STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085028	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wilmington Nursing & Rehabilitation Center	700 Foulk Road Wilmington, DE 19803

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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 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.

32545

Based on interview and record review, it was determined that one (R76) out of four residents reviewed for resident rights, the facility failed to identify and facilitate the resident's self-determination through support of resident choice with respect to his scheduled shower times. Findings include:

R76's clinical record revealed:

4/29/24 - The admission MDS assessment documented that R76's response to While you are in this facility, how important is it to you to choose between a tub bath, shower, bed bath, or sponge bath? R76's response was very important.

10/11/24 (last revised) - R76 was care planned for requiring one staff person assist for bathing.

According to the November 2024 CNA Documentation Survey Report, R76 was scheduled showers every Tuesday and Friday during day shift and as needed. However, closer review of the Report revealed that the report was setup for staff to document during day shift every Monday and Thursday and PRN (as needed). Four out of four scheduled opportunities from 11/18/24 to 11/30/24, no showers were provided to R76 nor was it documented that R76 refused. On Thursday, 11/21/24, staff documented that R76 received a shower during evening shift under PRN.

Review of the December 2024 CNA Documentation Survey Report revealed that five out of five scheduled opportunities from 12/1/24 through 12/16/24, no showers were provided to R76 nor was it documented that R76 refused.

12/19/24 at 8:30 AM - During an interview, R76 stated that he hasn't had a shower since last month. When asked about his scheduled showers, R76 explained that he gets up early every day and was already dressed when the staff approach him about a shower. R76 explained that he does not refuse showers, but that he doesn't want to get undressed.

12/19/24 at 11:00 AM - During an interview, E18 (CNA) stated that R76 was already up and dressed when day shift starts care. E18 confirmed that R76 was scheduled for showers every Tuesday and Friday day shift. E18 stated that she tells the assigned nurse when he doesn't take a shower.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/19/24 at 11:02 AM - During a combined interview with E4 (RN/UM) and E6 (RN/UM), E4 heard that R76 refused yesterday. Surveyor reviewed the November 2024 and December 2024 CNA Documentation Survey Reports where the CNAs are not documenting refusals. Surveyor asked if any nursing staff spoke with R76 to determine why showers were not being done and to determine his choice of a scheduled shower time. There was no response. Review of R76's nursing progress notes lacked evidence that staff identified and facilitated discussion with R76 to determine his choice of a scheduled shower time. 12/23/24 at 12:00 PM - Finding was reviewed during the exit conference with E1 (NHA) and E2 (DON).

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 32545 Based on interview and record review, it was determined that for one (R116) out of seven residents sampled for incontinence and one (R26) out of one resident sampled for hospice, the facility failed to review and revise each residents' care plan. Findings include: 1. Cross refer F690, example 5 R116's clinical record revealed: 8/20/24 - R116 was admitted to the facility. 8/20/24 at 9:50 PM - The Admission Nursing Collection Tool documented that R116 was cognitively intact upon arrival, continent of bowel and bladder with an intervention to supervise or cue to toilet as needed and required partial/moderate assistance for toileting transfer and toileting hygiene. 8/26/24 - The admission MDS assessment documented that R116's BIMS was a 9 (moderate cognitive impairment), required partial/moderate assistance for toileting transfer and toileting hygiene and was frequently incontinent of bowel and bladder. 10/1/24 at 10:48 AM - During an interview, E47 (MDS Coordinator) stated that the MDS Coordinator was responsible for the resident's care plan. E47 confirmed that R116 was frequently incontinent of bowel and bladder in the 8/26/24 admission MDS assessment. The facility failed to review and revise R116's continence care plan to ensure it was person-centered and reflected interventions for her frequent incontinence. 2. Cross refer to F849 R26's clinical record revealed: 8/4/23 - R26 was admitted to hospice services. 8/14/23 (revised on 9/23/24) - R26 was care planned for hospice services and is not expected to improve in condition for diagnosis of: advanced age. The approaches included the following: -hospice to provide bath or shower aide (8/14/23); and -see hospice plan of care; [name of hospice] (revised on 9/7/23). 1/2/24 (revised on 1/3/24) - R26 was care planned for End of Life: the resident requires assistance with ADLs and is receiving end of life care related to advanced age and chronic disease. The approaches included: -medicate as needed to maintain residents comfort; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-spiritual needs met as requested. The facility failed to review and revise R26's hospice care plan to establish who was responsible for her bathing needs as the hospice aid was not coming into the facility as of 1/1/24. In addition, the care plan did not establish what and how often hospice services were to be provided, including visits from nursing, chaplain and social work. The hospice care plan failed to address the medical equipment, supplies, and medications the resident was to be provided.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32545 Based on interview and record review, it was determined that for one (R116) out of two residents sampled for hospitalization and one (R127) out of seven residents sampled for falls, the facility failed to ensure each resident received treatment and care in accordance with the person-centered care plan. Findings include: 1. R116's clinical record revealed: 8/20/24 - For R116, the hospital interagency nursing communication record documented under the Follow-Up Care section to make an appointment with D1 (Nephrologist). 8/20/24 - R116 was admitted to the facility with diagnoses that included, but were not limited to, acute kidney injury. 8/21/24 - R116's family member, F1, signed the admission paperwork. The admission paperwork stated the following, Appointments & Transportation. All follow-up appointments will be scheduled by our unit clerk . 8/26/24 - The admission MDS assessment documented that R116 had a BIMS of 9, a moderate cognitive impairment; no rejection of care since admission; and had active diagnoses of renal insufficiency. 10/1/24 at 9:30 AM - During an interview, E48 (Unit Clerk/Scheduler) confirmed that the Nephrologist follow-up appointment was not scheduled. Review of R116's clinical record lacked evidence of facility staff discussions held with R116 and F1 regarding the follow-up appointment with the Nephrologist. 46134 2. According to the Mayo Clinic, May 2022, Orthostatic hypotension is a form of low blood pressure that happens when standing after sitting or lying down. Orthostatic hypotension can cause dizziness or lightheadedness and possibly fainting. A care provider might review medical history, medications and symptoms and conduct a physical exam to help diagnose the condition. A provider also might recommend orthostatic blood pressure monitoring. This involves measuring blood pressure while sitting and standing. A drop of 20 millimeters of mercury (mm Hg) in the top number (systolic blood pressure) within 2 to 5 minutes of standing is a sign of orthostatic hypotension. A drop of 10 mm Hg in the bottom number (diastolic blood pressure) within 2 to 5 minutes of standing also indicates orthostatic hypotension. Review of R127's clinical record revealed: 7/23/24 - R127 was admitted to the facility with multiple diagnoses including kidney disease, high blood pressure, and anemia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/31/24 - Physician's orders were written by E4 (Medical Director) for the following medications to be administered to R127 to treat his high blood pressure: -Amlodipine 10 mg, one tablet by mouth daily. -Doxazosin 2 mg, one tablet by mouth daily at bedtime. -Hydralazine 25 mg, one tablet by mouth twice daily. -Metoprolol Extended Release 100 mg, one tablet by mouth daily. -Valsarten 320 mg, one tablet by mouth daily. 8/8/24 7:09 AM - R127 had a fall without injury. 8/13/24 5:50 AM - R127 had a fall without injury, E4 ordered R127 to be sent to the hospital for an evaluation; no injuries were assessed during the hospital evaluation. 8/14/24 3:30 PM - R127 had a fall without injury. 8/14/24 - A physician order was written for R127 to have orthostatic vital signs taken because of falls, once a day for three days starting 8/15/24. The orthostatic blood pressure results were be documented in the electronic medical record (EMR) 9/26/24 - A review of R127's vital signs in the EMR revealed the following: -8/15/2024 2:16 PM 126/72 Lying -8/15/2024 3:15 PM 126/72 Lying -8/15/2024 3:27 PM 119/68 Lying -8/16/2024 12:34 PM 138/84 Lying -8/16/2024 1:39 PM 121/68 Lying -8/16/2024 1:40 PM 127/63 Lying -8/17/2024 9:10 AM 147/69 Sitting -8/17/2024 12:26 PM 148/70 Lying R127's orthostatic vital signs were not measured according to standards of practice, as evidenced by the following: -8/15/24 - R127's blood pressure was measured three times, but all while R127 was lying down. -8/16/24 - R127's blood pressure was measured twice, but while R127 was lying down both times. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8/17/24 - R127's blood pressure was measured twice, from a lying position to a sitting position, three hours apart. 9/26/24 1:45 PM - During an interview, E16 (RN) confirmed that the orthostatic vital signs listed above, and as shown in R127's Emr were not obtained according to E4's order and the standards of practice to obtain orthostatic vital signs. R127 was on five different blood pressure medications to treat his high blood pressure at the time that he experienced three falls in six days. The facility failed to ensure that R127's orthostatic vital signs were obtained according to according to physician order and standards of practice. 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

