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	05/11/2026

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. Based on observation, interview and record review, it was determined that the facility failed to ensure that one (R10) of 31 sampled residents, was given the right to self-determination when the resident was not provided an early lunch tray or a bagged lunch prior to his afternoon neurosurgeon appointment until the surveyor intervened. Findings include: Review of R10's clinical record revealed:12/5/25 - R10 was re-admitted to the facility with diagnoses including neck fracture. 4/14/26 - R10's quarterly MDS assessment documented a BIMS score of 5 indicating a severe cognition impairment, had adequate hearing and vision, usually makes self understood and understands others with clear speech. R10 ambulates with a wheelchair and is independent of eating. 4/22/26 10:23 - A nurse progress noted documented, . [R10's] appt (appointment) is 4/29/26 @ (at) 130pm 4/29/26 12:00 PM - During an observation in (unit dining room), R10, sitting on his wheelchair, was looking at the nursing staff taking out food trays from the food truck and passing the trays to the residents seated in the dining room. 4/29/26 12:20 PM - E50 (CNA) was heard talking to R10 and told him, Your food tray is not in here, it's on the next truck. Since you will be going out now for your appointment, you will just have your lunch later when you come back. R11 and his companion, FM3 (father) both nodded in agreement.4/29/26 12:25 PM - E27 (LPN) was heard instructing R11 and FM3 to go up to the 2nd (second) floor lobby and wait for the transportation to come and pick them up for R11's neurosurgeon appointment.4/29/26 12:30 PM - As instructed, FM3 was observed wheeling R11 out of the dining room heading up to the lobby on the 2nd floor.4/29/26 12:32 PM - When asked if R10 had his early lunch? E27 stated that R10 would eat his lunch when he returns from his 1:30 PM appointment. When asked if R11 brought a bagged lunch with him, E27 stated, No. When surveyor told E27 that it would be way past lunch time when E27 would return from the appointment. E27 replied to the surveyor that she will try to ask for bagged lunch from the kitchen.4/29/26 12:40 PM - During an observation, E27 was heard asking R10 if he wanted to take a quick lunch in the dining room or bring a bagged lunch with him to the appointment. R10 was heard saying, a bagged lunch is good, make sure you have soda in it.4/29/26 12:42 PM - In an interview, FM3 stated that he was appreciative that E27 offered to send a bagged lunch for R10. FM3 further stated, There's nothing much we can do. We don't want to miss this appointment even if lunch will be served late.5/4/26 4:00 PM - Findings were reviewed with E2 (DON) and E4(CRN). 5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review, interview, and review of other facility documentation, it was determined for four (R1, R18, R27 and R28) out of five residents sampled for reporting of injuries, injuries of unknown origin, abuse and activities of daily living, the facility failed to ensure that all injuries, including injuries of unknown source were reported to the State Survey Agency within the guidelines. R1, a dependent resident was observed with visible head injury on 4/22/26 at 6:00 AM and was not reported to the State Survey Agency until 4/23/26 at 8:30 AM, more than 26 hours later. For R18, R27, and R28, the facility failed to report incidents of abuse and alleged neglect and to submit a follow-up report within the required timeframe. Findings include:1. R1's clinical record revealed: 12/26/25 – R1 was admitted to the facility with diagnoses including, but not limited to, a stroke, deep vein thrombosis, heart failure, and dementia. 3/13/26 – R1's quarterly MDS assessment documented a BIMS score of 5, indicating a severe cognitive impairment. R1 required substantial to maximum assistance from staff for bed mobility and was totally dependent for all transfers between surfaces. 4/23/26 9:36 AM – E12 (LPN) documented in R1's nursing clinical record, Resident discovered in bed sleeping not easily aroused in deep sleep not able to explain what happen. Observation hematoma to right [forehead] and right eye bruising. Fully dressed. [Name of doctor] assessed resident and ordered to send resident out to the hospital for further evaluation. 4/23/26 12:24 PM – A facility reported incident report submitted to the Division documented, On 4/23/26 at approximately 0830 [8:30 AM], CNA reported to the Unit Manager that resident [R1] has a hematoma to the right side of her forehead and a right periorbital bruising. 4/29/26 9:00 AM – During a telephone interview, E8 (CNA) stated, My shift started on 4/21/26 at 11:00 PM and ended at 4/22/26 at 7:00 AM. I provided care to the resident [R1] two or three times during the night. Around 6:00 AM, I saw a discoloration on the right side of her forehead, but I forgot to tell the nurse. The Surveyor asked E8 if R1 showed any signs of pain when care was provided was provided to her. E8 stated, No. The Surveyor then asked E8 about R1's status during the 11-7 shift of 4/22/26 to 4/23/26. E8 stated, I saw the bruise around 5:00 AM but I did not see any additional injuries. The resident was responsive when I provided care to her during the shift. The Surveyor asked E8 if he reported the bruise to the nurse on duty or the oncoming aide. R8 stated, No. E8 failed to notify the nurse despite observing the bruise on R1's face on two separate occasions. 4/29/26 9:15 AM – During a telephone interview, E16 (LPN) stated, I worked the 11:00 PM to 7:00 AM shift on 4/21/26 into 4/22/26. I did an initial round when I came on the shift, and the resident [R1] was in her bed. I did not observe anything unusual with her. I gave her the morning medication between 5:30 AM to 5:45 AM, but I did not turn on the light in the room. The Surveyor asked E16 how she was able to see to give the resident her medication and if the resident was awake enough to take the medication. E16 stated, There was some light in the room, so I was able to see. And the resident took the medication fine. The Surveyor asked E16 if E8 informed her about any bruising or other concerns with R1. E16 stated, No. 4/29/26 9:30 AM – During an interview, E7 (CNA) stated, I was helping to feed the residents (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	breakfast in the dining/activity room around 8:30 AM on 4/22/26. I saw the bruising and swelling on the resident's [R1] right-side temple and forehead area. I asked if anyone saw this. I told E6 (UM) and she told me to tell the resident's nurse. I told the nurse [E15 LPN] and she stated, I will take a look at it. 4/29/26 9:45 AM – During an interview, the Surveyor asked E6 (UM) whether she was informed of the discoloration and swelling on R1's head. E6 stated, The aide told me, and I told him to tell her nurse. The Surveyor asked E6 whether she assessed R1, informed the ADON, DON, updated the provider or documented the change in the resident's status. E6 stated, No. 4/29/26 10:00 AM – During a telephone interview, E13 (AA) stated, [E7] and I were in the dining room around 8:30 AM to 9:00 AM on 4/22/26. We saw the bruise on the resident's face and the CNA went to tell the nurses. I stayed in the dining room to watch the residents. 