hearing aid. 5/14/25 9:00 AM - During an interview, R22 was observed repeatedly asking this Surveyor to raise her voice. R22 stated, I can not hear you! I have a hearing aid on my drawer but I don't have it on with me. A hearing aid sitting on the charger box was noted on the resident's bedside table. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/15/25 10:00 AM - Review of R22's physician's order did not indicate R22's use of a hearing aid. 5/15/25 11:15 AM - R22 was observed self propelling his wheelchair in the unit's hallway. R22 did not have a hearing aid applied on either ears. 5/22/25 8:45 AM - R22 was observed sitting on his wheelchair watching TV with no hearing aid on. R22 requested Surveyor to get the hearing aid lodged on the charger box on R22's bedside table. 5/22/25 9:10 AM - A follow up review of R22's hard of hearing care plan did not include R22's use of a hearing aid. 5/22/25 9:40 AM - In an interview, E29 (LPN) stated that she is not aware of R22's use of hearing aid. E29 confirmed that R22 has a hearing loss but did not have an order for the use of hearing aid. E29 further confirmed that the use of a hearing aid was not included in R22's hard of hearing care plan interventions. 5/22/25 10:55 AM - During a telephone interview, P2 (NP) confirmed that R22 has a hearing loss and hard of hearing. P2 further confirmed that R22 uses a hearing aid. When asked why there was no physician order indicated for the use of R22's hearing aid, P2 stated that she will talk to E3 (ADON) and will have the order clarified. 5/22/25 11:45 AM - Findings were confirmed by E3 who also said she updated R22's care plan and obtained physician's order for nurses to put hearing aid on R22's left ear after surveyor's intervention. 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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and review of the facility's policy and procedures it was determined that the facility failed to provide the appropriate care and services to one (R163) out of one sampled resident who had a PEG/feeding tube through the abdomen into the stomach for medication administration. Findings include: Cross refer F759 Review of R163's clinical record revealed: 3/28/25 - R163 was admitted to the facility. 3/31/25 - R163 had a care plan developed for potential for alteration in nutrition/hydration related to NPO (eating nothing by mouth) status and traumatic brain injury requiring tube feeding for nutrition/hydration. R163's interventions included tube feeding and flushes as ordered. 3/28/25 - R163 had a physician's feeding tube order to flush tube with 5 ml (milliliters) of water between each medication. 3/28/25 - R163 had a physician's feeding tube order to flush with 30 ml of water before and after each medication. 4/3/25 - R163's MDS (Minimum Data Set) assessment indicated that R163 had an intact cognition and is dependent with the use of the feeding tube for nutrition and hydration. 5/16/25 8:45 AM - 9:08 AM - During a medication pass observation, E16 (LPN) crushed eight medications and mixed together with approximately 30 ml of water. In a separate medication cup, E16 mixed a liquid medication with approximately 15 ml water. After checking the peg/feeding tube for placement, E16 flushed R163's feeding tube with 30 ml water, and began administering all the prepared medications followed by another 30 ml water to flush. 5/16/25 9:15 AM - During interview, E16 confirmed that she administered R163's medications all at the same time and not one medicine at a time. When asked why the 5 ml of water was not flushed in between medication per physician's order, E16 replied, I did not flush 5 ml of water between each medication. I already flushed it with 30 ml of water before and after the medication pass. The facility failed to flush R163's feeding tube with 5 ml (milliliters) of water between each medication. 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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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. Based on record review and interview, it was determined that for two (R1 and R81) out of three residents reviewed for respiratory, the facility failed to have the CPAP(a repiratory device the deliers continuous positive airway pressure) settings written in the orders. Findings include: 1. Review of R21's clinical record revealed: 12/13/24 - R21 was admitted to the facility with diagnoses including but not limited to, obstructive sleep apnea. 12/13/24 - P2 (NP) ordered in R21's EMR, CPAP on at HS (hour of sleep), off in AM in the morning and at bedtime apply. The facility failed to order the CPAP machine settings required for R21's care. 2. Review of R81's clinical record revealed: 7/8/24 - R81 was admitted to the facility with diagnoses including but not limited to, obstructive sleep apnea. 