32545

Based on observation, interview and review of clinical record and other documentation as indicated, it was determined that for three (R26, R105, R228 and R533) out five residents sampled for pressure ulcer, the facility failed to provide the necessary treatment and services consistent with professional standards of practice to promote healing and prevent new ulcers from developing. For R26, the facility failed to initiate and implement a sacral pressure ulcer care plan with appropriate interventions and hospice involvement and appropriately Stage her sacral pressure ulcer that started as MASD. As a result of multiple failures, R26 was harmed. For R105, R228 and R533, the facility failed to provide pressure ulcer wound care as ordered. In addition, the facility failed to complete weekly skin audits. Findings include:

A facility policy entitled, Pressure Ulcer Monitoring & Documentation (initiated 11/1/2019) included, A licensed nurse will assess patients for the presence of pressure ulcers/injuries.

A facility policy entitled, Skin Assessments (initiated 11/1/2019) included, A licensed nurse will ensure that the skin risk assessment is done upon admission and quarterly thereafter. The weekly skin assessment will be completed thereafter.

1. Cross refer to F641, F656, F657, F697, F849

R26's clinical record revealed:

12/23/23 - R26 was care planned for requiring assistance with ADLs (activities of daily living) related to physical limitations with an intervention for one person assist for bed mobility and transfers.

1/1/24 - R26 was readmitted to the facility from the hospital and remained on hospice services.

1/2/24 - R26 was care planned for at risk for pressure ulcers related to chronic diseases, PVD, incontinence episodes and decreased mobility. The approaches included:

-assess resident for risk of skin breakdown;

-assist the resident to turn and reposition often;

-encourage to turn and reposition often;

-keep skin clean and dry as possible;

-offload heels while in bed as tolerated;

-skin assessments as indicated;

-Treatment per TAR (Treatment Administration Record).

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F 0686 Level of Harm - Actual harm Residents Affected - Few	From 1/1/24 through 3/17/24, R26's nurse's notes documented that that she was being turned and repositioned every 2 hours and oral intake monitored. From 2/15/24 through 2/29/24, R26 was diagnosed and treated for a Stage 2 pressure ulcer on the sacrum. Per C1's (WCC) progress note on 2/29/24, the sacral pressure ulcer was resolved. 3/9/24 at 3:09 PM - E8 (LPN, Wound Nurse) documented that R26's Braden scale for predicting pressure sore risk was 13, a moderate risk. 3/18/24 at 11:48 PM - A nurse's note documented that R26's room was changed to another floor. 4/19/24 - A hospice nurse's note documented that a Stage 1 pressure ulcer on the sacrum, painful. Review of the facility's nurse's notes lacked evidence that R26's sacrum pressure ulcer was being assessed and monitored. 4/28/24 - A facility Skin Assessment documented no issues. Review of R26's clinical record lacked evidence that weekly skin assessments were completed by nursing staff from 4/29/24 through 6/5/24. 5/20/24 - The quarterly MDS assessment documented that R26 was moderately impaired for daily decision making; no rejection of care; required supervision or touching assistance for eating and toileting hygiene; required partial/moderate assist with rolling left to right in bed; always incontinent of bladder and bowel; active diagnoses but were not limited to, coronary artery disease, dementia, adult failure to thrive, malnutrition; weight loss; at risk for pressure ulcers; no unhealed pressure ulcers at the present time; no other skin problems; and current skin treatments were pressure reducing device for bed and applications of ointments/medications. 5/22/24 at 12:09 PM - A nutrition note documented, . significant weight loss . Resident is on comfort care so wt (weight) loss is anticipated. PO (oral) intake is variable 25-75%. Pt (Patient) receives Magic cup q (every) day which she accepts. Family is aware and NP made aware . Monitor . po intake . 5/28/24 at 2:45 PM - E8 (LPN, Wound Nurse) documented that R26's Braden scale for predicting pressure sore risk was 13, a moderate risk. 5/30/24 at 11:04 AM - A skin note by C1 (WCC) documented, . new skin and wound consult . location: sacrum primary etiology: MASD stage/severity: partial thickness . size: 2cm x 2 cm x 0.1 cm . treatment: apply collagen, zinc oxide paste to base of the wound, leave open to air, BID (twice a day) . Recommend washing area with soap and water and pat dry thoroughly . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/31/24 - R26 was care planned for MASD to the sacrum with interventions to: -notify MD as indicated; -observe for signs and symptoms of worsening or improvement; -supplement to aid in wound healing; and -treatments as ordered. 6/5/24 at 2:43 PM - A skin note by C1 (WCC) documented, .Location: sacrum . Stage/severity: partial thickness . size: 1 cm x 2 cm x 0.2 cm, stable . treatment . medical grade honey fiber to base of the wound . bordered gauze. Change daily, and prn . The patient was noted to have incontinence associated dermatitis . Recommend washing area with soap and water and pat dry thoroughly . 6/5/24 at 9:43 PM - E8 (LPN, Wound Nurse) documented that R26's Braden scale for predicting pressure sore risk was 13, a moderate risk. 6/13/24 at 9:51 AM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/severity: partial thickness . improving without complications, Size: 1 cm x 1.5 cm x 0.2 cm . Treatment .medical grade honey fiber to base of the wound . bordered gauze. Change daily, and prn . reviewed treatment plan with nursing staff. 6/20/24 at 8:15 AM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/severity: partial thickness . stable . Size: 1.5 cm x 2.2 cm x 0.1 cm . moderate amount of serosanguineous exudate . Treatment . Apply calcium alginate to base of the wound . Change daily and PRN . noted to have incontinence associated dermatitis . Continue with turning and repositioning schedule per protocol for pressure prevention. Position patient side to side as tolerated. Recommend an alternating air/low air loss mattress for pressure redistribution. Ensure settings are maintained at an appropriate level based on the patient's needs and body habitus. 6/25/24 at 2:30 PM - A nutrition note documented, . hospice . magic cup q day . po intake: variable, typically 50-75% . weight loss is anticipated with decline and advanced age/hospice status . Recommend: continue with Magic Cup q day, honor pt preferences, comfort over satiety . 6/27/24 at 7:06 AM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/severity: full thickness, stable, Size: 3 cm x 1 cm x 0.1 cm, periwound fragile, moderate amount of serosanguineous exudate . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	debrided 100% removal of biofilm causing delayed wound closure. Removal of necrotic tissue . topical lidocaine . Treatment . Apply medical grade honey fiber to base of the wound . bordered gauze . Change daily, and PRN . Continue with turning and repositioning schedule . The facility lacked evidence of R26's pressure ulcer stage as the severity increased to full thickness and removal of necrotic tissue was completed by debridement. In addition, there was no evidence in the clinical record of turning and repositioning R26. 7/2/24 at 7:14 AM - A skin note by C2 (WCC #2) documented, . Location: sacrum . Stage/severity: full thickness, improving without complications . Size: 2.5 cm x 1.2 cm x 0.1 cm, wound base 100% epithelial, attached wound edges, periwound fragile, intact, moderate amount of serosanguineous exudate . Treatment . medical grade honey fiber to base of the wound . bordered gauze . Change daily, and prn . continue with turning and positioning schedule per protocol for pressure prevention. Position patient side to side as tolerated . Review of R26's clinical record lacked evidence that R26 sacral pressure ulcer was staged and R26 was being turned and repositioned. 7/11/24 at 10:13 AM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/severity: full thickness . stable . Size: 1.5 cm x 2 cm x 0.3 cm, 75-99% granulation, 1-24% slough, attached wound edges, fragile/intact periwound, moderate amount of serosanguineous exudate . debrided 100% removal of biofilm causing delayed wound closure, removal of necrotic tissue, topical lidocaine . Treatment . medical grade honey fiber to base of the wound . bordered gauze . Change BID and PRN . continue with turning and repositioning . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	The facility lacked evidence of R26's pressure ulcer stage as the severity was full thickness and removal of necrotic tissue was completed by debridement. In addition, there was no evidence in the clinical record of turning and repositioning R26. 7/18/24 at 6:23 AM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/severity: full thickness, stable . Size: 1.5 cm x 2.5 cm x 0.2 cm, 75-99% granulation, 75-99% slough . moderate amount of serosanguineous exudate . A sharp debridement was not performed today due to patient is palliative and/or under hospice care and debridement is not recommended at this time . Treatment . medical grade honey fiber to base of the wound . bordered gauze . Change BID and PRN . continue with turning and repositioning. The facility lacked evidence of the sacral PU stage and turning and repositioning of R26 in the clinical record. 7/24/24 at 11:18 AM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/severity: full thickness . Size: 1.5 cm x 2 cm x 0.4 cm, 1-24% epithelial, 75-99% granulation . moderate amount of serosanguineous exudate. A sharp debridement was not performed today due to patient is palliative and/or under hospice care and debridement is not recommended at this time . Treatment . calcium alginate to base of wound . bordered gauze . Change daily, and prn . Continue with turning and repositioning schedule . The facility lacked evidence of the sacral PU stage and turning and repositioning of R26 in the clinical record. 7/26/24 - A progress note by E4 (MD) documented, . po intake has been relatively stable . 7/30/24 - A skin note by C1 (WCC) documented, . Location: sacrum . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Stage/severity: full thickness, stable . Size: 1.5 cm x 2 cm x 0.4 cm, 1-24 % epithelial, 75-99% granulation . moderate amount of serosanguineous exudate . A sharp debridement was not performed today due to patient is palliative and/or under hospice care and debridement is not recommended at this time . Treatment . calcium alginate to base of the wound . bordered gauze . Change daily, and PRN . Continue with turning and repositioning . for pressure prevention. Position patient side to side as tolerated . The patient was seen today for evaluation and management of a chronic ulcer. Despite individual interventions in place in accordance with the standards of care for patient's needs and goals . It is this provider's opinion that the ulcer is unavoidable due to the patient's chronic medical/comorbid conditions . The patient has the following risk factors and/or co-morbities that delay, impair, or impede wound healing: age, bladder incontinence, bowel incontinence, fragile skin. The facility lacked evidence of the sacral PU stage and turning and repositioning of R26 in the clinical record. 7/31/24 at 5:15 PM - A nutrition note documented, .She often refuses wts (weights), but past month was agreeable to obtaining wt . has gained significant amount of wt which is favorable considering her underweight status . Some wt loss and decline may be unavoidable due to medical condition. PO (oral intake) appears to be stable with most meals at 50-100% and good acceptance of supplements. Per wound notes, sacral wound is stable . 8/9/24 at 1:53 PM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/severity: full thickness, improving without complications . Size: 2 cm x 2 cm x 0.1 cm, 100% epithelial, no exudate . Treatment . zinc oxide paste to base of the wound . leave open to air . (every) shift . continuing turning and repositioning . The facility lacked evidence of the sacral PU stage and turning and repositioning of R26 in the clinical record. 8/13/24 at 7:37 AM - A skin noted by C1 (WCC) documented, . Location: sacrum . Stage/severity: full thickness, stable . Size: 1 cm x 2 cm x 0.3 cm, 50% epithelial, 30% granulation, 20% slough, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Wilmington Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 700 Foulk Road Wilmington, DE 19803	