4/29/26 10:30 AM – During a telephone interview, E14 (CNA) stated, This was my assignment on 4/22/26 on the 7-3 shift. I gave morning care to the resident and saw the bruise when I was washing her face. I dressed her and brought her into the hallway, and I asked her nurse [E15], Did you see this? What happened to her? The nurse replied, It happened overnight, and remained at the medication cart. I took the resident into the dining room for breakfast. 4/29/26 11:00 AM – During a telephone interview, E15 stated, The night nurse did not tell me anything about a bruise on this resident. It was around 8:30 AM to 9:00 AM on 4/22/26 when the aide [E7] told me that [R1] had a knot on her head. I was passing medications, and I stopped and checked on the resident. I took her vital signs and checked her neuros [neurological status]. I saw a mildly raised area on the right side of her forehead, but there was no discoloration and her eyes were clear. The Surveyor asked E15 if she reported her observations to the supervisor or the medical provider. E15 stated, No, I did not report it to anyone. I don't work with this resident very often and I thought it was an old bruise that was already addressed and did not need to be reported again. The Surveyor asked E15 if she documented the results of R1's neurological check and updated the 3-11 shift nurse about the bruise. E15 stated, No, I did not tell the 3-11 nurse, and I forgot to document the neuros. R1's medication administration record revealed that E15 administered oral medications to R1 at 9:00 AM and oral supplements at 1:00 PM on 4/22/26 but failed to identify, assess or report the visible bruise on the right side of her head. 4/29/26 11:30 AM – During a telephone interview, E19 (CNA) stated, I was in the hallway around 8:30 AM or 9:00 AM on 4/22/26 when I heard the aide [E14] tell the nurse [E15] that the resident had a knot on her forehead. The nurse replied, It was not reported to me from the previous shift, and I saw the injury already. 4/29/26 1:30 PM – During a telephone interview, E17 (LPN) stated, I worked on the 3-11 shift on 4/22/26 but I did not see any bruising or swelling on the resident. R1's medication administration record revealed that E17 gave her oral medications at 4:00 PM and 8:00 PM but failed to identify the obvious bruise on the right side of her head. 4/29/26 2:00 PM – During a telephone interview, E21 (CNA) stated, I worked with the resident [R1] on the 3:00 PM to 11:00 PM shift of 2/22/26. I saw the bruise on the right side of her head. I don't usually work with her. When I saw the fall mat near her bed, I thought that she had a previous (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fall, and the nurses already knew about it. That is why I did not think the bruise was new and did not report it. E21 failed to report the bruise on R1's face despite the lack of a report of an injury from the previous shift. 4/30/26 9:00 AM – During a telephone interview, E20 (RN) stated, I worked with the resident [R1] on the 1:00 PM to 7:00 AM shift on 4/22/26 to 4/23/26. I checked on all the residents at the start of the shift. I did not turn on the lights because I didn't want them to wake up. [R1] slept all night and took her medication in the morning around 5:45 AM. The Surveyor asked R20 if R1 was awake and alert when she gave her the medication. R20 replied, I did not turn on the light when I gave her the medication with some applesauce. I did not give her water or anything else to drink. 4/30/2026 9:30 AM – During a telephone interview, E11 (CNA) stated, The resident [R1] was on my assignment on the 7:00 AM to 3:00 PM shift. I did a quick round when I came on the shift to check that none of the residents had fallen out of bed. [R1] appeared to be sleeping so I went and got a couple of other residents up and then went to get her up. She was breathing in and out but I could not wake her up. And I saw bruises on her forehead and right eye. I told the unit manager who was outside of the room. The facility failed to ensure that R1's injury of unknown origin was reported to the State Survey Agency for more than 26 hours after the injury was identified by the staff. 2. 4/3/26 2:30 PM – A facility report documented an incident of resident-to-resident abuse between R18 and R12. 4/3/26 11:06 PM- The facility submitted an incident report to the State Agency over six hours after the two-hour reporting requirement for alleged resident abuse. 4/13/26 – A facility 5 Day Follow-Up Report was submitted to the State Agency. The 5 Day Follow-Up Report was submitted three days after the required due date. 3. 4/22/26 – A facility investigation statement signed by E22 (RN Supervisor, UM) and E23 (LPN) documented, [E24] was scheduled to work on [unit] 4/21/26 for 3-11 PM shift. [R27] complained that [E24] assisted him in using the toilet at approximately 3:45 PM. [R27] stated that [E24] did not return to assist him with care for the rest of the shift. [E22] called [E24] on the staffing phone, but [E24] did not pick up. This was approximately 10:30 PM. [E22] did not see [E24] for the rest of the shift. 4/22/26 - A facility investigation statement signed by E22 and E23 documented, [R27] had his call bell on, but [E24] never went back to assist him with care.[E24] was not on the floor at this time and did not return to the floor. [R27] was finally assisted by the overnight nurse when she came on duty at 11PM. 4/23/26 3:41 PM – A facility incident report submitted to the State Agency documented that R27 and R28 reported to E22 an allegation of neglect by E24 on 4/21/26 during the 3:00 PM to 11:00 PM shift. The incident report also documented that E23 reported to E22 that she completed care for residents assigned to E24 and that E22 was not aware of the need to report the allegation of neglect. The incident report was submitted to the State Agency forty (40) hours after the required timeframe (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for reporting alleged neglect. 5/5/26 1:09 PM – During a telephone interview, E23 stated, I saw the call lights on in the hallway. I went in [R27]'s room.[R27] was very upset.I told him I would get someone to help him .[E24] did not pass hydration or get any snacks during the shift. I took care of the residents. At 8:00 PM or 8:30 PM, I helped [R27] change into his night clothes. I reported it to [E22]. 4. 4/22/26 – A facility investigation document signed by E22 and E23 documented, .[R28] complained [E24] assisted her with a shower and then to bed around 4:30 PM.Care was given by the nurse when called.[R28] stated that [E24] did not return to her room the remainder of the shift. 4/22/26 – A facility investigation document signed by E22 and E23 documented, .[R28] also stated [E24] did not assist with her care for the rest of the shift despite [R28] calling for help.Most of the patients on [R28]'s assignment complained to the night nurse that they did not get care on the evening shift. 4/23/26 3:41 PM – A facility incident report was submitted to the State Agency documenting an allegation of neglect when E24 assisted R28 to bed at 4:30 PM on 4/21/26 and did not assist R28 again for the rest of the shift. The incident report was submitted to the State Agency forty hours after required timeframe for reporting alleged neglect. 5/5/26 - During a telephone interview, E23 stated, .I saw [E24] in [R28]'s room around dinner time. I did not see [E24] after that. 5/5/26 3:30 PM – Findings were reviewed with E1 (NHA) and E4 (CRN). 5/11/26 12:30 PM – Findings were reviewed with E1, E2 (DON) and E4 during the exit conference.

