STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore at Parkside	255 Possum Park Road Newark, DE 19711

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on observation, interview and record review, the facility failed to provide adequate supervision for R22, an independent resident who told multiple staff prior to the incident that he wanted to go home. On 11/10/25, R22 self-ambulated his wheelchair from the healthcare area to the independent living front lobby entrance and exited the building without staff knowledge. R22 continued down a main traffic road where the speed limit was 45 miles per hour for 0.3 of a mile and then called 911 where police officers responded. As a result of the inadequate supervision, R22's elopement from 4:50 AM to 5:21 AM had the potential to have a serious outcome, injury or death. An immediate jeopardy past non-compliance was called on 1/8/26 at 9:57 AM. Based on review and confirmation of the actions taken by the facility in response to this incident and no further elopements had occurred, the facility was back in substantial compliance as of 11/15/25. Findings include: Review of R22's clinical record revealed: 7/10/25 - R22 was admitted to the facility for short term rehab with diagnoses that included, but were not limited to orthostatic hypotension, repeated falls and dementia. 7/10/25 10:03 PM - The elopement evaluation by E23 (LPN) documented that R22 was not at risk for elopement. 7/16/25 - The admission MDS assessment revealed that R22 had a BIMS score of 13, which revealed that R22 was cognitively intact, and had no wandering behaviors. 7/17/25 - A follow-up note by E6 (Medical Doctor) documented that R22 . carries a history of recurrent falls. [R22] was actually asking when he would be able to be discharged . discussed with staff. Will review disposition with case management social services. 7/17/25 9:38 PM - The elopement evaluation by E23 (LPN) documented that R22 was not at risk for elopement. 7/31/25 10:56 PM - The elopement evaluation by E23 (LPN) documented that R22 was not at risk for elopement. 8/14/25 - A follow-up progress note by E6 (MD) documented that . Staff reports ongoing issues with impaired daily care and mobility. There was concern regarding his discharge plan. I was contacted by his primary care physician [D4's name] regarding his plan of care. She had concerns regarding his cognitive decline and his capacity for medical decision making. There were concerns regarding his safety at home and discharge planning issues. The patient denied any issues in this regard. At this time he indicates his goal would be to return home where he lives independently. We did discuss concerns regarding his underlying medical conditions and risks of failure. 8/28/25 - An acute progress note by E6 (MD) documented that . Staff reports that patient has completed his course of subacute rehabilitation. There was concern regarding his safety and appropriateness for discharge to home to live alone. Patient with desire to return home to live alone. Some concern regarding patient's ability to fully participate in the medical decision-making process as he may be unaware and fully understanding of the risks associated with his underlying medical conditions. 9/30/25 3:57 PM - A social services note by E4 (SSD) documented Spoke to resident today about discharging home tomorrow. Resident has been requesting to return home every day and states he is able to make his own decisions. 10/1/25 8:24 AM - A discharge note by E4 (SSD) documented Resident is discharging home where he lives alone. Resident has been requesting to return home. 10/1/25 9:18 AM - A social services note by E4 (SSD) documented SW [Social Work] had a meeting. Discussed the safety concerns with resident going home alone. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident is adamant about going home. It should be noted that R22 was not discharged from the facility on 10/1/25. 10/15/25 - A follow-up psych evaluation by E24 (NP) documented, .has a past psychiatric history of anxiety, depression, dementia, cognitive deficit. alert and oriented x 3. Patient reports that he wants to go home, reports that he is sad to be (sic) because it is not where he belongs. has some mild forgetfulness due to dementia. 10/16/25 9:42 PM - The elopement evaluation by E25 (MDS Coordinator) documented that R22 was not at risk for elopement. 10/22/25 3:12 PM - An activity note by E26 (AD) documented that R22 sits near the lobby or in the hall from time to time. He states his interest is to go home. 10/23/25 - A progress note by E6 (MD) documented . It has been 60 days since patient transition into long-term nursing care. He [R22] continues to focus on his discharge to home. We again had a lengthy discussion regarding safety issues in this regard. The patient carries a history of neurocognitive disorder and is unable to provide daily care to himself. 11/3/25 11:15 AM - A social services note by E4 (SSD) documented that . Today, resident [R22] asked for his checkbook and told me he would like to hold it in his room. 11/10/25 5:02 AM - The police report documented . I was dispatched to 201 Possum Park Road, [NAME] DE in reference to check on the welfare (sic). Upon arrival, I made contact with [R22] who advised he does not want to be at Millcroft Living anymore and walked out the door. [R22] stated he did not want to go back because he felt trapped. I responded to 255 Possum Park Road (Millcroft Living) and made contact with nurse [E27] who advised he received a phone call from RECOM advising that a patient has left the facility. I advised [E27] that we have [R22] and another Trooper will be transporting him over. [E27] is unsure how he escaped and I advised him that they should be more careful. [R22] refused any medical treatment. 11/10/25 8:00 AM - A nurse's note by E27 (LPN) documented, At approximately 0425 [4:25 AM] hours, I entered resident room to check on resident in B bed and observed resident leaving his room toward the area near the nurses station; he typically sits on a sofa near there. By 0500 [5:00 AM] hours, the resident was not in his usual location near the nurses station. I proceeded to search the building and then reported to the night supervisor, who informed me that he had just received a call indicating the resident exited the building and was in someone's custody. I went outside the building with the supervisor to locate the resident. The resident was brought back to the facility by two police officers and handed over after an interview. Resident (sic) when asked where he was going, he stated, ?I was going home in New Castle Delaware (sic) to come get me'. 11/10/25 9:21 AM - The elopement evaluation by E28 (RN/UM) documented that R22 was at risk for elopement. Following the elopement incident, the facility took the following immediate actions:-11/10/25 - Evening shift and night shift employees were educated on residents remaining within eyesight during shift if not in their rooms.-11/10/25 8:00 AM - Signs were posted to identify risk of elopement. 30-minute checks for 72 hours and check in and out log was created for R22.-11/10/25 9:57 AM - Physician's order obtained for wanderguard bracelet, applied to left ankle and monitored every shift for placement.-11/10/25 10:00 AM - R22 moved to second floor.-11/10/25 all day - Elopement protocol training.-11/13/25 - Elopement drills on evening and night shifts.-11/14/25 - Elopement drill on day shift.-11/14/25 - Elopement protocol training completed.-11/17/25 - Quality assurance meeting held. Reviewed identified time/location of incident; implemented visual site of all resident out of bed between 11 PM - 7 AM outside of 2-hour bed checks; all residents elopement risk have been updated; elopement evaluations to be completed every 4-weeks post admission; communicate any risk; education completed for all staff on risk identification; and elopement drills completed. 1/7/26 at 1:57 PM - During an interview, E29 (Receptionist) stated that the front entrance of independent living has coverage from 8:30 AM to 8:00 PM. E29 stated that the doors are on a timer and lock at 8:00 PM and the main phone transfers to the healthcare nursing station. E29 stated that no doors lock between the healthcare area and the independent living front entrance lobby. 1/7/26 2:05 PM - During an interview, E30 (Maintenance Director) stated that the front entrance door of independent living locks from the outside, not the inside. E30 stated that nobody can get in, but anybody can get out. 1/7/26 2:15 PM - During an (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	interview, E2 (DON) confirmed that he and E30 watched the facility video of the 11/10/25 elopement and E2 documented the timeline that was provided to the surveyor. The 11/10/25 timeline was: 4:45 AM - [R22] Exited room & [and] goes past the nursing station.4:48 AM - Goes into IL [independent living] hallway.4:50 AM - [R22] Left the building.5:21 AM - Police enter building.5:28 AM - Nurse met them.5:42 AM - Escorted [R22] back to his room. 1/7/26 2:55 PM - During a combined interview, E2 and E3 (ADON) confirmed that there have not been any elopements since the 11/10/25 incident involving R22. 