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F 0686 Level of Harm - Actual harm Residents Affected - Few	moderate amount of serosanguineous exudate . Treatment . medical grade honey fiber to base of the wound . bordered gauze . Change daily . continue with turning and repositioning . The patient is currently under hospice services. Goals of care remain to minimize pain and risk of infection. Continue palliative wound management. The facility lacked evidence of R26's sacral PU stage and turning/repositioning in the clinical record. 8/14/24 at 1:24 PM - E8 (LPN, Wound Nurse) documented that R26's Braden scale for predicting pressure sore risk was 14, a moderate risk. Despite having a full thickness, unstaged sacral PU, the facility assessed R26's pressure sore risk as moderate. 8/18/24 - The annual MDS assessment documented that R26 was moderately impaired for daily decision making; no rejection of care; required supervision or touching assistance for eating and was dependent for toileting hygiene; required substantial/maximal assist with rolling left to right in bed; always incontinent of bladder and bowel; active diagnoses but were not limited to, coronary artery disease, peripheral vascular disease, dementia, adult failure to thrive, malnutrition; at risk for pressure ulcers; no unhealed pressure ulcers at the present time; other skin problem was MASD; and current skin treatments were pressure reducing device for bed and applications of nonsurgical dressing and ointments/medications. Despite R26 having a full thickness, unstaged sacral PU with 20% slough on 8/13/24, the MDS assessment was coded that R26 had MASD and no pressure ulcer. In addition, under current skin treatments, turning and repositioning was not checked as being completed nor was the nutrition or hydration intervention. 8/20/24 at 12:27 PM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/severity: full thickness, stable . Size: 2 cm x 2 cm x 0.3 cm, 50% epithelial, 30% granulation, 20% slough, moderate amount of serosanguineous exudate . Treatment . medical grade honey fiber to base of the wound . bordered gauze . Change daily . continue with turning and repositioning . 8/23/24 - A nutrition note documented, . Supplements: magic cup .daily . active liquid protein . BID (twice a day) . Supplements in place to assist w/ (with) weight gain and also for healing of MASD to sacrum which is stable per recent wound report . MD notified of significant weight gain . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Despite R26 having a full thickness, unstaged sacral PU with 20% slough, the facility's dietician documented MASD on the sacrum. 8/28/24 at 10:55 AM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/severity: full thickness, stable, Size: 1 cm x 3 cm x 0.3 cm, 100 % granulation, moderate amount of serosanguineous exudate . Treatment . medical grade honey fiber to base of the wound . bordered gauze . Change daily . continue with turning and repositioning . 9/6/24 at 10:24 AM - A skin note by C2 (WCC #2) documented, . Location: sacrum . Stage/severity: full thickness, worsening . Size: 4 cm x 5 cm x 0.3 cm, 50% granulation, 50% slough, periwound evolving DTI, moderate amount of serosanguineous exudate . Treatment . medical grade honey fiber to base of the wound . bordered gauze . Change daily . continue with turning and repositioning . Patient with worsening sacral wound to sacrum due to decreased PO intake, failure to thrive and end of life skin changes. Wound etiology changed to disorder of the skin: Kennedy ulcer. 9/11/24 at 10:45 AM - A skin noted by C1 (WCC) documented, . Location: sacrum . Stage/severity: full thickness, worsening . Size: 4 cm x 5 cm x 0.3 cm, 10% epithelial, 50% slough, 40% eschar, evolving DTI periwound, moderate amount of serosanguineous exudate . continue turning and repositioning . Treatment . medical grade honey fiber to base of the wound . bordered gauze . Change daily . Patient with worsening sacral wound to sacrum due to decreased PO intake, failure to thrive and end of life skin changes. Wound etiology changed to disorder of the skin to Kennedy ulcer. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	9/17/24 at 11:02 AM - A nutrition note documented, . wound sacral . presenting with a favorable weight gain . Per wound records, pt wound has worsening. Will increase pro liquid from BID to TID for optimal wound healing. Continue with magic cup QD (every day) . 9/17/24 - A physician's orders documented, Active Liquid protein three times a day for wound healing 30ml . po, supplement . 9/18/24 at 9:37 AM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/Severity: Full Thickness . worsening . Size: 4 cm x 7.5 cm x 0.2 cm . 10% epithelial, 50% granulation, 40% eschar . Periwound: Fragile, intact, evolving DTI. Exudate: Moderate amount of serosanguineous . A sharp debridement was not performed today due to patient is palliative and/or under hospice care and debridement is not recommended at this time . Treatment . medical grade honey fiber to base of the wound . bordered gauze . Change daily, and PRN . Continue with turning and repositioning . Position patient side to side as tolerated. The patient has the following risk factors that delay, impair, or impede wound healing: age, bladder incontinence, bowel incontinence, fragile skin. NEW RECOMMENDATIONS: The patient is currently under hospice services. Patient with worsening sacral wound to sacrum due to decreased PO intake, failure to thrive and end of life skin changes. Wound etiology changed to disorder of the skin to Kennedy ulcer. Goals of care remain to minimize pain and risk of infection. Continue palliative wound management. 9/24/24 - Observations of R26 revealed: -at 9:00 AM, R26 laying on her left side facing doorway; -at 10:31 AM, R26 laying on her left side facing doorway; -at 12:02 PM, R26 sitting up in bed eating lunch with assistance of staff; -at 2:07 PM, R26 laying on her left side facing doorway. 9/25/24 at 8:11 AM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/severity: full thickness . worsening . Size: 4.2 cm x 6.5 cm x 0.2 cm . 10% epithelial, 50% granulation, 40% slough . Periwound: fragile, intact, evolving DTI Exudate: moderate amount of serosanguineous . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Treatment . medical grade honey fiber to base of the wound . bordered gauze . change daily, and PRN . continue with turning and repositioning . position patient side to side as tolerated . Patient with worsening sacral wound . due to decreased PO intake, failure to thrive and end of life skin changes. Wound etiology changed to disorder of the skin to Kennedy terminal ulcer . can be present up to 6 weeks . 9/25/24 at 8:00 AM - An observation of wound care with C1 (WCC) and E8 (LPN) revealed the following: -observed R16 moaning when R26 was being repositioned in bed and during the dressing change; -observed the saturated wound dressing dated 9/23 in black ink on R26's sacrum. The Surveyor asked if this was a daily dressing and E8 confirmed that it was and the dressing was not changed yesterday. -no enhanced barrier precautions were in place for R26's chronic wound and thus no gowns were worn during the dressing change; -observed that the low air loss mattress device at the foot of the bed was on standby; -observed C1 state 6 cm x 4 cm as she measured and took a picture of the wound; Immediately following the wound dressing change, the Surveyor asked C1 if she believed that the area was a Kennedy ulcer, which C1 replied no. C1 stated that her colleague, C2, filled in for her once about two weeks ago and believed it to be a Kennedy ulcer, but it has gone on too long. C1 stated that she believes R26 has rebounded. When the Surveyor asked about the black area on the sacrum, C1 stated that it was slough and that slough can be black in color. When the Surveyor asked about debridement, C1 stated that she does not do debridement because the resident was on hospice. When the Surveyor asked if she spoke to R26's hospice nurse, C1 stated no and that she would only talk to them if he/she are here in the facility when she was present. It should be noted that R26's daily sacral wound treatment was signed off on the September 2024 eTAR as completed on 9/24/25. 9/25/24 at 8:17 AM - During an interview, E26 (LPN) stated that she did not administer any medications to R26 this morning. 9/25/24 at 8:45 AM - Observed E26 administer two Tylenol tablets for pain to R26. 9/25/24 at 11:00 AM - During an interview, the Surveyor asked C3 (Hospice Nurse) if hospice would prohibit debridement of a wound. C3 replied no, being on hospice does not prevent debridement. 9/25/24 at 12:26 PM - Observed R26's low air loss mattress device on the footboard still on Standby. 