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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 observations, interviews and record reviews, it was determined that in one (R10) out of 31 sampled residents, the facility failed to develop a person centered care plan to address an identified need when R10 refused to wear his neck brace when out of bed. Findings include:Review of R10's clinical record revealed:12/5/25 - R10 was re-admitted to the facility with diagnoses including neck fracture. 4/14/26 - R10's quarterly MDS assessment documented a BIMS score of 5 indicating a severe cognition impairment, had adequate hearing and vision, usually makes self understood and understands others with clear speech. R10 ambulates with a wheelchair and is independent of eating.4/21/26 - R10 had a physician's order for neck collar to be worn when out of bed every shift and for monitoring.4/25/26 10:49 AM - A nurse progress notes documented Neck collar . frequently remove.4/27/26 12:53 PM - A nurse progress notes documented, Neck collar . removes.4/28/26 2:57 PM - A nurse progress notes documented, Neck collar . removes.4/29/26 11:50 AM - R10 was observed out of bed and sitting on his wheelchair watching TV in his room. R10's neck collar was not in use.4/29/26 11:55 AM - In an interview, E50 (CNA) stated that R10 was supposed to wear his neck collar when not in bed but he likes to take it off.4/29/26 11:58 AM - E27 (LPN) entered the room and asked R10 if he wanted to put the neck collar on. R10 stated, It's uncomfortable. E27 was looking at this surveyor and said, Sometimes [R10] likes to put it on, sometimes he likes it off him. 4/29/26 1:53 PM - A nurse progress notes documented, . resident frequently removes neck brace.encouraged not to remove leave on when OOB (out of bed).4/30/26 12:43 PM - R10 was observed sitting in the dining room. R10's neck collar was not in use.4/30/25 12:45 PM - In an interview, E28 (LPN) confirmed that multiple nurse progress notes documented that R10 refused to wear his neck collar. E28 further stated that it was not documented in the care plan as an identified behavior problem of refusal. 5/4/26 4:00 PM - Finding was discussed with E3 (DON) and E4 (CRN)5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, it was determined that for one (R1) out of three residents reviewed for injuries, the facility failed to ensure that R1 received adequate care and treatment that met professional standards. R1, a cognitively impaired and dependent resident, was observed by a staff member with a visible head injury on 4/22/26 at approximately 6:00 AM and failed to inform the nursing staff at that time. The nurses were informed of the injury on 4/22/26 at approximately 8:30 AM, but failed to appropriately assess and provide care and treatment, including neurological checks. Each of the following shifts failed to identify and assess the injury, including failing to initiate neurological checks. As a result of this delay, R1 was found unresponsive in her bed on 4/23/26 at approximately 8:30 AM, more than 26 hours later, and was sent to the hospital, where emergency surgery was performed for a massive brain bleed. Due to this failure, an Immediate Jeopardy (IJ) was called at 1:30 PM on 4/30/26. For R11, the facility failed to ensure timely physician notification and follow-up of abnormal laboratory results. As a result, R11 experienced a delay in treatment and required emergent hospital transfer for acute kidney injury. Additionally, the facility failed to ensure that the physician's order for sodium chloride 0.9% intravenous infusion was administered when R11 developed signs and symptoms of dehydration on 3/18/26. The facility also failed to ensure R14 received timely care and services after a change in condition, and critical labs were identified, resulting in a hospital transfer requiring admission to the ICU for an acute kidney injury, resulting in harm. Findings include: 1. 1/29/24 – A facility document entitled, Neurological Assessment, included, A neurological assessment will be completed by a licensed nurse in order to detect potential early signs of brain injury. Complete the neurological checklist assessment in the medical record. Assess vital signs, orientation, level of consciousness, pupillary response, verbal response, pain, and movement and sensation of extremities. Complete assessment every 15 minutes for the first hour, every 30 minutes for the next two hours, and every hour for the next four hours. Notify provider and responsible party of any abnormal findings. Document in the medical record and follow provider recommendations. R1's clinical record revealed: 12/26/25 – R1 was admitted to the facility with diagnoses including, but not limited to, a stroke, deep vein thrombosis, heart failure, and dementia. 12/26/25 – R1's care plan (reviewed 3/24/26) included, . At risk for bleeding, hemorrhage, excessive bruising and complications related to anticoagulant use. The interventions included, .Monitor for signs/symptoms of bleeding, bruising, and complications and notify MD as indicated. 3/12/26 – R1's medications included aspirin 81 mg daily and Eliquis 5 mg, two times a day for deep vein thrombosis. 3/13/26 – R1's quarterly MDS assessment documented a BIMS score of 5, indicating a severe cognitive impairment. R1 required substantial to maximum assistance from staff for bed mobility and was totally dependent for all transfers between surfaces. 4/23/26 8:58 AM – R1's physician clinical record included, Right periorbital [tissues surrounding the eye socket, including the eyelid, skin and underlying soft tissue] bruising, right temporal hematoma, altered mental status. evaluated emergently at this a.m., nursing informed me that the aide had gone into her room and noticed that the resident was not communicating with her (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	and [was] concerned for her level of responsiveness. The nurse was called, and upon examination, noted the patient had a right periorbital bruise and what appeared to be a right temporal sub-gluteal hematoma.No apparent reports of a fall.Patient is on Eliquis as well as a baby aspirin. Advised nursing to call 911 immediately to transport to the hospital for further evaluation .Patient was lying on her left side and also noticed a small area of what appeared to be vomitous on her sheet. I attempted to awaken the resident by calling her name but no response and I also attempted to touch her arm to see if she would respond and she did not.Patient with apparent fall, however no report of a fall at this time and I did speak to the assistant director of nursing to contact the night nurse to further discuss whether or the patient may have had a fall during the course of the evening hours. Sent to the emergency room for further evaluation as patient needs an emergent heat CT [scan].altered mental status.nonresponsive to verbal or stimulus. 4/23/26 9:36 AM – E12 (LPN) documented in R1's nursing clinical record, Resident discovered in bed sleeping not easily aroused in deep sleep not able to explain what happen. Observation hematoma to right [forehead] and right eye bruising. Fully dressed. [Name of doctor] assessed resident and ordered to send resident out to the hospital for further evaluation. 