1/7/26 2:28 PM - Observation of the front entrance door of independent living revealed that it is a fire exit door and has a sign in emergency push to open. 1/8/26 9:57 AM - An immediate jeopardy was called in the presence of E1 (Interim NHA), E2 and E3 regarding the 11/10/25 elopement of R22. Based on the immediate actions taken by the facility, no further elopements occurred, and interventions verified by the surveyor onsite during this survey, this incident was past non-compliance. 1/12/25 3:30 PM - Finding was reviewed during the exit conference with E1 and E2.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and facility record review, it was determined that the facility failed to ensure that it had a documented and updated facility assessment that included the conditions in the addendum. Findings include:Review of facility documents revealed:1/5/26 - A Significant Organizational Change facility assessment tool was completed by E1 (Interim NHA). 1/9/26 3:00 PM - A review of the facility assessment tool lacked evidence that the following addendums were included and attached in the assessment:- Facility - Payroll Based Journal Report- Staff Certification Requirements - Education Schedule Summary- Infection Control Risk Assessment - Inventory Listing- All Hazards Risk Assessment/Emergency Preparedness Plan- HIPAA Security Compliance Information- Authorization for Disclosure Policy & Procedure 1/12/26 9:00 AM - A request for the attachments to the addendum was made to E1 (Interim NHA). 1/12/26 2:46 PM - E1 confirmed that the facility did not have the attachments to the facility assessment addendum. 1/12/26 3:30 PM - Findings were reviewed with E1 and E2 (DON) during the Exit Conference.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation and interview, it was determined that the facility failed to handle, store, process, and transport laundry in a manner that prevents crossˆcontamination.Findings include:1/7/26, 10:30 AM - During a laundry tour with E32 (Housekeeping Staff), the surveyor observed that a smaller auxiliary laundry room was located adjacent to the main washer/dirty room, with its only entrance/exit door opening directly into the dirty laundry area. The smaller room contained a householdˆtype washers and dryers. The door to this room was open at the time of the observation.E32 stated that personal clothing for residents is washed and dried in this smaller room, and that clean laundry is then transported out through the main washer/dirty room. E32 reported that this practice has been in place for years. A designated clean laundry room exists on the opposite side of the main washer room; however, it was not being used for the processing or transport of these personal clothing items.1/7/26 4:15 PM - The findings were reviewed with E1 (Interim NHA).

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. Based on record review and interview, it was determined that for four (R3, R22, R28 and R94) out of four residents reviewed for care planning, the facility failed to ensure the care planning process facilitated the inclusion of the resident and/or resident representative in the development and implementation of each residents' person-centered care plan. Findings include: 1. Review of R22's clinical record revealed: 7/10/25 – R22 was admitted to the facility. 7/16/25 – The admission MDS assessment was completed. There was no evidence that a care plan conference was held with the resident/resident representative. 10/16/25 – The quarterly MDS assessment was completed. There was no evidence that a care plan conference was held with the resident/resident representative. 2. Review of R94's clinical record revealed: 12/13/25 – R94 was admitted to the facility. 12/19/25 – The admission MDS assessment was completed. R94 was discharged to hospital and returned on 12/24/25. 12/30/25 – The 5-day MDS assessment was completed. There was no evidence that a care plan conference was held with the resident/resident representative. 1/5/26 11:58 AM – During an interview, R94 and R94's family member stated that they don't recall participating in a care plan conference since admission. 1/8/26 3:50 PM – During an interview, E4 (SSD) stated that new admissions have an interdisciplinary meeting within 7 days of admission and short-term rehabilitation residents have care plan meetings based on each resident's progression in therapy. E4 stated that residents in long-term care have a care plan conference every 3 months within the month of the MDS assessment. E4 stated that she either sends an email to the interdisciplinary team members or announces care plan conferences during the morning meeting. E4 stated that she emails an invitation letter to the resident/resident representative. When asked by the surveyor where the care plan conferences are documented to show who participated and the resident's status addressed, E4 stated the care plan information was documented in the electronic health record under progress notes. The surveyor asked E4 to provide copies of the invitation letters to residents/resident representatives and the care plan conference progress notes. 1/9/26 8:55 AM – During a combined interview with E2 (DON), E28 (RN/UM) and E26 (AD), the surveyor was handed a document with handwritten note No care plan info. Surveyor confirmed that the facility had no evidence of documented care plan conferences and invitations to residents/resident representatives to participate. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of R3's clinical record revealed: 9/7/23 – R3's initial admission to the facility with diagnoses including anxiety disorder. 2/26/24 – R3 was readmitted to the facility from the hospital with diagnoses including pulmonary embolism (sudden blockage in a lung artery by a blood clot) and multiple sclerosis (nervous system disease that affects the brain and spinal cord). 1/5/26 1:30 PM – In an interview, R3 stated that she cannot recall attending a care plan meeting. 1/9/26 11:00 AM – A review of R3's progress notes lacked evidence of care plan meeting notes for the year 2025. 1/9/26 11:19 AM - In a telephone interview, F3 (Family Member) stated that she was not invited to any care plan meetings in years. 1/9/26 11:35 AM - During an interview, E3 (ADON) stated that she does not take down notes during care plan meetings, but she would check with the Social Worker, (E4 SSD) who was off that day (1/9/25). 1/9/25 2:00 PM – In a follow up interview, E3 confirmed that the facility lacked evidence of R3's care plan conferences. 3. A review of R28's clinical record revealed: 10/21/23 – R28 was admitted to the facility with diagnoses including hypertension and acute respiratory failure. 10/28/25 – R28's annual MDS assessment documented a BIMS score of 13, indicating intact cognition. 12/3/25 – A facility document entitled, Care Plan Report stated, .Last Care Plan Review Completed: 12/03/2025. 1/5/26 4:08 PM – During an interview, R28 stated, I don't know about anything regarding my care. The Surveyor asked R28, Are you informed of when care plan meetings will be held and invited to come? R28 stated, No. I haven't been to any care plan meetings. 1/8/26 3:45 PM – During an interview, E2 (DON) stated, [R28] does not come to care plan meetings and [R28]'s son doesn't return phone calls to come to care plan meetings. The Surveyor asked E2, Is there any documentation of when R28 or R28's son was informed of or invited to care plan meetings? E2 (DON) stated, [E4, Social Services Director] handles the documentation of care plan meetings. 1/8/26 4:15 PM – The Surveyor submitted a written request to E4 for documentation of R28's care plan meetings, attendees of the meetings and any correspondence to R28 or R28's son informing them of when care plan meetings were scheduled. During an interview E4 stated, I will look for [R28]'s care plan documents. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/9/26 10:15 AM – During an interview, E2 stated, [E4] left a note about [R28]'s care plans. No care plan documentation for [R28] was found. 1/9/26 2:49 PM – Finding was confirmed with E2 and E3 (ADON). 1/12/26 3:30 PM – Findings were reviewed with E1(Interim NHA) and E2 during the Exit Conference.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents foodborne illness to the residents, in reference to the FDA Food Code. Findings include:1/7/26 9:40 AM - During a kitchen tour with E31 (Director of Food and Beverages), the surveyor observed multiple open food items in the walk^in freezer that were not dated. The undated items included one bag of potato French fries, one bag of uncooked sweet potato fries, three bags of dinner rolls, three bags of bagels (one of which contained a moldy bagel), three bags of English muffins, and seven bags of sliced wheat bread.1/7/26 4:15 PM - The findings were reviewed with E1 (Interim NHA).