9/25/24 at 12:34 PM - During an interview, E52 (Maintenance) was asked if he could confirm if the low air loss mattress device on the footboard was working as the Standby green light was on. E52 stated no, it was not on and then he pushed the On button and the device turned on. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the September eTAR lacked evidence that R26's prescribed daily wound treatment to her sacrum was completed on 9/11/24, 9/16/24 and 9/18/24. 10/1/24 at 1:48 PM - Reviewed findings with E1 (NHA), E2 (DON), E3 (ADON), E53 (Regional), E46 (VPO). No further information was provided to the Surveyor. 10/2/24 at 9:44 AM - A skin note by C1 (WCC) documented, . Location: sacrum . Stage/severity: full thickness . worsening . Size: 4 cm x 6.7 cm x 0.2 cm . 10% epithelial, 40% slough 50% eschar . Periwound: fragile, intact, evolving DTI Exudate: moderate amount of serosanguineous . Treatment . medical grade honey fiber to base of the wound . bordered gauze . change daily, and PRN . continue with turning and repositioning . position patient side to side as tolerated . Patient with worsening sacral wound . due to decreased PO intake, failure to thrive and end of life skin changes. Wound etiology changed to disorder of the skin to Kennedy terminal ulcer . Review of R26's progress notes from 5/31/24 through 9/25/24 lacked evidence of any documentation of turning and repositioning R26 or monitoring her pressure ulcer on the sacrum by the nursing staff. With respect to R26's sacral pressure ulcer, the facility failed to do the following: - failed to develop a pressure ulcer care plan with appropriate interventions as of 6/27/24; - failed to implement turning and repositioning from 5/31/24 through 9/25/24; - failed to complete weekly skin assessments during the month of May 2024, August 2024 and September 2024; - failed to complete four daily sacral wound treatments on 9/11/24, 9/16/24, 9/18/24 and 9/24/24; - failed to ensure that wound care was not signed off on the eTAR as completed on 9/24/24 when it wasn't done; - failed to ensure that on 9/25/24 R26's air loss mattress device on the footboard was turned on; - failed to collaborate with R26's hospice provider from 6/27/24 through 9/25/24 on sacral wound care and treatment; and - failed to Stage R26's sacral PU from 6/27/24 through 10/2/24 on weekly wound assessments. 46134 (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	2. Review of R533's clinical record revealed: 9/10/24 - R533 was admitted to the facility with multiple diagnoses including CVA, right sided paralysis, aspiration pneumonia, aphasia and dysphagia. R533 had a PEG tube for nutrition. 9/10/24 11:30 PM - A nursing admission progress note revealed that R533's skin assessment included that he had a scar on his sacrum. 9/10/24 - A Braden Scale Assessment revealed R533 had a moderate risk for pressure ulcer development. 9/11/24 - A nursing skin assessment was completed on R533 that revealed that he had no skin impairments. 9/16/24 - MDS Assessment, section M Skin Conditions: R533 had no unhealed pressure ulcers/injuries. 9/17/24 - A Braden Scale Assessment for R533 revealed a high risk for pressure ulcer development. 9/18/24 - A progress note was written by E10 (Nurse Practitioner) that R533 had a new wound to the sacrum: Wound: 1 Location: sacrum Primary Etiology: Incontinence Associated Dermatitis (IAD) Stage/Severity: Partial Thickness Wound Status: New Size: 2.7 cm x 5 cm x 0.1 cm. Calculated area is 13.5 sq cm. Wound Edges: Attached. 9/18/24 - A physician order was written to apply collagen particles/zinc oxide paste to sacrum incontinence associated dermatitis (IAD) twice a day and as needed for incontinence care. 9/23/24 - A Braden Scale Assessment revealed a very high risk for pressure ulcer development. 09/24/24 10:33 AM - During an observation, wound care was performed on R533 by E8 (LPN wound care). The wound on R533's sacrum was observed to be a stage II pressure ulcer wound. The following electronic medical record documents were reviewed on 9/24/24: -9/11/24 care plan revealed: The resident is at risk for pressure ulcers related to chronic health conditions, cognitive impairment, inability to turn and reposition independently, incontinence. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	- The kardex aide task list revealed the lack of a regular timed turning and repositioning task for R533. The Resident Care section of the Kardex documented for the aide to encourage to turn and reposition often. Additionally, the kardex directed that R533's should roll left and right. R533 was dependent on staff to reposition him while he was in bed. R533 was not repositioned for six out of forty-two opportunities from 9/17/24-9/25/24. Additionally, the times that R533 was repositioned in bed from 9/17/24-9/25/24 was not consistent, and the times were documented anywhere between two hours apart to fourteen plus hours apart, meaning R533 was left in one position for ten to fourteen hours on several occasions. 9/24/24 10:45 AM - During an interview E11 (LPN) confirmed that R533's Kardex documented to encourage to turn and reposition often, but that R533 could not turn himself in bed. 9/24/23 - A physician order was written to cleanse sacrum with wound cleanser, apply medical grade honey fiber and cover with bordered gauze, every day shift AND as needed for incontinence care. 9/25/23 - A review of a September Medication Administration report revealed that collagen particles/zinc oxide paste was applied once a day 9/19/24 thru 9/23/24, and not twice a day as ordered. 9/26/24 2:30 PM - During an interview, E9 (RN UM) confirmed that collagen particles/zinc oxide paste was applied once a day to R533 on 9/19/24 thru 9/23/24, and not twice a day as ordered. R533's stage II sacral wound was acquired after he was admitted to the facility. R533 entered the facility with a scar on his sacrum, but eight days later, that scar was a stage II 2.7 cm x 5 cm x 0.1 cm. pressure ulcer wound. The wound required changes to wound care management; the orders were not followed by nursing as written by the physician. R533 did not have bed turning and prepositioning as an aide task, which made it difficult to determine how often he was turned and repositioned in bed. 50650 3. Review of R105's clinical record revealed: 4/30/24 - R105 was admitted to the facility with a diagnosis of a stroke and had two existing pressure ulcers to her buttock area. 7/23/24- A review of the care plan revealed that R105 had a chronic wound or pressure ulcer: stage 4 on the right buttock and stage 4 on the left buttock. 8/21/24 - A physician's order was written by E4 (MD) to cleanse the left buttock wound with wound cleanser, apply collagen/ hydrogel, and to cover the wound with bordered gauze, every day shift. The same treatment order was written for the right buttock wound. 9/25/24 - A review of the treatment administration record (TAR) revealed the lack of dressing changes to both the left and the right buttock on 9/17/24 and 9/23/24. 9/25/24 - During an interview with E8 (LPN), she verbally confirmed the dressing changes were not documented on 9/17/24 and 9/23/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	48409 4. Review of R228's clinical records included: 10/24/22 - R228 was admitted to the facility with diagnoses including muscle weakness and stroke affecting the left side. 4/8/24 - 4/12/24 - R228 was hospitalized . 4/13/24 - R228 was readmitted to the facility. The admission skin assessment documented open areas on her groin and sacrum. R228's physician's orders included, Weekly skin audits. An undated Kardex entry included, Daily skin audits. 6/5/24 - R228's clinical records documented, Clean sacral MASD . and cover with hydrocolloid dressing . 10/1/24 - A review of R228's clinical records lacked evidence that the daily or weekly skin audits were completed for 4/17/24, 4/24/24, 5/8/24, 5/15/24, 5/22/24 and 6/12/24. R228's clinical records lacked evidence of treatment for the groin and sacral area from 4/13/24 through 6/4/24. 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 48409 Based on observation, interview, record review, it was determined that for one (R64) out of two residents reviewed for accidents, the facility failed to ensure that R64 received supervision to prevent accidents. Findings include: 9/3/24 - R64 was admitted to the facility with diagnoses including dementia and muscle weakness. R64's admission assessment documented a fall score of 18, which indicated a high fall risk. 9/4/24 - R64's fall care plan included, At risk for falls related to cognitive impairment, poor balance, and muscle weakness. The interventions included, Low bed, and place items within reach of resident. 9/9/24 - R64's admission MDS assessment documented a BIMS score of 00, indicating severe cognitive impairment. R64's ADLs (Activities of Daily Living) documented, Dependent for bed mobility/turning and repositioning. 