4/23/26 12:24 PM – A facility reported incident report submitted to the Division documented, On 4/23/26 at approximately 0830 [8:30 AM], CNA reported to the Unit Manager that resident [R1] has a hematoma to the right side of her forehead and a right periorbital bruising. 4/28/26 1:20 PM – During a telephone, FNE1 (Forensic Nurse Examiner) stated, [R1] was completely unconscious when she arrived at the hospital. She went immediately to surgery and did not regain coconsciousness. Approximately one quarter of her brain was filled with blood. She had a massive brain bleed and was dying. It did not look like she was going to recover, and her family decided to put her on end-of-life care because she would not want to live like that. 4/29/26 9:00 AM – During a telephone interview, E8 (CNA) stated, My shift started on 4/21/26 at 11:00 PM and ended at 4/22/26 at 7:00 AM. I provided care to the resident [R1] two or three times during the night. Around 6:00 AM, I saw a discoloration on the right side of her forehead, but I forgot to tell the nurse. The Surveyor asked E8 if R1 showed any signs of pain when care was provided was provided to her. E8 stated, No. The Surveyor then asked E8 about R1's status during the 11-7 shift of 4/22/26 to 4/23/26. E8 stated, I saw the bruise around 5:00 AM but I did not see any additional injuries. The resident was responsive when I provided care to her during the shift. The Surveyor asked E8 if he reported the bruise to the nurse on duty or the oncoming aide. R8 stated, No. E8 failed to notify the nurse despite observing the bruise on R1's face on two separate occasions. 4/29/26 9:15 AM – During a telephone interview, E16 (LPN) stated, I worked the 11:00 PM to 7:00 AM shift on 4/21/26 into 4/22/26. I did an initial round when I came on the shift, and the resident [R1] was in her bed. I did not observe anything unusual with her. I gave her the morning medication between 5:30 AM to 5:45 AM, but I did not turn on the light in the room. The Surveyor asked E16 how she was able to see to give the resident her medication and if the resident was awake enough to take the medication. E16 stated, There was some light in the room, so I was able to see. And the resident took the medication fine. The Surveyor asked E16 if E8 informed her about any bruising or other concerns with R1. E16 stated, No. 4/29/26 9:30 AM – During an interview, E7 (CNA) stated, I was helping to feed the residents breakfast in the dining/activity room around 8:30 AM on 4/22/26. I saw the bruising and swelling on (continued on next page)

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	085028	A. Building B. Wing	05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	the resident's [R1] right-side temple and forehead area. I asked if anyone saw this. I told E6 (UM) and she told me to tell the resident's nurse. I told the nurse [E15 LPN] and she stated, I will take a look at it. 4/29/26 9:45 AM – During an interview, the Surveyor asked E6 (UM) whether she was informed of the discoloration and swelling on R1's head. E6 stated, The aide told me, and I told him to tell her nurse. The Surveyor asked E6 whether she assessed R1, informed the ADON, DON, updated the provider or documented the change in the resident's status. E6 stated, No. 4/29/26 10:00 AM – During a telephone interview, E13 (AA) stated, [E7] and I were in the dining room around 8:30 AM to 9:00 AM on 4/22/26. We saw the bruise on the resident's face and the CNA went to tell the nurses. I stayed in the dining room to watch the residents. 4/29/26 10:30 AM – During a telephone interview, E14 (CNA) stated, This was my assignment on 4/22/26 on the 7-3 shift. I gave morning care to the resident and saw the bruise when I was washing her face. I dressed her and brought her into the hallway, and I asked her nurse [E15], Did you see this? What happened to her? The nurse replied, It happened overnight, and remained at the medication cart. I took the resident into the dining room for breakfast. 4/29/26 11:00 AM – During a telephone interview, E15 stated, The night nurse did not tell me anything about a bruise on this resident. It was around 8:30 AM to 9:00 AM on 4/22/26 when the aide [E7] told me that [R1] had a knot on her head. I was passing medications, and I stopped and checked on the resident. I took her vital signs and checked her neuros [neurological status]. I saw a mildly raised area on the right side of her forehead, but there was no discoloration and her eyes were clear. The Surveyor asked E15 if she reported her observations to the supervisor or the medical provider. E15 stated, No, I did not report it to anyone. I don't work with this resident very often and I thought it was an old bruise that was already addressed and did not need to be reported again. The Surveyor asked E15 if she documented the results of R1's neurological check and updated the 3-11 shift nurse about the bruise. E15 stated, No, I did not tell the 3-11 nurse, and I forgot to document the neuros. The facility lacked evidence that R1's neurological status was monitored, or the medical provider was notified of the swelling and discoloration on the right side of her face. R1's medication administration record revealed that E15 administered oral medications to R1 at 9:00 AM and oral supplements at 1:00 PM on 4/22/26 but failed to identify, assess or report the visible bruise on the right side of her head. 4/29/26 11:30 AM – During a telephone interview, E19 (CNA) stated, I was in the hallway around 8:30 AM or 9:00 AM on 4/22/26 when I heard the aide [E14] tell the nurse [E15] that the resident had a knot on her forehead. The nurse replied, It was not reported to me from the previous shift, and I saw the injury already. 4/29/26 1:30 PM – During a telephone interview, E17 (LPN) stated, I worked on the 3-11 shift on 4/22/26 but I did not see any bruising or swelling on the resident. R1's medication administration record revealed that E17 gave her oral medications at 4:00 PM and 8:00 PM but failed to identify the obvious bruise on the right side of her head. 4/29/26 2:00 PM – During a telephone interview, E21 (CNA) stated, I worked with the resident (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3/24/26 2:47 PM – A medical note from P1 documented, . Acute on chronic renal failure worsened related to pre-renal azotemia . I reviewed BMP 3/17/2026. BUN/creatinine: 53/2.9 . awaiting follow up BMP. she is at risk for deterioration, hospitalization . 3/24/26 – R11 had a physician's order for CBC, CMP, magnesium and phosphate. Despite ongoing concerns regarding deterioration and hospitalization risk, the follow-up BMP referenced by P1 had not yet been reviewed. 3/25/26 – R11 had CBC, CMP, magnesium and phosphate labs drawn. 3/26/26 – 7:11 AM (another fax transmittal time stamped 7:14 AM) - A laboratory results of R11's labs drawn on 3/21/26 revealed the following results: elevated phosphorous 4.7 (2.6 – 4.5) BUN 44 (5-20) creatinine 2.6 (0.5 – 1.3) WBC 15.20 (4.5 – 11.00) and low hemoglobin 8.2 (11.7 – 16.1). Results of R11's physician order for stat lab work on 3/21/26 were not reported to the facility until five days later on 3/26/26. Results of R11's physician order for stat laboratory work collected on 3/21/26 were not reported to the facility until five days later, on 3/26/26. The laboratory results reflected continued worsening renal function and abnormal findings. Despite the stat laboratory order and documented concerns regarding worsening kidney function and hospitalization risk, the facility lacked evidence of timely follow-up regarding the pending laboratory results prior to 3/26/26. 