8/3/24 - E5 (DO) ordered in R81's EMR, CPAP on at HS, off in AM, settings at bedtime apply and in the morning remove. The facility failed to order the CPAP machine settings required for R81's care. 5/22/25 11:07 AM - During a telephone interview, P5 (respiratory therapist) stated, Those two residents brought their home CPAP machines (to the facility). Likely their settings came from a sleep center. So all you have to do to find out the settings is plug the machine in and turn it on. The doctor is the person who enters the settings on the CPAP orders. 5/22/25 2:35 PM - During an interview, E2 (DON) confirmed that the CPAP orders for R21 and R81 did not contain the necessary settings for the machine. 5/23/25 2:30 PM - Findings were reviewed at the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview it was determined that the facility failed to ensure that it was free of medication error rate of 5 percent or greater. During medication pass observation on 5/16/25, 9 medication errors out of fourty four opportunities were identified, resulting in a medication error of 20.45% and affecting 1 resident (R163). Findings include: Cross refer F693 Observation of R163s' medication pass via the peg/feeding tube (a tube that is passed into a patient's stomach through the abdominal wall) revealed the following: 5/16/25 8:45 AM - E16 (LPN) opened the drawer of the medication cart and pulled out R163's morning medications. E16 proceeded to open the following medications and put into the medication cup: - Aspirin 81 mg capsule 1 cap - Multivitamin tablet 1 tab - Vitamin B12 1,000 mcg 1 tab - Vitamin D3 25 mcg 2 tablets - Gabapentin 300 mg 1 capsule - Magnesium Oxide 400 mg 1 tablet - Dantrolene Sodium 25 mg 1 capsule - Midodrine HCL 5 mg 1 tablet 5/16/25 8:48 AM - E16 poured the oral medications into the pill crusher pouch and then used the pill crusher to crush the capsules and tablets all together and in one batch. The 10 ml of Valproic Acid 250 mg/ml was poured in a separate medication cup. 5/16/25 9:06 AM - E16 entered R163's room, put on gloves and proceeded to check the peg/feeding tube for placement. E16 flushed the tubing with approximately 30 ml of water. Next, E16 dissolved the crushed medications in 30 ml water and E16 also mixed the 10 ml Valproic Acid separately in approximately 15 ml water. 5/16/25 9:08 AM - E16 was observed pouring all of R163's prepared medications into R163's peg/feeding tube which was flushed down with approximately 30 ml water. 5/16/25 9:15 AM - During interview, E16 confirmed that she administered R163's medications all at the same time and not one medicine at a time. 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and review of facility documentation, it was determined that the facility failed to establish and maintain 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 diseases and infections. The facility failed to have proper PPE (Personal Protective Equipment) worn for two employees after direct resident contact during bedside patient care observations. In addition, the facility failed to perform hand hygiene and change gloves for one employee during a wound dressing change observation. Findings include: The facility policy titled, Enhanced Barrier Precautions (2001) documented, . 1. Enhanced barrier precautions (EBPs) are used as infection prevention and control interventions to reduce the spread of multi-drug resistant organisms (MDROs) to residents . 2. 3. Gloves and gowns are applied prior to performing the high contact resident care activities . 4. Personal protective equipment (PPE) is changed and hand hygiene performed before caring for another resident. Review of the CDC (Centers for Disease Control and Prevention) Enhanced Barrier Precautions poster posted on the doors of R163 and R149 indicated that everyone must clean their hands before entering and when leaving the room . Providers and staff must also wear gloves and gown for the following High - Contact Resident Care Activities: - Dressing - Bathing/Showering - Transferring - Changing Linens - Providing Hygiene - Changing briefs or assisting with toileting - Device care or use: central line, urinary catheter, feeding tube, tracheostomy - wound Care: any skin opening requiring a dressing Cross refer F684 1. 4/9/25 - R163 had a physician's order for enhanced barrier precautions every shift. 5/16/25 8:45 AM - During a medication pass observation, E16 (LPN), proceeded to administer and pour a small cup of liquid medications into R163's peg/feeding tube (a tube that is passed into a patient's stomach through the abdominal wall). E16 did not wear a gown. The facility failed to apply complete enhanced barrier precaution when E16 did not wear a gown while administering medications on R163's feeding tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/16/25 9:10 AM - Observations were reviewed with E16, who also confirmed and stated, . I should have worn the gown . 