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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085033	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pike Creek Nursing & Rehabilitation Center	5651 Limestone Road Wilmington, DE 19808

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. 32545 Based on interview, record review and review of facility documentation as indicated, it was determined that for one (R324) out of four residents reviewed for falls, the facility failed to inform R324's representative/POA (Power of Attorney) of a fall. Findings include: Cross refer to F689, example 1 R324's clinical record revealed: 6/22/24 at 6:00 AM - The facility's incident report lacked evidence that F7 (R324's representative/POA) was notified of the fall. 7/6/24 - The facility's investigation of the 6/22/24 incident revealed a documented telephone statement from E43 (RN) that included, . Her [F7, representative/POA] was super involved every day. 7/31/24 at 7:30 PM - During an interview, F7 (R324's representative/POA) stated that R324 called him around 8:00 AM on 6/22/24 and told him that she fell during a transfer. F7 stated that the facility never informed him about the fall. 8/6/24 at 12:25 PM - During an interview, E52 (RN/House Supervisor) stated that E43 (RN), the assigned nurse, was to notify the doctor and the family of the incident. E52 stated that she did not know if the family member was notified. 8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 32545 Based on interview, record review and review of facility documentation as indicated, it was determined that for one (R340) out of two residents reviewed for death, the facility failed to consult with R340's physician of her repeated refusals of two medications. Findings include: R340's clinical record revealed: 7/24/24 - R340 was admitted to the facility with diagnoses that included, but were not limited to, chronic obstructive pulmonary disease (COPD/inflammatory lung disease), asthma and acute and chronic respiratory failure with hypoxia (insufficient oxygen in the blood). 7/24/24 - A physician ordered Breo Ellipta inhaler daily for shortness of breath and Spiriva inhaler daily for COPD. Review of the July 2024 eMAR revealed that five out of seven days, R340 refused both her Breo and Spiriva medications. Review of the August 2024 eMAR revealed that four out of six days, R340 refused both her Breo and Spiriva medications. There was no evidence that the physician nor R340's resident representative were notified that R340 was repeatedly refusing these medications per the plan of care. 8/9/24 at 1:40 PM - During an interview, E18 (LPN/UM) stated that she was not aware that R340 was refusing the Breo and Spiriva medications. 8/9/24 at 2:21 PM - During an interview, E38 (RN) stated that he does not recall notifying the doctor that R340 was refusing those medications. 8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 48409 Based on record review and interview, it was determined that for two (R323 and R423) out of two residents reviewed for grievances, the facility failed to ensure that concerns for missing dentures and a fall were resolved in a timely manner. Findings include: A facility policy and procedure, dated 1/23/20, and titled, Service Concerns documented, .Staff are trained appropriately in resolving . patient/family concerns .as promptly as possible . 3. The department manager receiving the company Service Concern Report actively and promptly initiates appropriate action (no later than 48 hours of receiving the concern). The department manager will follow up with the patient/family to determine satisfaction and will complete in full, the Step II Department Manager Response section on the yellow copy of the form and forward it immediately to the Administrator. 4. The Administrator will follow up as needed with the patient/family regarding satisfactory resolution and will verify the final outcome on the form. He/she will complete the Step III Disposition by Administrator section of the company Service Concern Report on his/her white copy of the form . 1. Review of R423's medical records revealed: 10/23/23 9:00 PM - R423 was admitted to the facility with diagnoses including difficulty swallowing and dementia. R423's admission nursing assessment documented, some or all natural teeth .no dentures. 10/24/23 11:10 AM - R423's discharge planning record documented, Patient has dentures. 10/24/23 - A facility document titled, Concern Form documented, Family notified staff her dentures are missing. The scheduled resolution date for the concern was 10/26/23. 8/8/24 11:00 AM - During a telephone interview, F1 stated, My mother (R423) was admitted to the facility with both upper and lower dentures. The next day the facility informed me that they were missing. They (the facility) told me that the dentist had already been there for the month, and I can take my mother to her own dentist to have replacement dentures made. The facility will pay for it. I gave them the bill for $4,700 on 12/7/23, and I keep getting the run around when I try to find out when I am going to get the money back. 8/8/24 12:00 PM - During an interview, E1 (NHA) stated, We have contacted the office about the payment for the dentures. 8/8/24 2:30 PM - E1 provided a copy of a check dated 8/8/24 for $4,700 and stated that it will be mailed out today to R423. 8/8/24 3:00 PM - During a telephone interview, F1 stated that she was informed by E1 that the reimbursement check will be sent out today. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility failed to resolve R423's concerns for the missing dentures for a total of 8 (eight) months. 32545 2. R323's clinical record revealed: 11/2/23 - A progress note by E6 (NP) documented that R323 fell on the right side and complained of pain. An x-ray of the right hip redemonstrated acute fracture of right femoral neck (hip joint) which was one of the admitting diagnoses. 1/10/24 - During a care conference, a concern form was completed by E46 (SS/Social Services) which stated that R323 and a family member were asking about the fall incident and they wanted a copy of the incident report. Under Section II, the following individuals' titles were listed as designated to take action on this concern: Therapy, SS, Unit Manager, NHA. The concern form's date of resolution was 1/15/24. The results of action taken under Section II was documented as staff met with patient and family and updates were given. NHA declined to give copy of incident document since internal document. Under Section III, the resolution of R323's concern was check No, family still wanted incident report copy. It was unclear what updates were given by each individual designated to take action on this concern form and which staff person had a one-to-one discussion with the resident on 1/15/24. In addition, the former NHA did not sign and date that R323's concern form was reviewed and verified as per the facility's policy. 