3/26/26 9:35 AM – A laboratory results of R11's labs drawn on 3/25/26 revealed the following: elevated phosphorous 5.8 (2.6 – 4.5) BUN 56 (5-20) creatinine 4.6 (0.5 – 1.3) WBC 16.30 (4.5 – 11.00) low sodium 130 (133- 145) and low hemoglobin 7.6 (11.7 – 16.1). Results of R11's physician order for lab work on 3/25/26 were not reported to the facility until the next day, on 3/26/26. 3/26/26 2:46 PM – A nurse progress note documented, New labs received., pt (patient) in AKI (acute kidney injury) and also not eating and drinking more than 50% per meal for the least two days. New order to send pt to ED (Emergency Department) for further eval . 3/27/26 10:33 PM – A medical note from P1 documented, . Acute on chronic renal failure worsened related to pre-renal azotemia . I reviewed BMP 3/26/2026. BUN/creatinine: 56/4.6 . She is acutely ill and at high risk for further deterioration. Transfer the patient to hospital for further evaluation and management. 5/4/26 10:08 AM – In an interview, P1 (physician) confirmed that R11 was sent out to the hospital when the abnormal lab results came back indicating that R11 had an acute kidney injury. 5/8/26 9:05 AM – In an interview, P2 (PA) stated that he was not immediately notified of the results of R11's stat lab draw order. I think it was that weekend. We had a third-party lab issue that time. We didn't know whom to call for follow up results. 5/8/26 9:10 AM – During an interview, E47 (LPN) stated, . When there's a stat lab order, the (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	nurses should call and follow up with the lab and notify the physician, especially if the results are critical and the resident is going through a change in condition. 5/5/26 4:00 PM – Findings were discussed with E1 (NHA), E2 (DON) and E3 (CRN). 3. Cross-refer F692 Review of R11's clinical record revealed: 3/18/26 5:12 PM – A medical note from P1 (physician) documented, . poor oral intake . optimize fluid intake . she is at risk for deterioration, hospitalization. 3/18/26 – R11 had a physician's order for Sodium Chloride 0.9 % (also known as normal saline solution) use 50 ml/hr intravenously every shift for hydration for 1 Day . for total of 1 Liter. 3/18/26 – A review of R11's eMAR lacked evidence that R11's sodium chloride intravenous solution was patent and infusing well on the 3-11 shift. 3/18/26 11:55 PM – A nurse progress note documented, IV access present: No. 3/19/26 12:48 AM – A nurse progress noted documented, IV site infiltrated, RN supervisor . notified. 3/20/26 8:49 AM – A medical note by P2 (NP) documented . pt refused IV fluids, . states . they were trying to stab her belly yesterday when they were attempting to place the hypodermoclysis . appears pt refused hypodermoclysis and NSS yesterday. 5/8/26 9:00 AM – During an interview, P2 (PA) confirmed that he did not receive any notification from the nursing staff that R11's IV site was infiltrated on 3/18/25 evening shift and that R11 refused the IV fluids until he learned about it on 3/20/26. 5/5/26 4 PM – Findings were discussed with E1 (NHA), E2 (DON) and E4 (CRN). 4. Review of R14's record revealed: 10/11/24 – R14 was admitted to the facility with diagnoses including psychosis, Alzheimer's Disease, cerebrovascular disease, bipolar disorder, hypertension, and aneurysm of the vertebral artery. 10/15/25 – Lab results include Sodium 142 (normal 135-145); BUN 22 (normal 10 – 26); Creatinine 0.8 (normal 0.5 – 1.5); WBC 7.6 (normal 4.8 – 10.8). 11/3/25 – R14's quarterly MDS documented a BIMS score of 0 (indicating severe cognitive impairment). The MDS further documented that the resident was able to ambulate at least 150 feet without assistance, was dependent for personal and oral hygiene, and was independent for eating. 12/29/25 6:00 PM – A progress note by P3 (Physician) documented History of Present Illness [R14] .will continue to be monitored and encouraged for oral hydration. Follow-up – Review CBC and CMP results when available. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, record review and review of other facility documentation, it was determined that for one (R2) out of three residents sampled for accidents, the facility failed to ensure that R2 received adequate supervision and assistive devices to prevent accidents to the extent possible. Findings include:1. R2's clinical record revealed:9/26/25 - R2 was admitted to the facility with diagnoses including but not limited to right hip pain and heart failure.9/26/25 - R2's fall care plan documented, At risk for falls related to cognitive impairment, poor memory and muscle weakness.9/28/25 - R2's admission MDS assessment documented a BIMS score of 00 indicating an inability to complete a cognitive assessment and required partial to moderate assistance from staff for wheelchair mobility.10/11/25 2:30 PM - R2's clinical record included, At 14:30 [2:30 PM], patient fell forward out of the wheelchair while staff member was wheeling her in the wheelchair in her room. Patient noted laceration to left eyebrow 2cm x 0.2 cm.Complained of pain to right hip.At 1535 [3:35 PM], patient heard yelling for help and found lying on the floor on her left side by her room.noted with hematoma below left eye.Send to the ER for evaluation.10/11/25 11:29 PM - A facility incident report submitted to the Division included, . At 1430 [2:30 PM] patient [R2] fell forward out of the wheelchair while staff member was wheeling her in the wheelchair in her room. Noted with a laceration to left eyebrow 2cm X 0.2 cm. Approximately 1530 [3:30 PM] resident was heard calling for help and was discovered on the left side of her room entrance. Noted with a hematoma below her left eye. Sent to the ER [emergency room] for evaluation.10/12/26 1:00 AM - R2's emergency room record included, . Laceration on left side of face . repaired with three stitches and steristrips.4/30/26 2:00 PM - A review of the facility's investigative document revealed that R2 asked E9 (Houskeeper) to wheel her to her room. E9 wheeled R2 and she fell forward to the floor. During an interview, the Surveyor asked E9 about the fall. E9 stated, [R2] asked me to push her into the room, and her feet got stuck and she fell out of the wheelchair.4/30/26 3:30 PM - During an interview, E2 (DON) stated, We provided education to [E9] that only nursing staff should push the wheelchair when the resident is in it. The nursing staff should be told if the resident asked to be pushed when they are in the wheelchair. We also educated the rest of the staff to ensure that the wheelchairs have foot pedals when they are wheeling the residents.4/30/26 4:00 PM - The facility's education and training entitled, Footrests on wheelchair, and dated 10/12/25 included, Before ambulating a resident on the wheelchair ensure footrests are attached to it. Footrests should be on all wcs [wheelchairs] during transport. Housekeeping staff should not transport residents in wheelchairs.The facility failed to ensure that R2 was free from accidents when she fell while she was transported in the wheelchair without footrests resulting in the injury. 5/6/26 4:10 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.