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on record review and interview, it was determined that for four (R3, R4, R39, R87) out of six reviewed for infection control, the facility failed to maintain an infection control program that obtained and documented on the monthly line listing the organism being treated by antibiotics. Findings include: 1. Review of R3's clinical record revealed:9/7/23 - R3 was admitted to the facility with diagnoses including but not limited to multiple sclerosis and neurogenic bladder with an indwelling suprapubic catheter.12/31/25- R3's EMR Follow Up note documented, .Patient seen for follow-up status post recent emergency room visit.She [R3] was recently seen in the emergency room for UTI (urinary tract infection) and continues on antibiotics at this time.1/8/26 11:41 AM - A review of the December 2025 infection control line listing revealed documentation of R3 receiving Cefpodoxime (an antibiotic) from 12/30/25 to 1/4/26. There was no documentation of the organism being treated on the line listing.1/8/26 1:15 PM - During an interview, E10 (Infection Preventionist) confirmed that the facility had not followed up with the emergency room to ascertain the urinary tract organism that R3 was being treated for.The facility failed to obtain and document the organism being treated with antibiotics as required for their infection surveillance program.2. Review of R4's clinical record revealed:9/25/25 - R4 was admitted to the facility with diagnoses including but not limited to dementia.1/8/26 11:45 AM - A review of the October 2025 infection control line listing revealed documentation of R4 receiving ciprofloxacin (an antibiotic) from 10/6/25 to 10/13/25. There was no documentation of the organism being treated in the line listing.The facility failed to obtain and document the organism being treated with antibiotics as required for their infection surveillance program.3. Review of R39's clinical record revealed:11/10/22 - R39 was admitted to the facility with diagnoses including, but not limited to, non-Hodgkin lymphoma.11/27/25 - E11 (NP) documented in R39's EMR progress notes, .He [R39] follows with Urology and had a urinalysis done and positive for UTI with recommendations for amoxicillin x 7 days.1/8/26 11:48 AM - A review of the November 2025 infection control line listing revealed documentation of R39 receiving amoxicillin from 11/25/25 to 12/2/25. There was no documentation of the organism being treated on the line listing.1/8/26 1:15 PM - During an interview, E10 (Infection Preventionist) stated that the facility uses McGeer's criteria for antibiotic stewardship.1/8/25 2:10 PM - A review of R39's EMR lacked documentation of symptoms that support prescribing an antibiotic according to the McGeer Criteria for Infection Surveillance. R39's documented vital signs showed no evidence of a fever at any time during the month of November 2025. R39 had not documented lab work since August 2025, so there were no documented leukocytosis or microbiologic urine specimen results.1/8/26 1:15 PM - During an interview, E10 confirmed that the facility had not followed up with the urology practice to ascertain the urinary tract organism that R39 was being treated for.The facility failed to obtain and document the organism being treated with antibiotics as required for their infection surveillance program.4. A review of R87's clinical record revealed:6/2/24 - R87 was admitted to the facility with diagnoses including, but not limited to, pancreatic cancer.1/8/26/12:01 PM - A review of the November 2025 infection control line listing revealed documentation of R87 receiving doxycycline from 11/25/25 to 11/29/25. There was no documentation of the organism being treated on the line listing.The facility failed to obtain and document the organism being treated with antibiotics as required for their infection surveillance program.1/8/26 11:30 AM - A review of the October, November, and December 2025 infection control line listing revealed multiple urinary tract infections documented as being treated with antibiotics without documentation of the pathogen/organism.-October 2025 Infection control line listing had four UTIs that were treated with antibiotics; only one listing named the organism.-November 2025 infection control line listing documented seven UTIs that were treated with antibiotics; only two listings named the pathogen.-December 2025 infection control line listing documented three UTIs treated with antibiotics; only one of the listings named the organism.1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interview and review of facility documentation, it was determined that for seven (E14, E15, E16, E17, E18, E20 and E21) out of seven facility staff reviewed, the facility failed to ensure that the required QAPI (Quality Assurance and Performance Improvement) training was completed. Findings include:1/12/26 1:30 PM - Review of the facility training records revealed a lack of evidence of QAPI training for the following facility staff:2/4/25 - E14's first day in the facility as RN (Registered Nurse).4/1/25 - E15's first day in the facility as RN.3/18/25 - E16's first day in the facility as CNA (Certified Nurse Aide).9/16/25 - E17's first day in the facility as CNA.6/10/25 - E18's first day in the facility as CNA.9/30/25 - E20's first day in the facility as Maintenance Tech.11/18/25 - E21's first day in the facility as Restorative Aide/CNA.1/12/26 2:00 PM - Findings were discussed with E1 (Interim NHA).1/12/26 3:30 PM - Findings were reviewed with E1 and E2 (DON) during the Exit Conference.