8/1/24 at 1:28 PM - During an interview, R323 stated that she was transferring from wheelchair to bed and she thought the CNA was still there. R323 stated that she went to stand up as she normally does and the CNA had moved the wheelchair and I fell real hard on my right side. R323 stated that she was recovering from multiple fractures from a motor vehicle collision. The CNA was trying to pull me up off the floor. I said you can't do that because of my fractures/injuries. 8/8/24 at 10:14 AM - During an interview, E13 (Rehab Director) stated that if a resident falls, the policy was to lift the resident off the floor with a hoyer lift. It was unclear in R323's concern form that this was addressed with R323. The facility failed to complete R323's service concern dated 1/10/24 about her fall. 8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 48409 Based on record review and interview, it was determined that for one (R109) out of three residents reviewed for abuse, the facility failed to ensure that R109 was protected from verbal and emotional abuse when a staff member accused him of stealing chips that were left over from a staff party. Findings include: Review of R109's clinical records revealed: 9/26/23 - R109 was admitted to the facility with diagnoses including cerebral palsy and bipolar disorder. 4/25/24 8:30 AM - A facility incident report submitted to the State Agency documented, [R109] reported that a facility employee [E11] called him a thief because he took some chips that were left over from a staff party earlier in the day. In response to R109's 4/25/24 incident, the facility implemented the following corrections: - From 4/25/24 to 5/16/24, the facility's training attendance sheet, titled, Abuse and Neglect, documented that nursing, dietary, administrative and housekeeping staff recieved training in response to this incident. 7/8/24 - R109's quarterly MDS assessment documented a BIMS score of 14, indicating a cognitively intact status. 8/2/24 10:49 AM - During an interview, R109 stated, I took some chips for a friend and me because we were told that we can have the leftovers. [E11] called me a thief and took the chips away. I tried to explain that I did not steal the chips, but he kept on insisting that I was a thief. I was very upset because I did not like to be called a thief. 8/2/24 12:00 PM - A review of the facility's investigation revealed that E11's accusations were witnessed by several staff members and residents. The facility substantiated R109's allegation of verbal and emotional abuse from E11. E11 was terminated from employment at the facility. The facility failed to protect R109 from verbal and emotional abuse. In response to the facility implementing corrections and no further incidents of abuse that were identified during the Survey, R109's incident was past non-compliance. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32545 Based on interview and review of clinical records and other documentation as indicated, it was determined that for two (R176 and R344) out of seventeen (17) residents reviewed for abuse, the facility failed to report alleged violations involving abuse no later than 2 hours after each allegation was made. Findings include: 1. 8/30/24 at 6:08 PM - Review of State Agency's incident intake revealed that the facility reported an allegation of abuse involving R175. 8/30/24 from 4:30 PM to 6:00 PM - The facility's investigation of R175's allegation documented that E46 (SW) interviewed other residents, which included R176. 9/3/24 at 5:30 PM - Review of the State Agency's incident intake revealed that the facility reported an allegation of abuse involving R176. 9/10/24 at 8:32 AM - During an interview, E46 (SW) confirmed that R176 hand wrote a statement. E46 collected the statement along with other residents' signed statements and handed all the statements to E59 (DON 2) on 8/30/24. 9/10/24 at 8:36 AM - During an interview, E59 confirmed that she received a stack of statements from E46 on Friday, 8/30/24, but she did not know about R176's allegation of abuse that was in her written statement. E59 stated that the paperwork was placed in a red file folder. R176's written statement was not seen until Tuesday, 9/3/24. E59 confirmed that R176's allegation of abuse was not reported within the required 2 hour timeframe. 40264 2. 8/7/24 1:18 PM - The facility reported to the State Agency an allegation of sexual abuse involving R344 and R172. 8/15/24 - The facility's follow up summary submitted to the State Agency documented: - .[R344] stated that this occurred on Sunday night 8/4/24 (going into Monday morning 8/5/24) . - .[R344] stated that he had reported this to only a CNA and Therapy . - . Per [E77 (CNA)] witness statement, [R344] reported to her on Monday, [DATE]th (8/5/24), that his roommate [R172] was wandering on his side of the room, but [E77] (sic) stated [R344] did not report that [R172] had touched him . - . Per statement from [E78 (Physical Therapist)], [R344] reported to her on Tuesday 8/6/24 that [R172] had come over and grabbed his crotch, [R344] said it happened at night, (sic) [E78] had asked [R344] if he had reported it and [R344] had said yes, (sic) [E78] did not report it further as she thought it had been . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- .Per statement from [E79 (COTA)], she worked with [R344] on Wednesday 8/7/24 and told her that [R172] had touched him in his private area .his penis, and reported it to .[E13 (DOR)] who in turn reported it immediately to E1 (NHA) and E2 (DON) on Wednesday 8/7/24 at approximately 11:00 AM . 9/6/24 9:21 AM - In an interview, E77 stated . [R344] was alert and oriented and he was on my assignment on that day shift. He did not tell me about his roommate [R172] groping his private area. He told me that [R172] was wandering on his [R344] side of the room looking for the bathroom. At no time do I recall him saying that [R172] groped him. Had he told me about it that he was groped, I would definitely report it to the nurse. 9/6/24 10:40 AM - During an interview, R344 stated that roommate [R172] walked to his side of the bed and grabbed his crotch. R344 stated .I did report it to the aid the following morning. I also talked to therapy about it. I don't know the staff names. 9/6/24 1:11 PM - In an interview, E13 confirmed that E78 did not take any further action in reporting R344's concerns to the management when R344 reported the allegation to E78 on 8/6/24. E13 stated that E78 was not familiar with the abuse mandatory reporting requirement. 9/9/24 10:30 AM - During an interview, E79 stated that R344 reported to him about his roommate [R172] groping his crotch one night - on a weekend. E79 also confirmed that she immediately reported R344's allegations to E13. 9/10/24 10:40 AM - In an interview, E78 stated that on that morning around breakfast time (8/6/24), R344 stated that his roommate was getting up and walking around to his side of the bed and grabbed his crotch. E78 further stated, I asked him if he [R344] reported it. [R344] said he already told nursing about it. I didn't ask details from [R344] regarding the incident. I just told him that it's not appropriate and that it should not happen. I made the mistake of not reporting it immediately to my DOR [E13]. The facility failed to identify and immediately report R344's allegation of sexual abuse by R172 on 8/6/24 around breakfast time. The facility reported the allegation of sexual abuse to the state agency after more than 24 hours on 8/7/24 at 1:18 PM. 9/10/23 2:10 PM - Findings were reviewed with E1 (NHA).