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	085028	A. Building B. Wing	05/11/2026

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview, record review, and review of other documentation as indicated, it was determined that for one (R11) out of four residents sampled for medication administration review, the facility failed to ensure that R11 was free from significant medication errors as evidenced by failing to check and monitor R11's blood sugars before meals, failing to administer ordered insulin and heparin injections. The facility's multiple failures to administer critical medications had the potential to cause a serious adverse outcome or death to R11. Due to the failures, an Immediate Jeopardy (IJ) was called on 5/8/26 at 1:24 PM. The IJ was abated on 5/9/26 at 11:59 PM. Findings include:The facility's policy titled, Medication Unavailability, effective 1/29/24, documented, . Procedure . 1. A licensed nurse will notify the provider of the unavailability of medication . 2. the licensed nurse will activate the backup pharmacy process and procedures. 3. A licensed nurse will document notification to the provider of the unavailability in the medical record . The facility's policy titled, Refusal of Medication/Treatment/Care, effective 1/29/24, documented that a licensed nurse is to document and notify the provider and responsible party when a patient refuses medication(s), treatment(s), and / or care.The facility's policy titled, Blood Glucose Monitoring, dated 3/17/25, documented, .Licensed nurses will complete blood glucose monitoring as ordered by the provider . Procedure.4. Blood glucose (sugar) checks will be documented in the medical record .Cross refer F865Review of R11's clinical record revealed: 1/17/26 - R11 was admitted to the facility with diagnoses including diabetes and stroke.1/17/26 - R11 had a physician's order for heparin sodium injection 1 mL subcutaneously every eight hours for blood clot prevention.1/19/26 - R11 had a physician's order for insulin Lispro injection subcutaneously for diabetes. Inject as per sliding scale:If 0-69 = 0 unit; call provider (physician) for BS (blood sugar) less than 70;70 - 100 = 0 unit;101 - 150 = 2 units;151 - 200 = 4 units;201 - 250 = 6 units;251 - 300 = 8 units;301 - 350 = 10 units;351 - 400 = 12 units Call provider for BS greater than 400.1/23/26 - R11 had a physician's order to check and record blood sugars before meals.A review of R11's insulin lispro administration from 2/1/26 through 2/14/26 revealed that R11 was administered insulin lispro coverages based of FSBS (finger stick blood sugar) on the following times:7:30 AM - 12 of 14 opportunities (86%); 2/1/26 went on LOA (leave of absence) and 2/2/26 refused12:00 PM - 13 of 14 opportunities (93%); 2/12/26 refused4:30 PM - 12 of 14 opportunities (86%); 2/1/26 went on LOA and 2/4/26 not given for blood sugar 79 mg/dlIt was noted that from 2/1/26 through 2/14/26, R11 was administered her insulin lispro coverages based on the results of her blood sugar checks 86% during breakfast and dinner times and 93% during lunch time.2/15/26 - Review of R11's eMAR revealed that E40 (LPN) administered R11's medications scheduled at 12:00 PM and 2:00 PM. Further review of R11's eMAR revealed that E40:- lacked evidence that R11's 12:00 PM blood sugar check was monitored;- lacked evidence that R11's 12:00 PM sliding scale insulin injection was administered nor did E40 document if insulin was not indicated; - lacked evidence that R11's 2:00 PM heparin injection was administered.2/16/26 - Review of R11's eMAR revealed that E40 (LPN) administered R11's medications scheduled at 7:30 AM, 12:00 PM and 2:00 PM. Further review of R11's eMAR revealed: - lacked evidence that R11's 7:30 AM blood sugar check was monitored;- lacked evidence that R11's 7:30 AM sliding scale insulin injection was administered nor did E40 document if insulin was not indicated;- lacked evidence that R11's 12:00 PM blood sugar check was monitored.- lacked evidence that R11's 12:00 PM sliding scale insulin injection was administered nor did E40 document if insulin was not indicated;- lacked evidence that R11's 2:00 PM heparin injection was administered.2/25/26 - Review of R11's eMAR revealed that E41 (LPN) administered R11's medications scheduled at 10:00 PM. E41 lacked that R11's 10:00 PM heparin injection was administered.3/11/26 - Review of R11's eMAR revealed that E42 (RN) administered R11's medications scheduled at 10:00 PM. E42 lacked evidence that R11's 10:00 PM heparin injection was administered.3/18/26 - Review of R11's eMAR revealed that E43 (LPN) administered R11's medications scheduled at 10:00 PM. E43 lacked evidence that R11's 10:00 PM heparin injection was (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	administered.5/5/26 3:30 PM - In an interview, E4 (CRN) stated that she had another nurse review the missing entries in R11's February and March 2026 eMAR. E4 further stated and confirmed that the facility lacked evidence and documentation that R11's blood sugar checks were monitored and the insulin and heparin injections were administered on those dates in question.5/8/26 9:00 AM - In an interview, P2 (PA) stated, I don't think I remember receiving a call about [R11's] missing meds or unavailable meds particularly.5/8/26 10:20 AM - During an interview, E40 (LPN) stated, I don't remember what happened back then, I can't remember why I did not document on R11's eMAR on all those doses left blank.5/8/26 10:30 AM - In a telephone interview, E41 (LPN) stated, I don't remember anymore. I must have given the heparin but I forgot to sign in the eMAR.5/8/26 10:49 AM - In a telephone interview, E42 (RN) stated, If the heparin injection was not signed, I don't know. it must be held for a reason.for unavailable meds, we have a back up in our Omnicell machine (computer - controlled systems used to manage and dispense medications and supplies) . if it was not documented, I don't know. 5/8/26 11:25 AM - In an interview, E49 (LPN) stated that when meds are not available, she would call the pharmacy, notify the physician and document in the progress notes. E49 further stated that most medication back up supplies including insulin lispro and heparin injections are found in the Omnicell machine. 5/8/26 1:24 PM - During a meeting with facility management, the Survey Team notified E1 (NHA) and E4 (RDCS) of an Immediate Jeopardy for R11's significant medication errors that occurred from 2/15/26 through 3/18/26. 