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. Based on interview and review of facility documentation, it was determined that for four (E16, E18, E20, and E21) out of four facility staff reviewed, the facility failed to ensure that the required Corporate Compliance and Ethics training was completed. Findings include:1/12/26 1:30 PM - Review of the facility training records revealed a lack of evidence of Corporate Compliance and Ethics training for the following facility staff:3/18/25 - E16's first day in the facility as CNA (Certified Nurse Aide).6/10/25 - E18's first day in the facility as CNA.9/30/25 - E20's first day in the facility as Maintenance Tech.11/18/25 - E21's first day in the facility as Restorative Aide/CNA.1/12/26 2:00 PM - Findings were discussed with E1 (Interim NHA).1/12/26 3:30 PM - Findings were reviewed with E1 and E2 (DON) during the Exit Conference.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on interview and review of facility documentation, it was determined that for seven (E14, E15, E16, E17, E18, E20 and E21) out of seven facility staff reviewed, the facility failed to ensure that the required Behavioral Health Care Needs training was completed. Findings include:1/12/26 1:30 PM - Review of the facility training records revealed a lack of evidence of Behavioral Health Care Needs training for the following facility staff:2/4/25 - E14's first day in the facility as RN (Registered Nurse).4/1/25 - E15's first day in the facility as RN.3/18/25 - E16's first day in the facility as CNA (Certified Nurse Aide).9/16/25 - E17's first day in the facility as CNA.6/10/25 - E18's first day in the facility as CNA.9/30/25 - E20's first day in the facility as Maintenance Tech.11/18/25 - E21's first day in the facility as Restorative Aide/CNA.1/12/26 2:00 PM - Findings were discussed with E1 (Interim NHA).1/12/26 3:30 PM - Findings were reviewed with E1 and E2 (DON) during the Exit Conference.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation and interview, it was determined that for one (R92) out of 32 sampled residents, the facility failed to ensure that R92 was treated with dignity and respect. Findings include: Review of R92's clinical record revealed:10/27/25 - R92 was admitted to the facility.10/30/23 - R92's admission MDS (Minimum Data Set) revealed that R92's cognition was moderately impaired. 1/7/26 1:50 PM - During an observation, R92, whose bed was near the open door, was seen from the hallway with her legs and thighs uncovered, exposing her skin and incontinence pad. R92 had a roommate with a male visitor (unidentified) at that time of observation. 1/7/26 - Subsequent observations from 1:53 PM through 2:01 PM revealed that R92's uncovered legs, thighs and incontinence pads were visible from the hallway. R92's roommate still had the male visitor with her in the same room. 1/7/26 2:05 PM - In an interview, E12 (LPN) confirmed the finding and stated that R2 had the tendency to kick her blanket off her. E12 further stated that she will attend to R92 and will put on her pants. 1/9/26 3:00 PM - Findings were discussed with E2 (DON) and E3 (ADON).1/12/26 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on record review and interview, it was determined that for three (R22, R80 and R106) out of four residents reviewed for accidents, the facility failed to allow these residents to exercise their right to self-determination by having their family contact representatives sign consents. Findings include: 1. Review of R22's clinical record revealed: 7/7/25 – The facility's Consent for Treatment, as part of the Resident Agreement was electronically signed by R22 that stated, You authorize Millcroft Living to provide care and treatment consistent with the terms of your Health Center admission Agreement, dated 7/10/25. You also authorize Millcroft Living to obtain all necessary clinical and/or financial information from the hospital or nursing facility from which you may be transferring. You have the right to request, refuse and/or discontinue treatment. If you are, or become, incapable of making your own medical decisions, we will follow the direction of the Delaware Consent Act. Under the Consent Act, persons shall have legal authority to make medical treatment decisions on your behalf in the following order of priority: -A court appointed guardian, if the health care decision is within the scope of the guardianship; -An attorney-in-fact appointed by you in a Durable Power of Attorney, if the health care decision is within the scope of authority; -A person giving priority by you based on another statutory provision;. This consent for treatment is executed this 7 day of July, 2025. 7/10/25 7:01 PM – An admission note by E15 (RN) documented that R22 was admitted to the facility. The note documented, . Resident A&O [alert and oriented] x [times] 2-3 and confused. DMOST and all admission paperwork was signed by one of the patients (sic) POA [F5]. The following consents were signed by F5 (R22's POA) and not R22, the resident: -Consent to scheduling/setting up transportation for appointments and requirement that a family member attend the appointment. F5 signed, dated 7/10/25 and wrote decline. -Authorization to use and/or disclose health information. F5 signed and dated 7/10/25. -Acknowledgement of receipt of resident rights. F5 signed and dated 7/10/25. -Consent to treatment and medication. F5 signed and dated 7/10/25. -Dental care authorization and assignment of benefits. F5 signed, dated 7/10/25 and wrote decline. -Immunization informed consent for influenza, pneumococcal and Covid-19 vaccinations. F5 signed, dated 7/10/25 and checked decline for all three vaccinations. -Pain management consent form. F5 signed, dated 7/10/25 and checked the consent for Tylenol medication. -Foot care authorization and assignment of benefits. F5 signed, dated 7/10/25 and wrote cut toe (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nails & [and] fingernails. -Patient portal access consent and authorization form. F5 signed, dated 7/10/25 and checked to voluntarily participate in and obtain access to the Patient Portal. -Bed rails informed consent and release. F5 signed, dated 7/10/25 and checked consent to the use of bed rails as recommended. -Delaware Medical Orders for Scope of Treatment (DMOST) was signed by F5 on 7/10/25 and signed by E11 (contracted NP) on 7/11/25. It should be noted that F5 signed the DMOST document in the signature section above the following statement: .If [aA]uthorized [rR]epresentative signs, the medical record must document that a physician has determined the patient's incapacity & the [aA]uthorized [rR]epresentative's authority, in accordance with DE [Delaware] law. 7/11/25 – An initial consult note by E11 (contracted NP) documented, . past medical history of. dementia, major neurocognitive disorder. alert and oriented x 2-3. Discussed with resident [R22] and POA [F5's name] overall goals of care. They wish to be a DNR with treatment of symptoms only. Consent: POA [F5] agreed to discuss advance directives. This note did not document R22's determination of incapacity. 7/12/25 3:53 PM – The speech therapy evaluation and plan of care documented R22's BIMS as a 13, cognitively intact. 7/13/25 – The social services initial evaluation documented that R22 had a BIMS score of 13, which revealed that R22 was cognitively intact. 