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 32545 Based on interview and record review, it was determined that for one (R320) out of four residents reviewed for accidents and one (R31) out of one resident reviewed for care planning, the faciliy failed to review and revise the residents' care plans. Findings include: 1. R320's clinical record revealed: 5/30/24 - R320 was admitted to the facility with a primary diagnosis of a urinary tract infection. 5/30/24 - R320 was care planned for incontinent of bladder and bowel with the following two approaches: - record bowel movements; and - refer to occupational therapy as indicated. 7/22/24 - In response to an incident that occurred on 7/2/24 at 7:30 AM, E3 (ADON) interviewed R320, who stated stated that he was reaching for his urinal and getting ready to use it at the same time and was probably too close to the edge of the bed and slid down. The facility failed to ensure R320's incontinence care plan was person centered and included the use of a urinal. 8/8/24 at approx. 3:45 PM - Finding was reviewed with E1 (NHA), E2 (DON) and (E3) ADON. No further information was provided. 40264 2. Review of R31's clinical records revealed: 1/18/24 - R31 was care planned to require assistance with ADLs and interventions included but not limited to Restorative Nursing Program Passive Range of Motion - provide Passive Range of Motion to bilateral lower extremities BID (two times a day) and PRN (when needed) as tolerated. 3/11/24 - R31's careplan intervention on Restorative Nursing Program Passive Range of Motion - provide Passive Range of Motion to bilateral lower extremities BID had no order to cancel. A review of R31's physician orders lacked evidence that R31's Passive Range of Motion to bilateral lower extremities BID was canceled or discontinued. 8/1/24 10:48 AM - E2 (DON) stated that she did not know how the care plan intervention on R31's PROM was canceled by the (elctronic health record) system. In addition, E2 stated, It's possible that [R31's] care plan intervention came off in the system when she was sent to the hospital and it was not reviewed when she was readmitted earlier this year. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/1/24 1:10 PM - During an interview, E13 (DOR) confirmed that R31 was referred to restorative nursing for passive rage of motion. E13 further stated, [R31's] intervention for Passive Range of Motion to bilateral lower extremities BID should have stayed current in R31's care plan. The facility failed to review and update the ADL care plan intervention of PROM which was initiated on 1/18/24 for bilateral lower extremity contractures and was canceled by the system on 3/11/24. 8/7/24 5:30 PM - Findings were discussed with E1 (NHA), E2 (DON), E3 (ADON) and E10 (VPO). 8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 32545 Based on observation, interview, record review and review of facility documentation as indicated, it was determined that for two (R94 and R31) out of seven residents reviewed for activities of daily living (ADLs), the facility failed to ensure each dependent resident received the necessary services to maintain grooming and personal hygiene. Findings include: 1. R94's clinical record revealed: 12/22/23 - R94 was care planned for incontinence of bladder and/or bowels: inability to control bowel and bladder. Approaches included: - 1 person assist with toileting; - check and change briefs frequently as needed; and - refer to occupational therapy (OT) as indicated. 7/2/24 - Review of the July 2024 CNA Documentation Survey Report revealed the absence of documentation of R94's care from 7 AM through 3 PM. In addition, R94's meal intakes (breakfast and lunch) were not documented too. 7/2/24 at 9:11 PM - The facility reported the following incident to the State Agency: On 7/2/24 at approx. 4:40 PM, [R94] (BIMS 13 [cognitively intact] - dependent on staff for care) reported to the nurse that he did not receive care on the previous shift. Observed in bed, his clothing and bedding soiled with urine and feces. Incontinence care was provided, skin was assessed and noted with redness to his peri-area. Zinc oxide applied. NP and resident representative were notified. The accused CNA, an employee of the facility, was suspended pending investigation. 7/2/24 at 10:32 PM - A nursing note documented that R94 was noted with MASD (moisture associated skin damage) on his sacrum, NP notified, ordered to wash resident with soap and water, then apply zinc oxide. Family notified. 8/7/24 at 9:50 AM - The Surveyor submitted a written request for the facility's incident report, entire investigation and the corrective actions taken. In response, the facility stated in their investigation that staff education was provided and audits were started on 7/3/24. The facility provided documented evidence that the CNA was terminated on 7/9/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/8/24 at 12:37 PM - During an interview, R94 confirmed that hygiene/toileting care was not provided at all on day shift (7/2). R94 stated that when the 3 PM shift came in, the CNA apologized for no care being provided. R94 stated that he hit his call bell numerous times, but no one responded to him. The Surveyor observed and confirmed with the resident that he clips his call bell to the bed control and to the linens so it doesn't fall on the floor so he was able to access it. R94 stated that he doesn't remember who the CNA was that day. R94 stated that different staff person brought his meals (breakfast/lunch) into his room and he remembered mentioning it to the staff person when his lunch was brought in that he hadn't received any care yet. When asked how did he feel that day about not receiving care or the call light not being answered, he stated he was irritated. He also added that he understands that he might have to wait because the aides are busy but all day? He appreciated the follow-up. R94 stated that the Social Worker came in after this incident and spoke to him. When asked if there have been more incidents of this nature since this incident on 7/2/24, he stated no. As of 8/12/24, the facility provided no evidence of corrective actions taken with respect to this incident in response to the Surveyor's written request on 8/7/24. The facility failed to ensure R94, a dependent resident, received hygiene/toileting care on 7/2/24 day shift. Care was not provided to R94 until the 3-11 PM shift. 