5/8/26 3:30 PM - E1 (NHA) submitted a signed, dated and timed written abatement plan to the State Agency.The facility's abatement included: Immediate Corrective Action for Identified ResidentNurses involved were identified and one on one education is in progress and with a scheduled completion date of 5/9/26 at 11:59 pm.Education for licensed nurses was initiated with a scheduled completion date of 5/9/26 at 11:59 pm.Identification of Other Residents at Risk On 5/8/26, the facility initiated a 100% audit of:All residents receiving insulinAll residents ordered blood sugar monitoringAll residents receiving anticoagulants including HeparinThe audit will include verification of:Medication administration completion and documentationCompletion of blood sugar checks as orderedPresence of any omitted doses and treatmentsAny identified concerns will be corrected, physician(s) notified as indicated, and residents assessed for adverse outcomes.Systemic Corrective ActionsThe facility immediately implemented the following systemic interventions to remove the likelihood of serious harm:Medication Administration Process ChangesA licensed nurse/designee will perform end - of - shift reconciliation ofInsulin administrationAnticoagulant administrationOrdered blood sugar checksAny omissions identified will be immediately escalated to the supervisor and Administrator/DON.Clinical Oversight EnhancementsDON/ADON, Unit Managers, and or/Clinical Consultants will initiate daily medication administration audits.Review of daily clinical meeting will include review if:Missed medicationsBlood sugar omissionsHigh - risk medication variancesFollow - up actions as requiredEducationEducation of licensed nursing staff was initiated with a scheduled completion date of 5/9/26 at 11:59 PM:Medication administration requirementsBlood sugar monitoring requirementsDocumentation accuracyProper follow - up for held/refused medicationsNotification expectations Ensure all documentation completed in medical recordMonitoring to Ensure Ongoing ComplianceNursing Leadership/Supervisors will audit medication administration compliance daily prior to end of each shift.Daily medication administration audits will be completed by Nursing Leadership in the scheduled Daily Clinical Meeting.Results of audits will be reviewed weekly by DON/AdministratorResults of audits will be reviewed Monthly in QAPI for ongoing compliance and identification of trendsAny identified concerns will result in immediate corrective action, re-education, and follow - up auditing.5/11/26 - Verification of facility's abatement plan included review of nursing staff education signed attestation. Interviews with nursing staff confirmed the facility's IJ was abated on 5/9/26 at 11:59 PM.5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on interview, record review, and review of other facility documentation, it was determined that for one (R11) out of 31 sampled residents, the facility failed to provide laboratory services to R11 when lab work ordered was not followed up after a failed specimen collection. In addition, the facility failed to ensure that a stat (at once) ordered lab draw result was reported to the physician in a timely manner. Findings include: Cross refer F684 example 2Review of R11's clinical record revealed:a. 3/18/26 - R11 had a physician's order for CBC and CMP for hyponatremia.3/23/26 - A labs result report from C6 (contracted laboratory vendor) with a specimen collection date of 3/19/26 documented . albumin . please reschedule . difficult draw specimen not obtained . WBC . please reschedule . difficult draw . specimen not obtained . a handwritten note also documented, CBC, CMP difficult stick.5/4/26 2:00 PM - A review of R11's nurse progress notes lacked evidence that the physician was notified of R11's lab draw for CBC and CMP was not completed due to difficulty in drawing R11's blood specimen.5/4/26 3:00 PM - In an interview, E4 (CRN) stated, That was approximately the time when we encountered change of service provider issues with between our laboratory [C6] and [C7, the lab vendor contracted by C6 to temporarily provide lab services to the facility while in transition]. A phlebotomist did come in on 3/19/26 and made an attempt to draw [R11's] blood specimen, but it was a hard stick and was not able to collect R11's specimen. Somebody else was supposed to follow up, come in and do [R11] again the next night (3/20/26) but nobody came. We did not know if it was supposed to come from [C6] or from [C7]. 5/5/26 4:00 PM Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN).b. 3/20/26 - R11 had a stat (at once) physician's order for CBC, CMP, magnesium, phosphate, B12, folate, Vitamin D for electrolyte derangements. 3/24/26 - A medical note by P1 (physician) documented . I reviewed BMP 3/17/26 . BUN/creatinine 53/2.9 . 3/25/26 - R11 had CBC, CMP, magnesium, phosphate, B12, folate, Vitamin D labs drawn.3/26/26 - 7:11 AM (another fax transmittal time stamped 7:14 AM) - Transmitted via fax by C7, R11's calcium, magnesium phosphorus, CMP, Vit B12 folate, CBC with diff profile lab results report revealed the following: elevated phosphorous 4.7 (2.6 - 4.5) BUN 44 (5-20) creatinine 2.6 (0.5 - 1.3) WBC 15.20 (4.5 - 11.00) and low hemoglobin 8.2 (11.7 - 16.1).3/26/26 9:35 AM - Transmitted via fax by C7, R11's magnesium, phosphorus, CMP and CBC profile lab results report revealed the following: elevated phosphorous 5.8 (2.6 - 4.5) BUN 56 (5-20) creatinine 4.6 (0.5 - 1.3) WBC 16.30 (4.5 - 11.00) low sodium 130 (133- 145) and low hemoglobin 7.6 (11.7 - 16.1).5/4/26 4:10 PM - A review of R11's progress notes lacked evidence that results of R11's 3/20/26 stat lab draw order for CBC, CMP, magnesium, phosphate, B12, folate, Vitamin D for electrolyte derangements was followed up by the nursing staff.5/5/26 10:40 AM - In an interview, E4 (CRN) stated that C7's reporting system was not connected to the facility's EHR (electronic health record system). E4 further stated, Unlike [EHR], we could not access the lab results from [C7]. They didn't call us, they only sent the results by fax. In the case of [R11], her lab results were only faxed on 3/26/26 in the morning. We had a contract with another laboratory vendor [C8] starting April 2026. 5/8/26 9:05 AM - In an interview, P2 (PA) stated that he was not immediately notified of the results of R11's stat lab draw order. I think it was that weekend. We had a third-party lab issue that time. We didn't know whom to call for follow up results. 5/8/26 9:10 AM - During an interview, E47 (LPN) stated, . When there's a stat lab order, the nurses should call and follow up with the lab and notify the physician, especially if the results are critical and the resident is going through a change in condition.5/8/26 4:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E3 (CRN). 