9/12/24 10:30 AM - R64's clinical records documented, . Notified that resident [R64] fell out of bed while receiving care . A scrape and hematoma were located separately on the right upper forehead . Sent to the hospital for evaluation . Staff education on body positioning techniques to use while performing personal care in bed to resident when alone . 10/1/24 10:15 AM - During an interview, E18 (CNA) stated, The resident [R64] was lying on her side, and I placed a clean brief under her. I turned to get some lotion from the table behind me and she rolled out of the bed. The facility failed to provide enough supervision to R64, a dependent resident which resulted in a fall and an emergent transfer to the hospital. R64 did not sustain any signigicant injuries. 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 46134 Based on interviews and record review, it was determined that for one (R83) out of four residents reviewed for nutrition, the facility failed to maintain acceptable parameters of nutrition. Findings include: Review of a facility policy titled, Weight Monitoring and Tracking, effective 1/29/24, indicated Policy: The center has a system in place to weigh, monitor, and track patient's weights. Weights are tracked, monitored, and analyzed by the Interdisciplinary Team. Procedure . 2. Patients will be weighed on admission/readmission and weekly x 4 weeks thereafter, or until the Interdisciplinary Team determines weight is stable, then monthly thereafter . 6. Weekly weights should continue greater than 4 weeks if one or more of the following criteria are met: .Patients < 100 pounds . Review of R83's clinical chart revealed: 7/19/24 - R83 was admitted to the facility with multiple diagnoses including pneumonia, malnutrition, swallowing disorder, and dementia. R83's weight was 96.6 pounds (lbs). 7/23/24 - Review of a dietary progress note revealed that R83's BMI was 14.7, indicating that he was severely underweight, and that his food intake was highly varied, ranging from 0-100%. The dietician recommended adding a nutritional supplement Magic Cup to R83's meal plan. 8/2/24 - An order was written for Magic Cup 4 oz daily with lunch by E4 (Medical Director), 10 days after R83's dietary recommendation. 9/25/24 - A review of R83's weights revealed the following: -8/5/24 - 97.2 lbs. -9/4/24 - 86.8 lbs. -9/13/24 - 89.2 lbs. -9/20/24 - 85.6 lbs. 09/26/24 10:42 AM - During an interview, E13 (Dietician) stated that in the presence of significant weight loss, the facility policy is to weigh a resident weekly. R83 had an 11% loss of weight in two months, July thru September 2024. The facility policy for obtaining weights was not adhered to when weights were not obtained for R83 when he was below 100 lbs. at admission thru his discharge on 9/26/24. R83 should have had weekly weights to monitor his declining nutritional status. Additionally, R83 was not ordered the nutritional supplement Magic Cup for almost two weeks after the dietician made the initial recommendation. 10/2/24 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 32545 Based on interview and record review, it was determined that for one (R116) out of two residents reviewed for hospitalization s, the facility failed to monitor and hold R116's blood pressure medication based on physician ordered parameters. Findings include: 1a. R116's clinical record revealed: 8/20/24 - R116 was admitted to the facility with diagnosis of high blood pressure among other medical conditions. 8/22/24 - A physician's order stated, Norvasc oral tablet 5 MG . Give 1 tablet by mouth one time a day . hold if sbp (systolic blood pressure) less than 110. Review of R116's eMARs and nurse's notes for August 2024 and September 2024 lacked evidence that R116's blood pressures were taken prior to administration of her daily blood pressure medication for: -four out of nine opportunities from 8/23/24 through 8/31/24; and -three out of five opportunities from 9/1/24 through 9/5/24. 1b. R116's clinical record revealed: 8/20/24 - R116 was admitted to the facility with diagnosis of high blood pressure among other medical conditions. 8/22/24 - A physician's order stated, Norvasc oral tablet 5 MG . Give 1 tablet by mouth one time a day . hold if sbp (systolic blood pressure) less than 110. Review of the September 2024 EMARs and nurse's notes revealed that R116 was administered her blood pressure medication on the following days despite the parameters: -blood pressure 98/51 on 9/8/24; -blood pressure 109/76 on 9/11/24; and -blood pressure 107/69 on 9/12/24. 9/30/24 at approximately 3:30 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON). No further information was provided to the Surveyor.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 32545 Based on interview and review of clinical record and other documentation as indicated, it was determined that for one (R116) out of two residents sampled for hospitalization , the facility failed to ensure that R116 was free from a significant medication error. R116 was prescribed and administered Metformin and Ibuprofen at 8:00 AM every day from 9/10/24 through 9/15/24 despite two pharmacy warnings. In the setting of poor oral intake and the facility initiating hypodermoclysis during this timeframe, R116's creatinine increased from 0.8 baseline to 4.2 and BUN increased from 23 to 87 prior to being sent emergently to the hospital, requiring treatment with intravenous fluids and the discontinuation of the Ibuprofen. R116 was harmed. Findings include: R116's clinical record revealed: 8/20/24 - The hospital records included a Nephrology consultation, dated 8/20/24 at 10:20 AM, that stated, . Acute kidney injury-due to intravascular volume depletion . creatinine has already improved from 2.5 to 1.7 . continue hydration with normal saline . baseline . creatinine 0.9 . on 6/5/24 . 8/20/24 - R116 was admitted to the facility with diagnoses that included, but were not limited to, acute kidney injury. 8/21/24 at 11:28 AM - R116's lab results revealed: -Creatinine = 0.8 (normal range 0.5-1.5) -BUN = 23 (normal range 10-26) -Calcium = 10.4 (normal range 8.5-10.5). 8/22/24 - A progress note by E4 (MD) documented, . Diagnoses, Assessment and Plan . Acute kidney injury. Follow-up labs reviewed and BUN/creatinine are at baseline at this time and continue to monitor clinically and encourage p.o. (oral) intake and maintain hydration . 8/22/24 at 5:10 PM - A nutrition note documented, . Resident received IVF (intravenous fluids) while in the hospital . admitted to the hospital with generalized weakness and an episode of hypotension. Resident also experienced AKI (acute kidney injury), acute metabolic encephalopathy, UTI (urinary tract infection), hypoglycemia (low blood sugar) and hyponatremia (low sodium) which per hospital records were affecting her mental status and PO intake. These issues have resolved and resident is now alert with improved energy levels and improved PO intake per resident's [family member] report . 9/6/24 at 12:23 PM (Late Entry) - A Physical Medicine and Rehabilitation Follow Up Note by C6 (NP) documented, . Chief Complaint: Weakness . PMHx (past medical history) reviewed . seen this am while working in the PT (physical therapy) gym. She reports lower back right-sided non-radiating muscle pain . A&P (Assessment and Plan) . Ibuprofen 600 mg q (every) 6 PRN (as needed) for muscle pain. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	9/6/24 at 4:09 PM - An Order Note automatically populated and stated, The order you have entered Ibuprofen Oral Tablet 600 MG . Give 1 tablet by mouth every 6 hours as needed for low back muscle pain Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction. The System has identified a possible drug interaction with the following orders: Metformin HCl Oral Tablet 1000 MG. Give 1 tablet by mouth two times a day for DM. Severity: Moderate. Interaction: Coadministration of Metformin and Ibuprofen Oral Tablet 600 MG may increase the risk of acute renal failure . This warning was acknowledged by E54 (LPN). 9/9/24 - A progress note documented by E4 (MD) documented, . Medication List: . Ibuprofen Oral Tablet 400 MG, Give 1 tablet by mouth one time a day for (sic) pain . ACTIVE, 9/10/2024 . Chief Complaint/Nature of Presenting Problem: Acute metabolic encephalopathy, diabetes type 2, hypertension . Patient this a.m. resting comfortably and appears (sic) no acute distress. Patient also with a history of acute kidney injury and I will repeat Chem-7 this week. P.o. intake has been stable and patient agrees to continued rehab services secondary to debility . Diagnosis, Assessment and Plan . Acute metabolic encephalopathy. Clinically patient has been stable and again reinforced safety and use of call bell and patient for rehab services secondary to debility . Diabetes mellitus type 2 with neurological manifestations. Patient continues with diabetic diet and metformin 1000 mg twice a day and sugars have been managed . continue to monitor . Acute kidney injury. Patient for follow-up Chem-7 this week . Measures . I have utilized all available immediate resources to obtain, update, or review the patient's current medications (including all prescriptions, over-the-counter products . 