1/9/26 8:25 AM – During an interview, E22 (Admissions Coordinator) stated that the facility's practice was that the admitting nurse obtain all of the signed consents and the resident's POA document, if applicable. E22 stated that she completed the resident admission agreement during business hours and that she was not involved with R22's consents or the POA document. The facility failed to promote and facilitate R22's right to self determination with respect to signing his own consents and DMOST. 2. Review of R106's clinical record revealed: 7/25/25 – R106 was admitted to the facility with diagnoses including but not limited to pancreatic cancer. 7/25/25 11:41 AM –R106's [Hospital] Interagency Discharge Orders documented, . Discharge Diagnoses: Acute hyperactive delirium due to another medical condition. Additional Instructions from the Care Team.You were admitted to the hospital with altered mental status, unable to exactly fond out the cause, but probably medication induced, but now mentation has improved. 7/25/25 – F7 (R106's wife) signed R106's consents for Acknowledgement of receipt of Resident Rights, Consent to treatment and Medication, Pain Management Consent form and Bed Rails Informed Consent and release form. 7/25/25 8:32 PM – R106's EMR (electronic medical record) admission Summary documented, . (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Patient awake, alert, oriented X3-4. Patient's wife signed all his admission consents and paperwork. 7/26/25 - F7 declined and signed R106's Dental Care authorization and assignment of benefits. 7/28/25 – E6 (MD) completed R106's DMOST (Delaware Medical Orders for Scope of Treatment) form and had F7 sign it. 7/30/25 – E24 (psych NP) documented in R106's Psychiatric evaluation, .Mental status Examination: Appearance/Behaviors: calm/cooperative, Sensorium: alert, Orientation: person, place, time, Speech: coherent, Affect: appropriate . Concentrations: fair, insight: poor, Judgment: fair. 7/31/25 – R106's admission MDS (Minimum Data Set) revealed R106's BIMS (Basic Inventory of Mental Status) as 13, which was reflective of normal cognition. 8/1/25 10:00 AM – F7 signed R106's [facility] Transfer/Discharge Report prior to discharge from the facility to home. 3. Review of R80's clinical record revealed: 8/28/23 – R80 was admitted to the facility. 8/4/25 - R80's quarterly MDS (Minimum Data Set) assessment documented that R80's BIMS (Basic Inventory of Mental Status) as 14, which is reflective of normal mentation. 9/25/25 – R80 was re-admitted to the facility after hospitalization for COVID pneumonia with acute respiratory failure and hypoxia (low oxygen saturation). 9/25/25 11:21 PM – R80's clinical admission nursing progress note documented, . mental Status: resident is alert & oriented X 3. Oriented to time. Oriented to person, Oriented to place. Level of cognitive impairment: alert. Resident is coherent. Speech is clear. Resident makes self understood (sic). Resident understands others. Mental Status note: alert and oriented X 3. 9/26/25 - E8 (RN/Unit manager) obtained consent via the telephone from F1 (R80's daughter) for the bedrails informed consent and release form. 9/27/25 – E8 obtained consent via the telephone from F1 (R80's daughter) for the appointment scheduling consent, the consent to treatment and medication, the pain management consent form, and the psychopharmacologic medication informed consent forms. The facility failed to allow R80 to exercise his right to self-determination by having his daughter sign consents when R80 was capable of understanding and signing his own consent forms. 10/1/25 – R80's admission MDS assessment documented that R80's BIMS (Basic Inventory of Mental Status) as 13, which is reflective of normal mentation. 10/14/25 – R80 signed his immunization informed consent form. 1/8/26 10:58 AM – During a combined interview, E8 (RN) stated, [R80} was his own person. He can make his own decisions. E9 (LPN) stated, Oh, he makes his own decisions. He is able to sign his (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	name. He has MS (multiple sclerosis) so he cannot move his lower extremities but his upper extremities are good. 1/8/26 11AM – During an interview, R80 confirmed that he is able to sign his signature with his right arm. 1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review and interview, it was determined that for one (R106) out of eighteen residents reviewed for quality of care, the facility failed to notify family representative of the resident's 8/1/25 lab work. Findings include:Facility Consent for Treatment form stated, We will keep you informed about the routine nursing and emergency care we provide to you, and we will answer your questions about the care and service we provide you. Last reviewed 7/9/20247/24/25 - E6 (MD) ordered in R106's EMR, Labs - CMP (complete metabolic panel), CBC (complete blood count) in one week from date of admission. 7/25/25 - R106 was admitted to the facility with diagnoses including but not limited to pancreatic cancer.7/31/25 - R106's admission MDS (Minimum Data Set) revealed R106's BIMS (Basic Inventory of Mental Status) as 13, which was reflective of normal cognition.8/1/25 8:12 AM - R106 had labs (CMP, CBC) drawn at the facility.8/1/25 10:00 AM - F7 (R106's wife) signed R106's discharge paperwork and R106 was discharged from the facility.8/1/25 11:29 AM - R106's lab results were reported to the facility. There were several abnormalities within the lab results, including hyponatremia (low sodium) and anemia (low hemoglobin).1/7/26 2:42 PM - During a telephone interview, F7 (R106's wife) stated, They [the facility] never called me with the lab results.Had I known this on Friday, August 1st, I would have taken [R106] to the ED (emergency room) immediately and perhaps we would have had a different outcome.1/9/26 10:09 AM - During an interview, E28 (RN/UM) stated, I remember telling his wife [F7] that he [R106] had labs that morning. I did not call her with the results. We don't have a protocol for that because we rarely get labs on the day of discharge. I guess she got the lab results from the portal.1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that for one (R6) out of one resident reviewed for discharge, the facility failed to ensure that R6 had home health services arranged per the discharge plan from the facility to home on [DATE] (Friday). Findings include: Review of R6's clinical record revealed:9/26/25 - R6 was care planned for discharge with the goal to be discharged to home. Approaches included:-home health services per physician order;-physician to review discharge and admission orders, care plan and prior level of function;-therapy services per physician order.12/5/25 - An insurance appeal determination letter documented, A review of the medical records received shows that the patient [R6] was admitted to a SNF [skilled nursing facility]. Self-care tasks such as bathing, dressing, and toileting require moderate to maximum assistance. Bed mobility tasks require supervision assistance. Transfer tasks require moderate assistance. The patient can walk up to 50 feet with a wheeled walker and moderate assistance. The patient can be transferred to Home with support from Home Health services.12/11/25 10:01 AM - A BIMS evaluation by E4 (SSD) revealed