40264 2. Review of R31's clinical record revealed: 5/12/23 - R31 was admitted to the facility with diagnoses including but not limited to stroke and hemiplegia (half of body paralyzed). 1/18/24 - R31 had a care plan for a toileting deficit related to bowel and bladder incontinence with the goal for R31 to remain as clean and dry as possible. Interventions included: - check and change briefs frequently as needed; - provide toileting hygiene with brief changes; and - refer to OT (Occupational Therapy) as indicated. 7/2/24 - A review of the July 2024 CNA Documentation Survey Report revealed the absence of documentation of R31's care from 7 AM through 3 PM. In addition, R31's meal intakes (breakfast and lunch) were not documented. 7/2/24 9:23 PM - The facility reported the following incident to the State Agency: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pike Creek Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 5651 Limestone Road Wilmington, DE 19808	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/2/24, at approximately 4:30 pm the C.N.A. assigned to provide care on the 3-11 shift, to resident, [R31], reported to the nurse that the resident, BIMs=2 (cognitively impaired) and dependent on staff for care, was observed incontinent of urine, with her clothing and bed linens wet with urine and what appeared to be dried areas of urine. Incontinence care was provided when the resident was observed and a skin assessment was completed, the resident did have previous existing moisture associated skin damage to her sacral area, it did appear to have increased redness from the assessment on wound rounds on 7/1/2024. Treatment in place, Zinc Oxide, and applied per orders. The NP and resident representative were notified. The accused C.N.A., (E21), an employee of the facility, was suspended pending investigation. Investigation is in progress. 7/2/24 at 10:38 PM - A nursing note documented that R31 was noted with MASD (moisture associated skin damage) on her sacrum, NP notified, ordered to wash resident with soap and water, then apply zinc oxide. Family notified. 7/2/24 - A facility incident/investigation report revealed that E2 (DON) conducted a telephone interview with E21. Further review of the report revealed that E21 did not provide patient care within the times she was assigned to provide care to R31. 8/1/24 10:45 AM - In an interview, E42 (LPN) stated that on 7/2/24, the 3-11 PM CNA reported to him that [R31] was soiled and the bed linen was dirty with dried areas of urine. E42 further stated that he and the 3-11 PM CNA changed R31's soiled incontinence briefs, gown and bed linens. The facility failed to ensure R31, a dependent resident, received hygiene/toileting care on the 7/2/24 day shift. Care was not provided to R1 until the 3-11 PM shift. 8/7/24 5:30 PM - Findings were discussed with E1 (NHA), E2 (DON), E3 (ADON) and E10 (VPO). 8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 32810 Based on observation and interview it was determined that for one (R129) out of two residents reviewed for pressure ulcers the facility failed to promote of healing of pressure ulcers when pressure ulcer prevention interventions were observed not in place. Findings include: The facility policy on wounds/skin impairments last updated 7/17/24 indicated, All mattress or devices will be pressure relieving. Provide treatments as ordered. Review of R129's clinical record revealed: 10/2/23 - R129 was admitted to the facility with multiple diagnoses including history of a traumatic brain injury, with severe bleeding to the brain, convulsions, and muscle weakness. 10/2/23 - A care plan was created for risk for pressure ulcers and skin breakdown that included interventions to assess the skin for breakdown, keep the skin clean and dry, pressure relieving mattress, pressure relieving chair cushions and skin assessments as indicated. 10/9/23 - A Braden scale skin assessment documented that R129 was very high risk for pressure ulcer development. 12/5/23 - A wound care assessment documented that R129 acquired an abrasion to the right ear. 1/12/24 - R129's care plan for risk for additional pressure ulcers and skin breakdown was updated to include an intervention to use an adaptive pillow to be positioned on the right side of head at all times. Make sure the ear is inside the center cut out and not on the pillow. 2/10/24 - 2/15/24 - R129 was admitted to the hospital. 2/19/24 - 2/27/24 - R129 was admitted to the hospital. 2/27/24 5:56 PM - An admission/readmission assessment documented that R129 was readmitted from the hospital with the continued open area to the right ear and new open areas to the great and second toes on the left foot. 2/28/24 - A wound care assessment documented that R129's formerly documented right ear abrasion was a stage 3 pressure ulcer. The open areas's to R129's toes were documented as arterial at that time. 3/1/24 - 4/19/24 - R129 was admitted to the hospital. 4/19/24 10:57 AM - An admission/readmission assessment documented R129 was readmitted to the facility with pressure ulcers to the right ear and left toes. 4/20/24 - A physicians order was written for R129 to have a donut shaped pillow to right ear to relieve pressure. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/29/24 - R129's open areas to left first and second toes that were formerly documented as arterial were assessed as unstageable pressure ulcers following diagnostic imaging results. 6/3/24 - R129's pressure ulcer to the second toe was resolved. 6/20/24 - R129's care plan for risk for additional pressure ulcers and skin breakdown was updated to include a foot cradle [metal bar that raises linen to prevent it from touching the patient] to the bed to prevent pressure from sheets. The care plan continued to have the intervention for the adaptive pillow. 7/22/24 7:20 AM - A wound care assessment documented that the stage three pressure ulcer to R129's right ear was resolved. R129's left great toe stage three pressure ulcer was improving without complications. 7/29/24 11:55 AM - R129 was observed in the bed and the adaptive neck pillow was absent. R129's feet were covered with blankets, no foot cradle was observed on the bed. 7/30/24 9:38 AM - R129 was observed in the bed and the adaptive neck pillow was absent. R129's feet were covered with blankets, no foot cradle was observed on the bed. A dry erase sign on the wall contained the following written message Leave feet uncovered - Mom. 8/1/24 - The Kardex documented the resident was to receive an adaptive pillow to be positioned on right side of head at all times, make sure his ear in side the center cut. Task- foot cradle and pillow on. 8/1/24 11:03 AM 11:18 AM - During a dressing change observation with E51(LPN) R129 was observed in the bed there were bright red stains on the sheets and pillowcase near R129's head, R129 did not have the adaptive neck pillow in place. R129's feet were covered with blankets. E51 removed the blankets and stated, They are supposed to keep them uncovered but therapy and the aides come in and they cover them up. When the surveyor inquired about the red liquid stains on R129's bedding, E51 stated, His right ear must've reopened, I will get new orders. 