9/9/24 at 12:41 PM (Late Entry) - A progress note by C6 (NP) documented, . seen for today . PMHx (Past Medical History) reviewed . seen this am while sitting in the therapy gym. She tells me that she has been comfortable and has not had any knee pain all weekend. She did tell me that she took Ibuprofen this morning. We will continue to monitor her knee pain to see if we need to make adjustments . 9/10/24 at 12:22 AM - An Order Note automatically populated and stated, The order you have entered Ibuprofen Oral Tablet 400 MG . Give 1 tablet by mouth one time a day for (sic) pain Has triggered the following drug protocol alerts/warning(s): Drug to Drug Interaction. The System has identified a possible drug interaction with the following orders: Metformin HCl Oral Tablet 1000 MG. Give 1 tablet by mouth two times a day for DM. Severity: Moderate. Interaction: Coadministration of Metformin and Ibuprofen Oral Tablet 400 MG may increase the risk of acute renal failure . This warning was acknowledged by E55 (RN). 9/11/24 at 12:42 PM (Late Entry) - A progress note by C6 (NP) documented, . Chief Complaint: Weakness . seen for today . did well today while in PT (physical therapy) and speech group . no changes to plan. 9/11/24 - R116's lab results received at 5:36 PM revealed: -Creatinine = 1.1, up from 0.8 on 8/21/24; -BUN = 49, up from 23 on 8/21/24. The BUN doubled; and -Calcium = 11.7, up from 10.4 on 8/21/24. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	9/12/24 - A progress note by E4 (MD) documented under the . Medication List: . Ibuprofen Oral Tablet 400, Give 1 tablet by mouth one time a day for pain . ACTIVE, 9/10/2024 . Chief Complaint/Nature of Presenting Problem: Acute metabolic encephalopathy, hypercalcemia, diabetes type 1, hypertension, acute kidney injury . Patient with follow-up laboratory studies and I note that she has an elevated calcium of 11.7 and this is new as previous laboratories demonstrated a normal calcium level. My immediate concern is that patient with volume depletion and I will initiate hypodermoclysis D5W . for 2 L (liters) and repeat a Chem-7 (labs) in the a. m. Patient this a.m. resting comfortably and appears in no acute distress and I reinforced with the resident the importance of maintaining hydration. If elevated calcium persists will consider further workup especially in the setting of metastatic breast disease . Labs . BUN 49, creatinine 1.1, calcium 11.7 . Diagnosis, Assessment and Plan . Hypercalcemia. Most recent calcium with normal limits and concerns for current elevation due to volume depletion and will initiate D5W (sugar in water fluid) . for 2 L and will repeat a calcium level in the a.m. If remains elevated and/or increases and/or changes in mentation may need to send to the emergency room for further treatment . Acute kidney injury. I do note slight increase in the BUN and creatinine from most previous and again encourage fluids and will initiate hypodermoclysis and repeat a Chem-7 in the a.m . Acute metabolic encephalopathy. Patient currently appears at her baseline and I again reinforced safety and use of call bell and encourage p.o. intake to maintain hydration . Measures . I have utilized all available immediate resources to obtain, update, or review the patient's current medications (including all prescriptions, over-the-counter products . 9/12/24 on 3-11 PM shift - R116 started to receive fluids by hypodermoclysis. 9/13/24 at 5:45 AM (LATE ENTRY) - A note by C6 (NP) documented that R116 was seen today and resident was on . fluids for elevated calcium levels. R116's major rehabilitation goals: improve functional level and pain. Under Assessment and Plan section, C6 documented, . Deconditioning/ gait instability: Secondary to Weakness, the patient is at high risk for functional impairment without therapy as needed, and adequate pain control . no changes to plan. 9/13/24 - A progress note by E4 (MD) documented under the . Medication List . Ibuprofen Oral Tablet 400 MG, Give 1 tablet by mouth one time a day for pain . ACTIVE, 9/10/2024 . Chief Complaint/Nature of Presenting Problem: Hypercalcemia, acute metabolic encephalopathy, acute kidney injury . past medical history of metastatic breast cancer . admitted to our facility for rehab services status post hospitalization for acute metabolic encephalopathy. Patient with follow-up labs and was found to have an elevated calcium of 11.7 and I initiated hypodermoclysis and patient appears to be tolerating at this time. I again reinforced the importance of hydration and proper nutrition with the resident (sic) staff working with the resident in this regard as well and if persist patient may need to be sent to the emergency room for further evaluation . Labs: . BUN 67, creatinine 1.7 . Diagnosis, Assessment and Plan . Acute kidney injury - Most likely due to hypovolemia as discussed earlier and patient is continuing with hypoderclysis (sic) staff working to encourage p.o. intake to maintain hydration and patient for follow-up labs which are pending at this time. As I stated before if persist patient may need to go to the emergency room . Hypercalcemia. Slight improvement of the calcium level and continue with the hypodermoclysis (sic) patient for follow-up (labs) . Acute metabolic encephalopathy. Patient hospitalized previously and resting comfortably this a.m. and I again reinforced the importance of nutrition and proper hydration . Measures . I have utilized all available immediate resources to obtain, update, or review the patient's current medications (including all prescriptions, over-the-counter products . (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	E4 documented that he reviewed R116's medications, but made no mention of the metformin and ibuprofen interaction having the potential to cause renal failure. 9/13/24 at 2:01 PM - R116's lab results revealed: -creatinine = 1.7, up from 1.1 on 9/11/24; -BUN = 67, up from 49 on 9/11/24; -Calcium = 11.5, down from 11.7 on 9/11/24. Despite initiating fluids by hypodermoclysis, both creatinine and BUN continued to elevate. Review of the nurse's notes and the CNA Documentation Survey Report during this timeframe lacked evidence that R116's oral intake was being encouraged and monitored by nursing staff. 9/14/24 at 9:30 AM (collected time) - R116's lab results revealed: -creatinine = 2.8, up from 1.7 on 9/13/24; -BUN = 76, up from 67 on 9/13/24; -calcium = 11.1, down from 11.5 on 9/13/24. R116's BUN and creatinine continued to elevate despite receiving fluids by hypodermoclysis. 9/14/24 at 3:45 PM - An Orders - Administration Note documented that 2 liters of . fluids were administered subcutaneously for elevated calcium level were completed. 9/14/24 at 10:08 PM - A lab note documented, Lab results received, Cr 2.8, BUN 76. Patient completed ordered Hypodermoclysis fluids today. Oncall NP [E56] notified and new orders given to repeat BMP in AM. Orders noted, patient and family aware. 9/15/24 at 6:26 AM - A nurse's note documented, STAT order called in for blood draw this morning d/t (due to) abnormal lab results . 9/15/24 at 11:09 AM - R116's lab results revealed: -creatinine = 4.2, up from 2.8 on 9/14/24; -BUN = 87, up from 76 on 9/14/24; -calcium = 11.0, down from 11.1 on 9/14/24. Despite the pharmacy's black box warnings, review of the September 2024 EMAR revealed that R116 was administered Ibuprofen medication daily from 9/10/24 through 9/15/24 at 8:00 AM, at the same time as Metformin medication. Six doses of Ibuprofen 600 mg were given to R116 from 9/10/24 to 9/15/24. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Review of the September 2024 CNA Documentation Survey Report revealed R116's daily fluid intake during meals, including the Ensure drink, as: -9/10/24 = 770 mls; -9/11/24 = 770 mls; -9/12/24 = 720 mls; -9/13/24 = 577 mls; -9/14/24 = 837 mls; and -9/15/24 = 142 mls. 9/15/24 (Sunday) at 12:08 PM - A change of condition note documented, Lab results received, Cr 4.2, BUN 87. Oncall NP . notified and gave new order to send patient to . ER for evaluation and treatment. Dx. Acute Kidney Failure . [F1, R116's family member] present and notified in person. Patient sent to . ER via 911 ambulance at 11:30 AM. 9/15/24 at 1:12 PM - The hospital ER record documented that R116's creatinine was 5.19, BUN of 86 . calcium 11.2 . continue with fluid resuscitation . 9/18/24 at 3:12 PM - The hospital record documented that . AKI (acute kidney injury) suspected due to decreased oral intake/dehydration. Also receiving ibuprofen at rehab facility. Nephrology is following. On IV fluids for prerenal AKI . 