that R6 was cognitively intact with a score of 15.12/11/25 10:03 AM - R6's discharge information was printed and included R6's facesheet, medication review report, 9/29/25 history and physical note by E6 (MD), 12/8/25 acute progress note by E6, 9/26/25 physician's orders to flush nephrostomy (tube) and change dressing, 12/9/25 physical therapy and occupational discharge summaries, and a handwritten prescription for home health care for PT/OT, RN and HHA by E6. (30 pages)12/11/25 - A discharge progress note by E6 (Medical Doctor) documented, . Suprapubic catheter and left percutaneous nephrostomy tube were maintained. Ultimately he met his therapy goals. Consequently he was felt stable for discharge to home with close ongoing care as an outpatient . Discharge Instructions: Reviewed with patient and staff Home Health: Per social services Physical and Occupational Therapy Skilled nursing Home health aide. Certification Period: 60 days I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. Impaired mobility leaving home requires a considerable and taxing effort a normal inability to leave the home Reason for Home Health Services: The patient requires home health services because of the below listed diagnosis. Chronic kidney disease. Hypertension. Hydronephrosis with renal and ureteral calculous obstruction. Bladder outlet obstruction. Physical deconditioning Plan: Patient appears medically stable for discharge to home in the morning with close ongoing care as an outpatient. Social services will arrange for home health care. This was all reviewed at length with the patient and the staff prior to discharge.12/12/25 11:00 AM - The Transition of Care and Discharge Summary, started on 12/4/25 at 9:32 PM, documented R6's discharge date of 12/12/25. Under the Social Services section, R6 was being discharged to home/community and had the following services checked that were recommended upon discharge: home health nursing services [B1's company name] and home health therapy services [B1's company name]. Under the nursing section, the summary included that R6 had a suprapubic catheter and a left nephrostomy tube. Under the therapy section, the summary documented that R6 required partial/moderate assistance with bed mobility, dressing, bathroom activity; required substantial/maximal assistance for transfers, bathing and the ability to move from one location to another.12/12/25 (untimed) - A facility fax cover sheet documented that E4 (SSD) handwrote to B1 (home health company name) [R6's name] D/C [discharge] 12/12/25 Needs PT, OT, HHA, RN.12/12/25 1:34 PM - An email transmittal from B1 (home health care company name) confirmed referral information of 31 pages received.12/12/25 2:06 PM - A discharge summary by E33 (RN) documented, Resident discharged home alert and in stable condition. discharged with facility transport with personal belongings, paperwork, remaining medications.1/5/26 - A typed statement by E4 (SSD) and provided to the surveyor documented, I have spoken to [R6's name] on several (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occasions as well as his [R6's family member] on one occasion to discuss the challenges of obtaining home health (PT, OT, HHA and RN) due to his [B8's name] insurance plan. Referrals were sent to [company names of B1, B2, B3, B4, B5, B6 and B7]. [B1]- Could not accept due to no staffing in his area. I also was told that [B1] was having a contracting issue with [B8, name of insurance company] therefore were not taking any of their members. [B2, B3 and B4]- Do not accept his insurance. [B7]- Does not service [NAME]/Bear area. [B5 and B6]- Had no staff during referral period.When speaking to [R6], I encouraged him that as the new year approaches, he should consider looking into other insurance options that may have better home health availability for any future needs he may have. This conversation took place via phone on 12/19/25. This was the last time I spoke to [R6]. I also let [R6] know that he should contact his PCP [primary care physician] to get an outpatient PT, OT script for continued therapy.The facility failed to ensure R6 had home health services arranged per the discharge plan.1/12/26 3:30 PM - Findings were reviewed during the exit conference with E1 (Interim NHA) and E2 (DON).

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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. Based on record review and interview, it was determined that for one (R46) out of one resident reviewed for PASARR (Preadmission Screening and Resident Review), the facility failed to complete MDS assessments to accurately reflect changes in R46's behavior and medication status. Findings include:Review of R46's clinical record revealed:11/15/2024 - R46 was admitted to the facility with diagnoses including hypertension and osteoarthritis.4/29/2025 - A Behavior Note entered in R46's clinical record documented, [R46] noted agitated sitting around nurse's station.asking roommate to get off his property.[R46] yelling at everyone to vacate his property.5/26/2025 9:30 PM - A Behavior Note entered in R46's clinical record documented, [R46] continues to yell at the nursing station.5/29/25 - A quarterly MDS assessment completed for R46 indicated no behaviors of delusions or yelling at others.8/22/25 9:04 AM - A Behavior Note entered in R46's clinical record documented, Staff reported that [R46] was aggressive verbally and physically hitting his CNA in the face.aggression started when [R46] was verbally aggressive to another resident, yelling and cursing at her with family present.8/25/25 5:34 PM - An Alert Charting Note entered in R46's clinical record stated, .[R46] is telling other residents to shut up or yells profanity at them. [R46] swatted his hand in front of another resident's face.9/2/25- R46's quarterly MDS assessment indicated R46 had not exhibited any behaviors consisting of delusions, hitting, threatening or cursing at others.8/27/25 7:24 PM - A Behavior Note entered in R46's clinical record documented, [R46] agitated [sic].talking about someone stealing his truck, cussing at staff members.11/3/25 9:02 PM - A Behavior Note entered in R46's clinical record documented, [R46] extremely agitated and hostile. [R46] asked this nurse if she had a gun so he could shoot another resident. [R46] yelled profanity towards other residents.11/4/25 4:05 PM - A Behavior Note entered in R46's clinical record documented, [R46] is agitated at this time and yelling profanity at staff and residents.redirection ineffective.11/5/25 5:00 PM - Review of R46's Medication Administration Record documented that Depakote Oral Tablet 125 MG, an anticonvulsant medication, was ordered for R46 to be given three times a day.11/22/25 - R46's annual MDS assessment indicated R46 had not exhibited any verbal behaviors of threatening, screaming, or cursing at others. The assessment also documented that R46 was not taking an anticonvulsant medication.1/9/26 2:45 PM - During an interview, E5 (MDS Coordinator) stated, The MDS assessments should have documented [R46]'s hitting, yelling, and cursing behaviors. The Depakote medication should have been documented as an anticonvulsant on the MDS.1/9/26 2:49 PM - Finding was confirmed with E2 (DON) and E3 (ADON).1/12/26 3:30 PM - Findings were reviewed with E1(Interim NHA) and E2 during the Exit Conference.