8/1/24 11:50 AM - R129 was observed in the bed foot cradle bar on the floor, resident's feet were uncovered, and a dressing to the right ear was intact. There was no adaptive pillow present on the resident. 8/1/24 1:31 PM - R129 was observed in the bed, the adaptive neck pillow was absent. R129's feet were covered with a blanket and no foot cradle was on the bed. 8/1/24 2:09 PM - E50 (LPN) and E35 (CNA) accompanied the surveyor to R129's bedside and confirmed that the residents adaptive neck pillow was not in place and that the foot cradle to keep the resident's feet uncovered was not in place. E50 stated, I need to check the orders first to see if they are supposed to be there, I don't know this patient. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/2/24 at 12:33 PM E18 (LPN/UM) confirmed that R129 was supposed to receive a neck pillow and have feet uncovered. E18 stated, The neck pillow I know that we have been having some issues and I expect that to be reevaluated. I've gone in and not seen it but typically that was during care. I rely on the cart nurses to ensure that things are being completed throughout the day. Once the cradle came, we knew it didn't raise the blankets high enough. His Mom has a note not to cover his feet but as you see staff still does. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32545 Based on interview and record review, it was determined that for three (R324, R170 and R270) out of 14 residents reviewed for accidents, the facility failed to ensure each resident received adequate supervision and assistive devices to prevent accidents. For R324, the facility failed to transfer R324 with a hoyer lift per the plan of care. For R170, the facility failed to provide supervision while care was being provided by a staff member. For R270, the facility failed to put the wheelchair foot rests on prior to transportation. Findings include: 1. Cross refer to F580, example 1 R324's clinical record revealed: 6/12/24 - R324 was admitted to the facility for rehabilitation with diagnoses that included, but were not limited to, glioblastoma (brain tumor) status post craniotomy (brain surgery) in February 2024, seizure disorder, lack of coordination, and long term use of blood thinning medication. 6/12/24 at 12:48 PM - R324's admission nursing collection tool documented that R324 was oriented at all times; had no history of falls; was bedbound; adequate vision; and was not able to perform walking assessment at this time. 6/12/24 at 1:33 PM - R324's weight was 210 lbs. 6/13/24 - A care plan documented that R324 required assistance with activities of daily living, including the use of a hoyer lift for all transfers with two (2) staff. 6/18/24 - The admission MDS assessment documented that R324 was dependent for transfers. 6/22/24 at 6:25 AM - A fall note by E52 (RN/House Supervisor) documented, Pt (Patient) was being transferred by CNA when their leg (sic) began to feel weak and the patient felt as though they were going to fall. The CNA that was present lowered her to the ground slowly, preventing harm to Pt at approximately 06:00 AM. Pt stated 'I felt weak and couldn't stand anymore.' Pt was assessed by RN. Pt PERRLA is intact at this time. Pt shows no sign of injury. Pt is able to perform Active ROM with right sided extremities and passive ROM on the left sided extremities which is her baseline. Pt was then assisted in to bed via Hoyer lift . 6/22/24 at 6:30 AM - A statement by E53 (CNA) documented that A co-worker asked me to help him to place [R324] on her wheelchair. We got into the room, then we were trying to put her on her wheelchair. Her CNA [E54] put [R324] on her chair, but she felt uncomfortable so she asked him if we are going to leave her on the chair like she was. I asked her if she wants to go back on (sic) bed and she said yes. [E54] was trying to put her on the bed, but he couldn't. He was holding her so I told him to lay her down on the floor so she won't fall and hit with something. [E54] told me to get the nurse so I went to get the nurse and he stayed on (sic) the room with her. She didn't fall because [E54] lay (sic) her down on the floor. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In response to R324's 6/22/24 incident, the facility implemented the following corrections: - on 6/28/24, the facility's Education Attendance Sheet by E2 (DON) documented that E53 (CNA) and E54 (CNA) received one to one education regarding failure to check patient Kardex (care plan) for transfer status and return demonstration to pull up Kardex for transfer status. In addition, all staff were also in-serviced by 6/28/24 in response to this incident. - from 7/1/24 through 8/8/24, the facility conducted audits of staff checking the Kardex and transferring residents using hoyer lift with two (2) staff. 8/6/24 at 12:25 PM - During an interview, E52 (RN) confirmed that the two CNAs did not use a hoyer lift when transferring R324. 32810 2. Review of R170's clinical record revealed: 7/17/24 - R170 was admitted to the facility with multiple diagnoses including sleep apnea, left sided weakness, lack of coordination, and unspecified convulsions. 7/23/24 - An admission MDS assessment documented R170 as cognitively intact. R170's functional ability was assessed as impaired on the one upper extremity, and partial moderate assistance needed for rolling in the bed. Partial moderate assistance is defined as the helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort. R170 had a history of falling in the last 2-6 months prior to admission. 7/17/24 - A care plan created for R170 included a care plan for risk of falls. Interventions for that care plan included remind the resident to use their call light to ask for assistance with ADL's and place common items in reach. 7/18/24 - A PT evaluation and plan of treatment indicated that R170's bed mobility, roll left to right required partial/moderate assist, moderate assist with left side. The assessment summary indicated that R170 had body awareness deficits and decreased safety awareness. 7/25/24 - A fall risk assessment completed for R170 indicated the resident was at high risk to fall with a score of 12. High risk is a score greater than or equal to 12. 