10/1/24 at 11:25 AM - During an interview, C6 (NP) stated that she prescribed Ibuprofen prior to Physicial Therapy to help R116 do better in therapy. C6 stated that R116 wasn't taking the PRN dose due to her cognitive deficit, so C6 ordered the scheduled Ibuprofen dose prior to therapy. C6 requested a BMP lab to monitor R116's renal function after ordering Ibuprofen. C6 stated that there were other contributing factors that may have played a part in her renal injury/hospitalization : metastatic cancer and poor oral intake. C6 stated that she spoke to E50 (NP) when she was prescribing the Ibuprofen. 10/2/24 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 32545 Based on interview and record review, it was determined that for one (R116) out of three residents reviewed for nutrition, the facility failed to order and provide an Ensure drink based on the admission nutrition assessment and resident preference. Findings include: R116's clinical record revealed: 8/20/24 - R116 was admitted to the facility. 8/22/24 at 5:10 PM - A nutrition note by E13 (Dietician) documented, . Her oral intake varies between 26-100%, and she eats independently without any issues with chewing or swallowing. No supplements are currently ordered, and food preferences were obtained through a conversation with her [family member, F1]. [F1] reports that resident enjoys drinking Ensure and would like for her to receive one in between meals. Will recommend to add Ensure once daily . 9/13/24 - A physician's order stated to give Ensure two times a day for optimal PO (oral) intake . 9/30/24 at 4:00 PM - During an interview, F1 (R116's family member) stated that during the care conference on 8/26/24, the request for Ensure drink was brought up again. The facility failed to order the Ensure drink until 9/13/24, 22 days after E13's dietary recommendation. 10/2/24 at 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON, E46 (VPO) and a representative from the Ombudsman's Office.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 32545 Based on interview and record review, it was determined that for three (R6, R26 and R116) out of 46 sampled residents, the facility failed to clinical records are complete and accurately documented. Findings include: 1. R26's clinical record revealed: 1/17/24 at 11:21 AM - A Medical Progress Note documented by E50 (NP) documented, . Assessment and Plan . 1. Protein malnutrition- encourage PO intake (sic) monitor CMP. 2. Muscle weakness-PT/OT. 3. MDD-Mirtazapine 7.5mg GDR not appropriate at this time. 4. GERD- D/C (discontinue) Omeprazole 20mg to trial symptoms and need for medication. 5. HTN- Monitor BP Q shift Lasix 40mg Amlodipine 5mg. 6. Constipation monitor BM Miralax, Fleet enema, MOM, Senna, Biscodyl, Colace. 7. CAD- ASA 81mg. 8. Anemia- Iron 325mg monitor CBC. 9. Cellulitis BLE- continue wound care LLE add Santyl and gauze. 10. ABD distention check US ABD Pelvis. 11. MI - Ativan and Morphine continue on oxygen and hospice Nitro SL . Chart and medications reviewed . The following 12 Medical Progress Notes documented by E50 repeated the same Assessment and Plan. - 2/6/24 at 2:03 PM; - 2/28/24 at 10:05 PM; - 3/11/24 at 2:33 PM; - 3/20/24 at 1:34 PM; - 3/27/24 at 1:15 PM; (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	- 4/15/24 at 10:58 PM; - 5/6/24 at 5:45 PM; - 6/11/24 at 1:03 PM; - 6/25/24 at 1:58 PM; - 7/8/24 at 10:14 PM: - 8/7/24 at 8:18 PM; and - 9/9/24 at 11:18 AM: The following should be noted that were not accurately documented in R26's medical progress notes by E50: -R26 was not receiving PT and OT services as they were discontinued on 1/2/24. -From 12/1/23 through 10/2/24, R26 was not prescribed Mirtazapine 7.5mg. -Omeprazole 40mg tablet was discontinued on 1/8/24. -Lasix and Amlodipine medications were discontinued on 1/8/24. -Miralax medication was discontinued on 1/1/24. Senna and Colace were discontinued on 1/8/24. -Aspirin was discontinued on 1/8/24. -Iron was discontinued on 1/8/24. -Santyl treatment was discontinued on 1/1/24. -Ultrasound abdomen/pelvis for abdominal distention was completed on 12/30/23. -Ativan was discontinued on 1/14/24. Oxygen was discontinued on 7/8/24. It should also be noted that from 6/27/24 through 10/2/24, R26 was being treated for an ongoing sacral pressure ulcer, which was not addressed in R50's progress notes. The facility failed to ensure documentation on the 1/17/24 Medical Progress Note by E50 (NP) was accurate and not repeatedly copied on 12 subsequent Medical Progress Notes for R26 from 2/6/24 through 9/9/24. 2. R116's clinical record revealed: 9/30/24 at 4:00 PM - During an interview, F1 (R116's family member) stated that he arrived at the facility and found R116 incontinent laying on her bed. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of the September 2024 CNA Documentation Survey Report revealed that care was not documented for R116 on 9/15/24 during 7 AM to 3 PM shift prior to R116 being sent to the emergency room at 11:30 AM. The facility failed to ensure R116's care was documented in the clinical record. 40264 3. Review of R6's clinical record revealed the following: A facility policy titled Fall Management Program effective 1/29/24 documented, .A fall is defined . unintentional change in elevation coming to rest on the ground or onto the next lower surface .Procedure . Prevention 1. A Fall Risk Scoring Tool will be completed .and as needed for change in condition . 8/6/24 11:55 AM - A nurse progress note documented that R6 was noted on the floor on her knees, and her head was over the bath tub in her bathroom. 8/7/24 - A facility Fall Risk Scoring Tool for R6 with a score of 7 (low risk) was completed by E28 (LPN). 8/11/24 3:51 AM - The same Fall Risk Scoring Tool for R6 was struck out for the reason: data entry error. 9/30/24 10:30 AM - In an interview, E2 (DON) stated that the Fall Risk Scoring Tool for [R6] completed by [E28] on 8/7/24 was not accurate. E2 further confirmed that R6's Fall Risk Scoring Tool after the 8/6/24 fall incident was not updated and not corrected. 10/2/24 at 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 32545 Based on interview and review of the clinical record and other documentation as indicated, it was determined that for one (R26) out of one resident reviewed for hospice, the facility failed to ensure that R26 received hospice care and services as per the written agreement with the Hospice Provider. Specifically in reference to the deficiency cited at Severity Level 3, at F686, the facility failed to notify and collaborate with the Hospice Provider on developing and implementing a sacral pressure ulcer plan of care with interventions to meet the resident's needs. In addition, the facility failed to update the Hospice Provider that R26's eight medications were discontinued in January 2024; and ensure that current Hospice documentation was present and readily accessible in R26's facility clinical record. Findings include: Cross refer to F686, example 1, F656, F657, F697 8/9/23 - The General Inpatient and Respite Care Skilled Nursing Facility Agreement stated the following: . 3.3 Designation of an Interdisciplinary Group Member. Facility will designate a member of the Facility's Interdisciplinary Group (IDG Member) who is responsible to work with Hospice staff to coordinate care provided to the Hospice Patient. The IDG Member must have a clinical background, function within their state scope of practice act, and have the ability to assess the Hospice patient or have access to another person who has the skills and capabilities to asses the Hospice patient. The IDG Member is responsible for the following: 3.3.1 Collaborating with Hospice representatives and coordinating Facility staff participation in the care planning process for those Hospice Patients receiving Hospice Services. This includes establishing how communication will be documented between Hospice and Facility to ensure the needs of the patient are addressed and met 24 hours per day; 3.3.2 Communicating with Hospice representatives and other healthcare providers participating in the provision of care for patient's terminal illness, related conditions, and other conditions to ensure quality of care for the patient and family. 3.3.3 Ensuring that Facility communicates with the Hospice medical director, the patient's attending physician . participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. 3.3.4 Obtaining the following information from the Hospice: a. The most recent Hospice Plan of Care for each Hospice Patient; b. Hospice election form; c. Physician certification or recertification of the terminal illness for each Hospice Patient; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Wilmington Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Foulk Road Wilmington, DE 19803	