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	085021	A. Building B. Wing	01/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore at Parkside	255 Possum Park Road Newark, DE 19711

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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. Based on observation, interview and record review, it was determined that for one (R94) out of two residents reviewed for catheters and one (R91) out of three residents reviewed for ADLs (Activities of Daily Living), the facility failed to ensure that a person-centered care plan was developed to address each residents' identified needs. Findings include:1. Review of R94's clinical record revealed: 12/13/25 – R94 was admitted to the facility with a diagnosis of a stroke. 12/15/25 – A physician's order stated to bladder scan q6 [every 6 hours]. Straight cath if PVR [post void residual] is greater than 400 ml [milli-liters]. Document output every 6 hours. Review of the R94's care plan lacked evidence of the development to address R94's urinary retention and the approaches on how the facility would meet R94's needs. 1/9/26 3:08 PM – During a combined interview with E2 (DON) and E3 (ADON), finding was reviewed and confirmed. 2. Review of R91's clinical record revealed: 12/16/25 – R91 was admitted to the facility with diagnoses including severe dementia with agitation. 12/17/25 – R91 had a care plan developed for impaired ability to perform or complete activities of daily living for oneself such as dressing, bathing or toileting. Interventions included to provide assistance as needed. 12/22/25 – R91's admission MDS (Minimum Data Set) revealed that R91's cognition was severely impaired with no mood nor behavioral issues. R91 required substantial to maximal assistance of one staff person for upper body dressing including the ability to dress and undress above the waist using fasteners if applicable. 1/5/26 12:49 PM – In an interview, F2 (Family Member) stated, Every time I come to visit my mom, she does not have her bra on. They [staff] are not putting my mother's bra on her! 1/7/26 2:30 PM – An observation of R91 in her room sitting in her wheelchair revealed that R91 did not wear a bra. 1/7/26 2:32 PM - In an interview, E13 (CNA) stated, I did not put her bra on because she refuses and fights back a lot when you put it on her. [R91] would say 'No, I don't want it'. When asked if she notified the nurse, E13 replied, No, I did not notify the nurse. 1/7/26 2:45 PM – A further review of R91's record lacked evidence that a person-centered care plan was developed to address R91's refusal to wear a bra when wearing day clothes. 1/9/26 3:00 PM – Findings were discussed with E2 (DON) and E3 (ADON). 1/12/263:30 PM – Findings were reviewed with E1 (Interim NHA) and E2 during the Exit Conference.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on record review and interview, it was determined that for one (R80) out of four residents reviewed for respiratory care, the facility failed to review and revise the resident's care plan. Findings include: 8/28/23 - R80 was admitted to the facility.9/25/25 - R80 was re-admitted to the facility after hospitalization for COVID pneumonia with acute respiratory failure and hypoxia (low oxygen saturation).9/25/25- E6 (MD) ordered in R80's EMR, Change mask/cannula and tubing and clean oxygen concentrator filter every night shift every Thursday.10/1/25 - R80's admission MDS (Minimum Data Set) assessment documented that R80 was using supplemental oxygen.1/8/26 12:30 PM - A review of R80's care plan lacked evidence of the addition of R80's supplemental oxygen intervention, goals and tasks.1/8/26 1:11 PM - During an interview, E7 (RNAC) stated, I don't see any mention of oxygen therapy in [R80]'s care plan. I will add it.The facility failed to revise R80's care plan to include his supplemental oxygen requirement after the 10/1/25 MDS assessment.1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.

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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, observation and interview, it was determined that for one (R80) out of four residents reviewed for respiratory care, the facility failed to provide care consistent with professional standards as the supplemental oxygen tubing was out-of-date. Findings include:8/28/23 - R80 was admitted to the facility.9/25/25 - R80 was re-admitted to the facility after hospitalization for COVID pneumonia with acute respiratory failure and hypoxia (low oxygen saturation).9/25/25- E6 (MD) ordered in R80's EMR, Change mask/cannula and tubing and clean oxygen concentrator filter every night shift every Thursday.9/25/25 10:51 PM - R80's alert charting note documented, Resident arrived at facility via stretcher on oxygen 2L (liters) via nasal cannula.1/5/26 (Monday) 2:15 PM - An observation of R80's supplemental oxygen tubing revealed that it was marked as having been changed on 12/26/25 (11 days prior).1/8/26 (Thursday) 1:11 PM - An observation of R80's supplemental oxygen tubing revealed that it was marked as having been changed on 12/26/25 (14 days prior).1/9/26 1:37 PM - An observation of R80's supplemental oxygen tubing revealed that it was marked as having been changed on 12/26/25 (15 days prior).The facility failed to provide care consistent with professional standards by failing to replace R80's supplemental oxygen tubing after seven days.1/12/25 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. Based on record review and interview, it was determined that for one (R22) out of four residents reviewed for accidents, the facility failed to ensure that R22 received medically-related social services, when it was determined that the resident lacked capacity for medical decision making in F6's (MD) progress note dated 11/10/25. Findings include: The facility's job description of Social Worker, updated July 2015, included, but were not limited to the following job duties:- . 2. Assists with the coordination of Health Center admissions. 9. Maintains regular and on-going relationship with family to discuss needs or concerns, mediates issues that may arise between resident/family/staff. Cross refer to F553 example #1 and F561 example #1 Review of R22's record revealed: 9/21/25 - A typewritten letter from F5 (R22's POA/friend) to R22 stated, September 21, 2025. [R22's name] As you have informed me, in a few days you'll be returning to your home. You've asked me for keys and I am enclosing the set you gave me some time ago . I am reminding you I will no longer be available for assistance effective date of this letter. I am officially retiring. I wish you the best in your journey ahead and hope you can find another assistant that gives as much as I have tried to do. 9/30/25 3:57 PM - A social services note by E4 (SSD) documented, . Resident states his POA [F5's name] is trying to keep him from returning home and it's his right to return home if he wants. POA [F5] had provided a letter to resident stating that she is handling over his keys to him and does not want to be involved in his care as she is retired. Called and left a message for POA [F5's name] to inform her of the discharge as well. No return phone call. It should be noted that R22 was not discharged from the facility. 10/20/25 - R22's printed facesheet revealed that F5 continued to be listed as R22's POA despite the 9/21/25 letter that F5 would no longer be available for assistance. There was no evidence of follow-up by social services in response to F5's 9/21/25 letter. 11/10/25 - An acute progress note by E6 (Medical Director) documented, . He [R22] remains frustrated and angry about being in this facility. We have had multiple discussions in the past regarding his disposition and the discharge planning process. We have discussed multiple times that he is unsafe to live at home alone. Unfortunately, he does not have any options in regards to help at home. He became somewhat agitated during our meeting and refused to answer additional questions regarding his condition. Encounter for assessment of decision-making capacity. Patient does not possess medical capacity to fully partake in medical decision making process. Patient with poor insight and unaware of safety risks. Patient unable to live at home alone without 24-hour supervision. Patient with recent elopement earlier this morning and was found off facility grounds down the street. Patient unable to provide details in regards to this elopement. Social services will continue to work with patient and any family members regarding disposition and ultimate discharge planning process. The facility lacked evidence of social services follow-up to the 11/10/25 determination of R22's incapacity for medical decision making. 