5/22/25 5:00 PM - Finding was discussed with E1 (NHA) and E2 (DON). 2. 4/11/25 - R149 had a physician's order for enhanced barrier precautions every shift. Right Upper Buttock 2.a. 5/16/25 2:00 PM - During a wound dressing change observation, E19 (LPN) donned her gloves and proceeded to remove and discard R149's soiled wound dressing on her right upper buttock. Without removing the contaminated gloves, E19 started cleaning R149's open area with a wound cleanser. E19 continued to use the same contaminated gloves and proceeded to apply the medication, medical grade honey to the base of the wound and secured it with a clean bordered gauze. Right Lower Buttock 2.b. 5/16/25 2:15 PM - During a wound dressing change observation, E19 (LPN) donned her gloves and proceeded to remove and discard R149's soiled wound dressing on her right lower buttock. Without removing the contaminated gloves, E19 started cleaning R149's open area with a wound cleanser. E19 continued to use the same contaminated gloves and proceeded to apply the medication, medical grade honey to the base of the wound and secured it with a clean bordered gauze. Right Calf 2.c. 5/16/25 2:20 PM - During a wound dressing change observation, E19 (LPN) donned her gloves and proceeded to remove and discard R149's soiled wound dressing on her calf. Without removing the contaminated gloves, E19 started cleaning R149's open area with a wound cleanser. E19 continued to use the same contaminated gloves and proceeded to apply the medication, medical grade honey to the base of the wound and secured it with an abdominal pad a rolled gauze. 5/16/25 2:30 PM - Observations were reviewed with E16, who also confirmed and stated, . Yes I did not change gloves after I removed the soiled dressings and before I started applying the clean dressings. 2.d. 5/16/25 2:35 PM - During an incontinence care observation, E17 (CNA) was observed donning on a gown and the ties were not securely tied around her neck and on her back. E17 assisted E19 (LPN) in removing R149's soiled incontinence brief and as E17 turned R149 towards E17's side, the top of E17's gown dropped and fell on R149's trunk. E17 picked up the top of the gown and put it back on her again, still not securing the ties for the gown to stay in place. 5/16/25 2:45 PM - Observations were reviewed with E17, who also confirmed and stated that she did not securely tie the back of her gown and did not properly use the PPE. E17 further stated, I did not know I have to wear a gown when doing care for R149. When the nurse [E19] told me, I went in and I was in a hurry to put on my PPE/gown and I was not able to securely tie them around my neck and on my back. The gown kept falling while I was doing care for R149 5/22/25 5:00 PM - Findings were discussed with E1 (NHA) and E2 (DON). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA) and E2 (DON).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review and interview, it was determined that for five (R119, R143, R158, R160 and R267) out of ten residents reviewed for vaccines, the facility failed to ensure that these residents' vaccination status was accurately documented. For four (R119, R143, R158, R267) out of ten residents reviewed for vaccines, the facility failed to offer the four residents the pneumococcal vaccine. For six (R119, R143, R158, R160, R267) out of ten residents reviewed for vaccines, the facility failed to assess and document the residents' influenza vaccine. For R267, the facility failed to check Delvax, where there was documentation of a flu vaccine on 9/18/2024. Findings include: 1. Review of R119's clinical record revealed: 2/20/25 - R119 was admitted to the facility. 5/19/25 11:25 AM - A review of R119's EMR revealed no evidence of the facility assessing and offering R119 the influenza and the pneumococcal vaccines. 2. Review of R143's clinical record revealed: 4/14/25 - R143 was admitted to the facility. 5/19/25 11:28 AM - A review of R143's EMR revealed no evidence of the facility assessing and offering R143 the influenza vaccine. 3. Review of R158's clinical record revealed: 2/26/25 - R158 was admitted to the facility. 5/19/25 11:32 AM - A review of R158's EMR revealed no evidence of the facility assessing and offering R158 the influenza and the pneumococcal vaccines. 4. Review of R160's clinical record revealed: 2/27/25 - R160 was admitted to the facility. 5/19/25 11:35 AM - A review of R160's EMR revealed no evidence of the facility assessing and offering R160 the influenza vaccine. 