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

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Names and contact information for the Hospice personnel involved in the care of each Hospice Patient; e. Instructions on how to access Hospice's 24 hour on call system; f. Hospice medication information specific to each Hospice Patient; g. Hospice physician and attending physician orders for each Hospice Patient; 3.3.5 Ensuring Facility staff provides orientation to Hospice staff concerning Facility policies and procedures, including patient rights, appropriate forms, and record keeping requirements. 3.4 Plan of Care. Hospice will collaborate with Facility on a coordinated Plan of Care developed jointly between Hospice and Facility. Each patient's written plan of care must include both the most recent Hospice Plan of Care and a description of the services furnished by Facility to attain or maintain the Hospice Patient's highest practicable physical, mental and psychological well-being . Facility agrees to abide by patient care protocols for palliative medicine established by Hospice and to collaborate with the Hospice Interdisciplinary Group prior to any action relating to treatment . 3.5 Medical Record . Documentation of care and services provided by Hospice will be filed and maintained in the Facility medical record. Facility will provide Hospice with a copy of the medical record . 3.12 Notification to Hospice. Facility will immediately notify Hospice if: 3.12.1 A significant change in a Hospice Patient's physical, mental, social, or emotional status occurs . R26's clinical record revealed: 8/14/23 (revised on 9/23/24) - R26 was care planned for hospice with the following interventions: -hospice to provide bath or shower aid (dated 8/14/23); and -see hospice plan of care [name of hospice]. (dated 8/14/23, revised 9/7/23). The facility failed to review, revise and collaborate with the Hospice Provider on R26's care plan. It should be noted that R26 was not being bathed or showered by Hospice staff from January 2024 through October 2024. 9/24/24 - Observation of R26's hospice binder located in the nurse's station revealed the following: -the absence of who and how to contact members of the Hospice Care Team; -sign-in sheet of hospice staff starting from 2/1/24 through 9/10/24; -8/4/23 hospice election statement; (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/4/23 admission agreement; -8/4/23 plan for primary caregiving; -8/7/23 verbal certification by attending physician; -8/7/23 hospice certification period adjustment order; -8/4/23 to 11/1/23 Hospice Certification and Plan of Care; -12/20/23 Hospice IDG Comprehensive Assessment and Plan of Care Update Report; and -handwritten hospice staff notes from 8/7/23 through 8/27/24, which included 28 notes from the Chaplain, one from a Priest and three from C5, hospice RN. The facility failed to ensure that current Hospice documentation was present and readily accessible in R26's facility clinical record. 9/25/24 at 11:00 AM - An observation of C1 (Hospice RN) at R26's bedside with R26's family member and C7 (Chaplain). Immediately following, the Surveyor interviewed C1 and asked if hospice would prohibit debridement of a wound. C1 replied no, being on hospice does not prevent debridement. The Surveyor asked C1 to observe R26's hospice binder in the nurse's station. C1 confirmed that there was no contact information for hospice on the front cover nor inside. After reviewing the hospice binder contents, C1 confirmed that there was no current recertification, no current care plan and no current list of medications. When asked if the hospice nurse assessed R26's sacral pressure ulcer, C1 could not answer, and she requested the nurse's notes to be sent over to the facility. C1 stated that the hospice contact was the Social Worker and documentation should be being sent to her so she can place it in the hospice binder. In response to the Surveyor's request with the facility management, the Hospice Provider provided the Hospice documentation for R26, which included: 9/25/24 Hospice IDG Comprehensive Assessment and Plan of Care Update Report - . Current Meeting Summary . Hospice Physician [documented] . plan of care reviewed . I attest that I have reviewed the medication profile . [C2, RN documented] . Describe what has occurred during the last two weeks . Is there any improvement or worsening in wound(s) condition, or any new wounds? (checked) No wounds present . [included in the Meeting Summary was] Medication List . Tylenol . Amlodipine . Aspirin . Colace . Ensure . Furosemide . Icy Hot Patch . Iron . Miralax . Morphine . Senna . Review of R26's current medications on her September 2024 eMAR in the facility were: Tylenol for pain, Active Liquid Protein for wound healing, Morphine as needed for pain, Milk of Magnesia, Bisacodyl suppository and an enema as needed for constipation. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R26 was no longer on Amlodipine, Aspirin, Colace, Furosemide, Icy Hot Patch, Iron, Miralax or Senna. The 9/25/24 IDG Report inaccurately documented R26 on seven medications that she was no longer taking. 9/30/24 at approximately 3:30 PM - Finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON). No further information was provided to the Surveyor. 10/2/24 at 3:00 PM - Finding was reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 46134 Based on observations and interview, the facility failed to provide a safe, sanitary, environment for residents, staff and the public. Findings include: 9/23/24 1:30 PM - An observation of three trash dumpsters located were located next to the facility. Two of the dumpsters contained full clear trash bags, and the third dumpster was full of ripped up boxes. The two dumpsters with the clear bags revealed the following: -Both dumpsters had opened lids, with clear bags of facility trash hanging over sides of dumpsters. -Both dumpsters had open bags of trash with the contents of the bags, including contaminated feces soiled resident briefs and used PPE gloves on the ground surrounding the dumpsters. 9/23/24 1:40 PM - During an interview, E1 (NHA) confirmed the above findings. 9/23/24 4:00 PM - An observation of the trash dumpsters revealed that the two dumpsters with resident trash had been emptied, but that the soiled resident briefs and used PPE gloves on the ground remained. 9/23/24 4:30 PM - During an interview, E1 confirmed the 4:00 PM findings. 9/24/24 8:00 AM - An observation revealed that soiled resident briefs and used PPE gloves on the ground in front of and next to the dumpsters had been removed, but soiled resident briefs and used PPE trash remained behind left dumpster and back fence. 9/24/24 9:40 PM - During an interview, E1 confirmed the above findings. 9/25/24 8:00 AM - An observation revealed that the trash behind left dumpster and back fence had been removed. 9/26/24 8:00 AM - An observation revealed a clear bag of resident trash was on the ground in front of the dumpster. 10/2/24 3:00 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON), E3 (ADON), E46 (VPO) and a representative from the Ombudsman's Office.