1/5/26 1:07 PM - A copy of R22's current facesheet revealed that F5 continued to be listed as R22's POA-Care despite the 9/21/25 letter provided to R22 and given to the facility stating that she would not be available going forward. The facesheet also listed F8 (R22's family member), but it did not identify F8 as a POA contact. 1/9/25 1:00 PM - During an interview, surveyor asked E2 (DON) for a copy of R22's POA document as it was not in his electronic clinical record. In response, the facility handed the surveyor a copy of an attorney's office cover letter only, dated 8/17/18, that stated the following, . I am enclosing a copy of a durable power of attorney [DPOA] which give (sic) [F8's first name only, F6's first name only, F5's first name only, and F9's first name only] the power to act for you, individually or jointly, effective immediately. This document gives [F8's first name, F6's first name, F5's first name, and F9's first name] the power to make health care decisions for you. It was confirmed that the facility failed to obtain a copy of the actual legal document to confirm the resident's four DPOAs with full names listed, which included F8 (R22's only family member). 1/12/26 3:30 PM - Finding was reviewed during the exit conference with E1 (Interim NHA) and E2.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on interview and record review, it was determined that for one (R3) out of two residents reviewed for dental services, the facility failed to provide or obtain from an outside resource, R3's routine dental services. Findings include:Cross refer F553 and F656Review of R3's clinical record revealed:12/15/25 - R3's quarterly MDS assessment revealed that R3 had a BIMS score of 15 and an intact cognition.1/5/26 1:35 PM - In an interview, R3 stated that it has been a long time since she was last seen by the dentist. R3 stated, I did not know that I can be seen by a dentist here in the facility.1/9/26 11:10 AM - Further review of R3's clinical records lacked evidence of dental consults and appointments for 2025.1/9/26 11:30 AM - In a telephone interview, F3 (Family Member and POA) stated that she and R3 prefer to set up the appointments and transportation services for R3's outside facility consultations and that included an unsuccessful dental clinic visit. When asked if R3 was seen by the dentist lately, F3 stated that R3 was all set up for the dental visit one time but the dentist (not identified) did not see R3. F3 stated, The dental clinic was very tight, the place for her to sit could not accommodate [R3's] motorized chair. [R3] was not seen at all. I am wondering if the facility has a dentist that visits the place so [R3] will not have the same accommodation issue again. 1/9/26 11:50 AM - During an interview, E3 (ADON) stated she was aware that R3 canceled her dental appointment in the past. E3 also stated that she was aware of the accessibility issue of R3's motorized chair when R3 went out to the dental clinic. E3 stated, I was just talking to [F3] on the phone now, and I told her we have a dentist [D3] who comes to the facility and he can see [R3]. 1/9/25 2:30 PM - In a follow up interview, E3 reported to the surveyor that D3 will see R3 for dental consultation on Sunday, 1/17/26. 1/12/26 3:30 PM - Findings were reviewed with E1 (Interim NHA) and E2 (DON) during the Exit Conference.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on interview and facility record review, it was determined that the facility failed to ensure that it had a written transfer agreement in effect with one or more hospitals approved for participation in Medicare/Medicaid programs. Findings include:Review of facility documents revealed:12/15/25 - A [NAME] of Sale between O1(former facility owner) and O2 (new facility owner) was made and entered into. 1/12/26 9:00 AM - A request for the facility's written transfer agreement was made to E1 (Interim NHA). 1/12/26 2:46 PM - E1 confirmed that the facility did not have a written transfer agreement. 1/12/26 3:30 PM - Findings were reviewed with E1 and E2 (DON) during the Exit Conference.

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F 0844 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Follow rules about disclosure of ownership requirements and tell the state agency about changes in ownership and/or administrative personnel. Based on interview and facility record review, it was determined that the facility failed to ensure that it has complied with the disclosure of ownership requirements. Findings include:Review of facility documents revealed:12/15/25 - A [NAME] of Sale between O1(former facility owner) and O2 (new facility owner) was made and entered into. 1/12/26 9:00 AM - A request for the facility's written notice to the State Agency responsible for licensing with disclosure requirements at the time of change was made to E1 (Interim NHA). 1/12/26 2:46 PM - E1 confirmed that the facility did not have the document with the facility disclosure of ownership requirements. 1/12/26 3:30 PM - Findings were reviewed with E1 and E2 (DON) during the Exit Conference.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation, record review and interview, it was determined that for one (R94) out of four residents reviewed for accidents, the facility failed to ensure R94's bilateral bed rails were being included in a routine maintenance safety check. Findings include: Review 94's clinical record revealed: 1/5/26 2:11 PM - Observation of bilateral bed rails positioned up on R94's bed. 1/9/26 9:49 AM - Observation of R94 in bed revealed bilateral bed rails positioned up and no gap. R94 confirmed that he used them during therapy sessions. 1/9/26 10:13 AM - During an interview, E30 (Maintenance Director) was asked if there are routine maintenance/safety inspections of bed rails being performed in the facility. He stated no, but he would start doing this. E30 stated that maintenance staff would apply resident bed rails when the request was submitted through the maintenance work order system. He also stated that therapy would remove bed rails if they were no longer necessary. 1/12/26 3:30 PM - Finding was reviewed during the exit conference with E1 (Interim NHA) and E2 (DON).

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. Based on interview and review of facility documentation, it was determined that for seven (E14, E15, E16, E17, E18, E19, and E21) out of seven facility staff reviewed, the facility failed to ensure that the required Communications training was completed. Findings include:1/12/26 1:30 PM - Review of the facility training records revealed a lack of evidence of Communications training for the following facility staff:2/4/25 - E14's first day in the facility as RN (Registered Nurse).4/1/25 - E15's first day in the facility as RN.3/18/25 - E16's first day in the facility as CNA (Certified Nurse Aide).9/16/25 - E17's first day in the facility as CNA.6/10/25 - E18's first day in the facility as CNA.10/8/24 - E19's first day in the facility as LPN (Licensed Practical Nurse).11/18/25 - E21's first day in the facility as Restorative Aide/CNA.1/12/26 2:00 PM - Findings were discussed with E1 (Interim NHA).1/12/26 3:30 PM - Findings were reviewed with E1 and E2 (DON) during the Exit Conference.

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F 0837 Level of Harm - Potential for minimal harm Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on interview and facility record review, it was determined that the facility failed to ensure that it has an active governing body that is responsible for establishing and implementing policies regarding the management of the facility. Findings include:Review of facility documents revealed:12/15/25 - A [NAME] of Sale between O1(former facility owner) and O2 (new facility owner) was made and entered into. 1/12/26 9:00 AM - A request for the names and contact information of the members of the governing body was made to E1 (Interim NHA). 1/12/26 2:46 PM - E1 confirmed that the facility did not have the names and contact information of the members of the governing body.1/12/26 3:30 PM - Findings were reviewed with E1 and E2 (DON) during the Exit Conference.