7/26/24 12:17 AM - A fall note in R170's clinical record documented, This writer was called to resident room stating resident fell . Found resident on right side of the bed, resident was lying on his side on his left side. Resident ear and left eye was lying on the bed cord. Resident states he does not know what happened but fell . Resident was with staff in the room and resident rolled over from the bed, resident complained of mild pain on his left side where he was lying on. Skin tear measuring 1.5 cm to the side of his left eye .Resident has left sided weakness as is baseline and is able perform passive range of motion to his right side. Resident [family member] made aware and NP made aware. Neuro checks initiated . Resident [family member] would like [R170] sent to the hospital to get CT scan of his head. What interventions were in place at the time of the fall?: Resident bed was in the lowest position and room well lit. What are the risk factors that could have contributed to the fall?: Unsteady gait, left sided weakness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/26/24 1:26 AM - Hospital records documented that R170 arrived to the hospital and received a CT of the head that did not show injury. 7/26/24 12:51 PM - A progress note in R170's clinical record documented, Resident returned from ER Visit as per report, blood work and CT Scan was done and results were reassuring. No new orders at this time. Resident family and E6 (NP) made aware. Resident in his bed with all fall precautions in place. 7/26/24 - R170's risk to fall care plan was revised to include the following interventions, bilateral fall mats, CNA education, perimeter mattress and place bed in lowest position while resident is in bed. 7/29/24 - A progress note written by E6 (NP) documented that R170 was Seen and examined laying in bed. Patient had a fall yesterday and was sent to ER. Imaging was unremarkable and patient returned. Patient denies any pain today. 8/2/24 - A follow up incident report was submitted to the State Agency that indicated, Resident possibly falling asleep while care was provided. Combined with inability to stop self from falling related to left sided weakness were factors causing him to fall from his bed. While the CNA turned away after removing the draw sheet to drop it with the dirty brief, he heard the resident make a sound .and witnessed him rolling off the bed. System changes included education related to change draw sheet and repositioning patient on the draw sheet. During an interview on 7/30/24 at 10:40 AM, R170 stated, I fell because of them . I fell and then he went and got someone and they checked me out. Then they got me back up with a Hoyer lift. I called my sister and told her and she told them to send me to the hospital. I was there about a day but they didn't find anything wrong. When R170 was asked if he was able to roll in bed independently R170 stated, Yes. But I was turning on my weak side and I kept going. I rolled and kept on going. R170 then confirmed that he was not provided assistance when turning in the bed. During an interview on 8/6/24 at 8:59 AM, E47 (CNA) stated that R170 Was laying on his back his left side was weak I rolled him wiped him then I rolled him on his right side removed the draw sheet and turned to drop it on the floor and when I turned around it was mid fall I went to get the nurse on my hall. E47 then stated, that R170 was a One person assist, limited he can help you turn with a small nudge and he usually stay's put. I assume he nodded off because he was sleep with the cpap on when I first came in to change him. E47 confirmed that when R170 rolled out of bed, E47 was not providing support or assistance, and the E47 had turned around to drop soiled linen. E47 stated,I am scheduled for additional training. I guess the facility feels I improperly turned him and I should have had one hand on him. 3. Review of R270's clinical record revealed: 7/8/24 - R270 was admitted to the facility. 7/8/24 - The admission assessment documented R270 has at a risk to fall with a score of 16. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/8/24 - A risk for falls care plan was created for R270. The interventions implemented included place common items within reach of the resident, and remind the resident to use their call light to ask for assistance with ADL's. 7/15/24 - A PT fall risk assessment documented that R270 had three falls in the past year. R270 was high risk to fall and had poor safety awareness. 7/16/24 -Review of the transportation form for R270's transportation to dialysis indicated, transfer status wheelchair. 7/23/24 9:04 - A fall note documented, Description of the fall injuries if any: Small round laceration (.3 cm) to center of forehead. Scant bleeding. Band aid applied. Resident states an absence of pain. Resident is alert and oriented, answering questions appropriately. Resident states he desires to go to dialysis treatment .What are the risk factors that could have contributed to the fall?: Resident's footrests were not in place .What new interventions were implemented in response to the fall? Ensure footrests are in place at all times during assisted wheelchair mobility. 7/23/24 9:31 AM - A progress note in R270's clinical record documented, Resident sustained a witnessed fall. This writer was called by a staff member who informed this writer that resident had fallen out his wheelchair in the hallway during transport out to dialysis. Resident stated that he still wishes to go out for his dialysis treatment. Vitals obtained, ADON aware, NP notified, and Daughter. 7/23/24 3:20 PM - A progress note in R270's clinical record documented, Prior to and during the time of the fall, resident was being transported, via wheelchair, by ambulance service personnel. 7/23/24 - R270's care plan was updated to include ensuring foot rest are in place at all times during assisted wheelchair mobility. 7/27/24 - The post fall documentation assesment indicated, [R270] fell on [DATE]. Resident stated his foot got on the tile. 7/30/24 - A follow up incident report submitted to the State Agency documented, Assisted propulsion in wheelchair without leg rest in place caused resident's foot to come in contact with the floor causing him to fall from the wheelchair. During an interview on 7/29/24 at 3:49 PM, R270 stated, I fell in the hall with no foot rest on, my foot got caught up about a week ago. During an interview on 8/1/24 10:46 AM, CW1 (TA) was observed transporting R270 to dialysis who had foot rest on the wheelchair at that time. When asked if the residents foot rest were on prior to being transported CW1 stated, If not we apply them because we are trained not to transport them without them. During an interview on 8/5/24 at 10:59 AM, E18 (LPN/UM) stated, Ideally the CNA should've put them [foot rest] on and transport should wait at the desk for the resident but that did not happen. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/6/24 at 10:33 AM, E49 (COTA) confirmed that she assisted R270 the morning of his fall. E49 stated, I went in he was anxious because he had dialysis and wanted to get ready, so we got up did ADL's. Then we were in morning meeting I remember them saying he fell . E49 confirmed she assisted R270 into the wheelchair without his leg rest and stated, It's because if they get around it can be a hindrance. If they're going to be transported or I'm transporting them I know to apply them but that wasn't said before. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. 48409 Based on observation, interview, and record review, it was determined that for one (R111) out of two residents reviewed for nephrostomy catheter, the facility failed to provide safe and sanitary urinary catheter care to prevent urinary infections to the extent possible. Findings include: Review of R111's clinical records revealed: 7/1/24 - R111 was admitted to the facility with diagnoses including urinary tract infection, acute pyelonephritis (kidney infection), and right nephrostomy tube (a tube inserted into the kidney to drain urine because of kidney stones.) R111's hospital discharge records included, Follow up in one week for urology consult for removal of kidney stones. 7/11/24 - R111's admission MDS assessment documented a BIMS of 12, indicating a moderate cognitive impairment. 7/3/24 - R111's MAR documented, Empty nephrostomy drainage bag every shift. 7/30/24 8:30 AM - R111 was observed lying on the bed. An undated urinary collection bag with yellow urine was observed on the left-hand side of the bed. 7/30/24 9:30 AM - R111 was observed lying on the bed. An undated urinary collection bag with yellow urine was observed on the left-hand side of the bed. 7/30/24 10:30 AM - R111 was observed lying on the bed. The undated urinary collection bag with yellow urine was observed on the left-hand side of the bed. 7/30/24 2:00 PM - A review of R111's clinical records (physician's orders, MAR, TAR, Kardex, care plans) lacked evidence of a urology consult. 7/30/24 3:00 PM - Findings were confirmed with E41 (LPN). 7/31/24 - R111's urinary catheter collection container was observed on the floor of the room at 8:30 AM, 9:30 AM and 10:00 AM. 7/31/24 10:30 AM - Findings were confirmed with E2 (DON). 8/3/24 10:35 AM - R111's clinical records documented, Urine sample obtained. 8/5/25 7:00 PM - R111's physician orders documented, Macrobid Oral Capsule 100 milligrams [antibiotics], give 1 capsule by mouth two times a day for UTI {urinary tract infection} for 7 days. The facility failed to provide safe and sanitary nephrostomy catheter care to prevent urinary tract infections. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 32545 Based on interview, review of clinical records including two incidents involving significant medication errors and other documentation as indicated, it was determined that for 29 out of 29 licensed nurses reviewed, the facility failed to have a system/process in place to ensure each licensed nurse had competencies and skills sets necessary to care for current residents' needs. - On 7/6/24, E43 (RN) administered another resident's medications to R322, which resulted in a serious adverse outcome. R322 required emergent admission to the ICU for treatment and monitoring. The facility failed to ensure E43 had a medication administration competency and skill set validated during his orientation. In addition, the facility allowed R322 to continue to administer medications for 14.5 days after the 7/6/24 incident without evidence of a competency and skill set validation for medication administration. An Immediate Jeopardy (IJ) was called on 8/26/24 at 7:07 PM. The IJ was abated on 8/30/24 at 5:00 PM. - On 8/18/24, E55 (LPN) administered another resident's medications to R95. The facility lacked evidence of E55's competency and skill set validation for medication administration during her orientation. - For 24 out of 24 nurses scheduled to work from 3 PM on 8/26/24 through 3 PM on 8/27/24 plus three additional nurses (E56, E57 and E58), the facility lacked evidence of each nurses' competency and skill set validations necessary to care for current residents' needs. Findings include: The facility assessment, dated 7/2024, documented, . 1.1 The facility is licensed to care for 177 residents . 3. 5 Staff training/ education and competencies. All staff members have a competency checklist upon hire that is completed during orientation to provide adequate care for our residents . Topics . Date Presented: Orientation & Annually, and as needed . The facility's form entitled Skills Validation Record for a Charge Nurse, last revised 5/2024, included the following sections: -General: job description, employee guide, required education, customer service, survey process, policies & procedures, QAPI, Residents' Rights, Safe smoking practices, Abuse; -Environment: facility tour, emergency eye wash stations, security practices, water shut off process, oxygen storage, call light system, phone/paging system, work orders, missing person process, emergency preparedness/red book review; -Infection Control: hand hygiene/glove usage; cleaning and disinfecting equipment; linen handling/appropriate bagging; transmission based precautions; PPE (donning/doffing); Vaccines; PPD/Screening; -OSHA: Bloodborne standard; Hepatitis B vaccine protocol; Regulated Medical Waste; Respiratory Protection Program (N95 fit test); Exposure Control (post exposure process); (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Equipment: Glucometer; Coagucheck; Vital sign machine; CPAP/Bipap; Trach oxygen compressor; Oxygen concentrator/tanks; Nebulizer machine; Device(s) filter care; Suction machine; Mechanical lifts/scales; IV pump; Tube feeding pump; Wound vac; Air mattresses; Fall prevention devices; -Supervising CNAs: Observe hygiene; Shower schedule; Turning/repositioning; Documentation verification; Hydration; Snacks; Feeding assistance; Rounds; -Clinical Processes: Nursing chain of command; Central Supply; Medication room; Medication Pass Observation; Treatment Pass Observation; Refusal process; Behavior management; Restorative nursing; Restraints; Code status (DNR validation, advanced directives, etc.); Code blue; Dietary Processes and communications; Dialysis protocols (communication form, medication scheduled, documentation, etc.); Scheduling (appointments, procedures, transportation, etc.); Nursing documentation best practices (dos & donts sic); ADL documentation review; -Pharmacy Services: Admission orders (cut off times, admission alert); Back up pharmacy; Omnicell review (narcotic code, adding new user); Narcotic processes (shift count, discontinued, ordering); OTC medication procedure (Medline); -PCC (PointClickCare) Clinical Documentation: Admissions/Readmissions; Risk Management; Allergies; Batch Orders; Dashboards; Discharges; Elopement; Emergency EMAR backup; Falls; Immunizations; Infection Control Dashboard; Labs and Radiology; Entering IV solution orders; Entering SSI orders; Order entry; Overview Clinical; POC documentation; Progress Notes; Receiving meds from Pharmacy and refills; Reports; Skin Assessments; Tasks; Weights and Vitals; -Clinical Skills Competencies: Intravenous catheters; Venipuncture; Enteral Feeding Tubes; Urinary Catheters (foley/suprapubic/straight/external); Ostomy; Respiratory Care; Tracheostomy; Wound Vac; JP Drain; and Center Specific Skills. 