5. Review of R267's clinical record revealed: 5/5/25 - R267 was admitted to the facility. 5/19/25 11:38 AM - A review of R267's EMR revealed no evidence of the facility assessing and offering R267 the influenza and the pneumococcal vaccines. Per the Delvax website, R267 received the influenza vaccine on 9/18/24 and the PPV23 pneumococcal vaccine on 2/17/22. The facility failed to offer R267 the PCV20 pneumococcal vaccine as per CDC recommendations. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/20/25 2:45 PM - The facility was unable to provide evidence of these residents' vaccination or declination of the vaccines when documentation was requested. 5/21/25 11:30 AM - During an interview, E2 (DON) stated that the facility was between a full-time infection preventionist (IP). E2 stated, The new IP will start at the end of May. 5/23/25 2;30 PM - Findings were reviewed at the Exit conference with E1 (NHA), E2 (DON) and E3 (ADON).

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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. Based on record review and interviews, it was determined that for three (R143, R158, R160) out of ten residents reviewed for vaccines, the facility failed to assess and offer the COVID vaccine. Findings include: 1. Review of R143's clinical record revealed: 4/14/25 - R143 was admitted to the facility. 5/19/25 11:28 AM - A review of R143's EMR revealed no evidence of the facility assessing and offering R143 the COVID vaccine. 2. Review of R158's clinical record revealed: 2/26/25 - R158 was admitted to the facility. 5/19/25 11:32 AM - A review of R158's EMR revealed no evidence of the facility assessing and offering R158 the COVID vaccine. 3. Review of R160's clinical record revealed: 2/27/25 - R160 was admitted to the facility. 5/19/25 11:35 AM - A review of R160's EMR revealed no evidence of the facility assessing and offering R160 the COVID vaccine. 5/20/25 2:45 PM - The facility was unable to provide evidence of these residents' vaccination or declination of the vaccines when documentation was requested. 5/21/25 11:30 AM - During an interview, E2 (DON) stated that the facility was between a full-time infection preventionists (IP). E2 stated, The new IP will start at the end of May. 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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on record review and interview, it was determined that for one (R65) out of thirty-five sampled residents, the facility failed to provide and evaluate staff for appropriate competencies and skill sets regarding R65's LVAD (left ventricular assist device) as identified in the resident assessment. Findings include: 5/19/25 1:30 PM - A review of the facility assessment, Section III Resources Needed documented the facility as having Special Care Needs population regarding: dialysis, hospice, ostomy care, tracheostomy care, bariatric care, palliative care, end of life care and LVAD (left ventricular assist device). 5/19/25 4:21 PM - During an interview, E1 (NHA) stated, I don't have competencies for the LVAD. [E41], the unit manager, has started some education for the LVAD but we don't have anything formalized. We need to get the staff more education on this. 5/20/25 2:15 PM - During an interview, R65 stated that the staff were knowledgeable about his LVAD. R65 stated that during the weekly drive line exit site dressing change, the staff wear the gowns and gloves. 5/20/25 2:35 PM - During an interview, E41 (LPN) reviewed the tasks involved in caring for a resident with an LVAD. E41 spoke knowledgably about charging the device and changing the batteries as well as about the weekly dressing change and the need for enhanced barrier precautions with care. 5/21/25 9:30 AM - A review of the [Hospital] LVAD Heartmate Discharge Binder revealed twenty-four (24), double-sided pages of pertinent information for the care of a person with an implanted LVAD. The topics covered in this manual included: emergency contact for the [hospital] LVAD team, daily care needs, system maintenance, allowed activities, instructions regarding the LVAD power module, mobile power unit, universal battery charger, the significance of the charge status lights, checking charge status, patient cable, and system controllers, as well as information regarding dental procedures, traveling, warfarin therapy, nosebleeds and cardiac medications. There were instructions regarding donning sterile gloves to perform the weekly, sterile Drive Line Exit site dressing. 5/23/25 - The facility furnished a two-page HMII (heartmate II) VAD (ventricular assist device) Competency checklist and initiated training for the staff. 5/23/25 2:30 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E3 (ADON).