5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interviews and record reviews, it was determined that for one (R11) out of 4 residents reviewed for nutrition, the facility failed to maintain clinical records that meet professional standards of practice when R11's missing nutrition assessments were completed and signed by another Registered Dietitian on 5/5/26, one month after R11 was discharged from the facility on 3/26/26. Findings include:Review of R11's clinical record revealed: 1/17/26 - R11 was admitted to the facility.1/19/26 - R11's nutrition assessment was completed by C1 (contract RD/ Registered Dietitian).3/26/26 2:00 PM - A nurse progress note documented that R11 was transferred to the hospital.5/4/26 - A review of R11's electronic health record under the evaluation/assessment tab revealed only one nutrition assessment completed by C1 on 1/19/26.5/4/26 3:00 PM - In an interview, E2 (DON) confirmed that R11 was discharged from the facility on 3/26/27. E2 further stated that R11 did not return to the facility after she was transferred to the hospital on 3/26/26. 5/5/26 3:25 PM - E2 presented to the surveyor copies of R11's nutrition assessment for 2/19/26 and 3/17/26 completed by another RD (C5) and signed on the same day, 5/5/26. 5/5/26 3:30 PM - E2 informed this surveyor that C1 was on leave and they have an interim RD (C2) who fills in and sees patients in C1's absence. E2 provided C2's contact information.5/5/26 3:38 PM - During an interview, C2 told this surveyor that she has never met R11 and never completed a nutritional assessment for R11. When asked if C2 was familiar with C5, C2 stated, Yes, she is my boss and the owner of our contract dietary agency. I can call her for you now to get clarification on why [R11's] nutrition assessments were dated back in 2/19/26 and 3/17/26 and she's only signing them with her name today.5/5/26 3:46 PM - In an interview, C5 (Owner of contract RD company) stated that C1 (contract RD) was on leave and was not available to answer this surveyor's questions regarding R11's assessments. C5 further stated, The facility called me today and asked about these nutrition assessments. I went over C1's risk management notes and since I can't find any assessments, I just typed the information in the template, signed it and dated it today. When asked if C5 had personally met R11 for a nutrition assessment in the past, C5 replied, No.5/4/26 4:00 PM - Findings were discussed with E1 (NHA), E2 (DON) and E4 (CRN).5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and review of facility documents, it was determined that the facility failed to identify and correct R11's significant medication errors involving blood sugar checks, heparin and insulin injections. Findings include:Cross refer 7605/8/26 3:15 PM - During QAPI interview, E1 (NHA) confirmed that the facility failed to identify and correct quality issues for R11's nutrition and hydration status requiring emergent hospitalization on 3/26/26.5/8/26 3:50 AM - In a follow up interview, E1 further confirmed that facility failed to identify and correct R11's significant medication errors involving blood sugar checks, heparin and insulin injections from 2/15/26 to 3/18/26. 5/11/26 12:30 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E4 (CRN) during the Exit Conference.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, interviews and review of records and the facility's policy and procedure, it was determined that for two (R29 and R30) out of 31 residents sampled during the survey, the facility failed to ensure infection control and prevention practices were followed. Findings include:According to the Center for Disease Control's (CDC) website, the Infection Control Guidance: Preventing Methicillin-resistant Staphylococcus aureus (MRSA) in Healthcare Facilities, dated 6/27/25, stated, . The prevention of MRSA infections is a priority for CDC . Based on the current evidence, CDC recommends the use of Contact Precautions for MRSA-colonized or infected patients . The facility's policy and procedure entitled Transmission Based Precautions, effective 2/6/2020, stated, . Transmission based precautions are designed for patients documented as suspected to be infected or colonized with highly transmissible or epidemiologically important pathogens for which additional precautions beyond standard precautions are needed to interrupt transmission . 3. Contact precautions (e.g., MRSA . C. difficile .). In addition to standard precautions, for specified patients known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the patient (hand or skin-to-skin contact that occurs when performing patient-care activities that require touching the patient's dry skin) or indirect contact (touching) with environmental surfaces or patient care items in the patient's environment . 1.Review of R29's clinical record revealed: 4/28/29 - An active physician's order for R29 documented, CONTACT PRECAUTIONS every shift for MRSA . 4/29/26 9:57 AM - Observation by the surveyor revealed a contact precautions sign and an isolation cart with personal protective equipment available outside R29's room. Further observation with the door opened revealed E38 (RN) only wearing gloves while in R29's room administering an injection in the resident's right arm. Interview upon exit of R29's room, E38 confirmed that that he should have applied a gown on before entering R29's room. 2. Review of R30's clinical record revealed: 5/2/26 - A physician's order for R30 documented contact precautions for diagnosis of C-Diff. 5/3/26 10:41 AM - A telehealth note documented that R30 was evaluated by C9 (contracted telehealth APN) with E39 (LPN) present for vomiting. 5/3/26 approximately 1:00 PM - Observation by the surveyor revealed C2 (contracted dietician) ask E39 (LPN) at the medication cart if she needed to apply personal protective equipment before entering R30's room if she was only going to be asking her questions. E39 replied no if only you are asking questions. Further observation revealed that outside of the R30's room there was a contact precautions sign posted with instructions to apply gown and gloves before entering the room and an isolation cart was present with personal protective equipment (PPE) available. C2 entered the R30's room without applying PPE. 5/3/26 approximately 1:10 PM - Surveyor reported observation to E2 (DON) and E4 (CRN). 5/4/26 - An individual inservice record for C2 was provided to the surveyor by E2 (DON), which stated Isolation Requirements - Before entering any room that has a posted isolation sign, stop, read the instructions before entering. The information on the signage will direct you to the proper PPE. 5/6/26 4:10 PM - Findings were reviewed during the exit conference with E1 (NHA), E2 (DON) and E4 (CRN).