1. Cross refer F760, example 1 6/4/24 - E43 (RN) was hired by the facility. 7/6/24 at 3:40 PM - A nurse's note documented, Patient was given medications that were prescribed for another resident . 7/6/24 at 4:21 PM - The hospital record documented, . presents to the ED (emergency department) with hypoglycemia (low blood sugar) and hypotension (low blood pressure) after receiving the wrong medications at his rehab facility . will need an ICU admission for management . 7/11/24 - The facility submitted to the State Agency a five day follow up investigation and response to the 7/6/24 incident involving R322. In the follow up it stated that All licensed nurses were re-educated on the rights of medication administration and medication competencies were performed. Review of the facility's follow-up documentation provided to the Surveyor for the 7/6/24 incident revealed that re-education/competencies of all licensed facility nurses were incomplete. In addition, the facility lacked evidence that E43's skills/competency was validated after this incident. E43 continued to work in the facility for 14.5 days after the 7/6/24 medication error incident. (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8/26/24 at 12:50 PM - During an interview, E48 reviewed the facility's form entitled Skills Validation Record for a Charge Nurse that was being used to validate each nurse's competency and skills set. E48 (Staff Educator) confirmed that she had no evidence of E43's competency and skill set. 8/26/24 at 7:07 PM (revised 9/5/24) - During a meeting with facility management, the Survey Team notified E1 (NHA), E2 (DON 1) and E59 (DON 2) of an Immediate Jeopardy for the failure to have evidence of E43's competency and skill set validation during his new hire orientation, as outlined in the facility assessment. 8/26/24 at 9:07 PM - E1 (NHA) submitted a signed, dated and timed written abatement plan to the State Agency. The facility's abatement included: - Licensed Nurses will be trained on the following competencies: enteral feeding tubes; respiratory care and oxygen equipment (to include CPAP and BiPAP); wounds/skin impairments; bladder scans; hemodialysis; urinary catheters; ostomy care; blood glucose monitoring. - The first staff members to be trained will be the Unit Managers, Shift Supervisors, and Staff Development Coordinator. Training will then be completed by Licensed Nurse Managers (DON, ADON, Unit Managers, Staff Development Coordinator) as well as Licensed Nurse Corporate Level Clinical Directors and will include return demonstration. Training will (sic) conducted on a daily basis until staff threshold met. - Licensed Nurses and Facility Manager will be educated on circumstances relating to Immediate Jeopardy tag. - Pending admissions will be evaluated based on needs to ensure staff working have required competencies completed to provide care. - Because the Center employs a high number of nurses and utilizes agency nurses when needed, education will be ongoing to ensure nurses are educated on the above competencies and the circumstances leading to this education. - 100% of Licensed Nurses will receive education with return demonstration by date of abatement . 8/30/24 at 5:00 PM - The IJ was abated based on interviews with licensed nursing staff and review of facility documentation of individual licensed nurses' competency and skill set education/validations of current residents' needs. 2. Cross refer F760, example 2 6/24/24 - E55 (LPN) was hired by the facility. The facility provided the Surveyor the following information on E55's schedule upon hire: -6/24/24 through 6/28/24, E55 was in classroom training; (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-7/3/24 through 7/15/24, E55 was trained on the floor; and -Starting 7/16/24, E55 was working on the floor by herself. 8/18/24 at 8:00 PM - The facility's incident report documented that R95 was administered R48's prescribed medications by E55 (LPN). 8/26/24 at 12:50 PM - During an interview, E48 (Staff Educator) stated that she took over the position of Staff Educator at the end of April 2024. E48 stated that nursing orientation includes the first week with classroom review/training, then orientation with another nurse on the floor for 5 to 8 days, based on the nurse's experience. When discussing the facility's Skills Validation Records for nursing staff, E48 stated that the forms were not being returned to her timely. In fact, E48 stated that E55's Skills Validation Record appeared on her desk recently. While reviewing E55's Skills Validation Record with the Surveyor, E48 confirmed that it was not completed correctly. E55's Skills Validation Record was signed off by E52, an agency RN, but never signed by E55 herself. E52 printed and signed her name, and utilized a down arrow for each section, but did not record the date that each skill was reviewed and validated. E52 signed and dated page 6 in the Supervisor's Signature section and dated 7/14/24. In response, the Surveyor requested to see E52's Skills Validation Record since she signed attesting that she validated E55's skills. E48 confirmed that the facility lacked evidence of E52's Skills Validation Record. Review of the facility's Employee Report revealed that E52's hire date was 10/31/23. The facility lacked evidence of E48 and E52's competency and skill set validation. 3. Review of 100 out of 165 current residents in the facility revealed the following nursing care needs, but were not limited to: -accucheck using a glucometer; -dialysis access sites: chest wall or AV fistula, care and assessment of bruit/thrill; -respiratory care (oxygen, nebulizer, CPAP, BiPAP, Aerobika, incentive spirometer, Acapella valve); -bladder scan; -urinary catheters: foley, straight catheter; -wound care; -enteral feeding: pH testing, checking placement, administering meds - G tube; -colostomy; -pacemaker; -urostomy, nephrostomy; and (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Life Vest heart monitor. 8/26/24 at 3:50 PM - The Surveyor provided a list of the following scheduled nurses to facility management and requested each nurses' Skills Validation Record (Checklist): E9 (LPN), E16 (LPN), E18 (LPN), E36 (LPN), E38 (RN), E42 (LPN), E50 (LPN), E60 (RN), E61 (LPN), E62 (LPN), E63 (LPN), E64 (LPN), E65 (LPN), E66 (RN), E67 (RN), E68 (LPN), E69 (LPN), E70 (RN), E71 (LPN), E72 (LPN), E73 (LPN), E74 (LPN), E75 (LPN) and E76 (LPN). In response to the request, the facility was not able to provide the Surveyor with each nurse's most recent Skills Validation Record. The facility did provide some documentation on Relias web training completed by some nurses. 40264 4. Review of E56's (LPN) training and competencies records indicated that the employee was hired 7/8/24. No completed nursing skills validation checklist could be located for E56. Review of E57's (Agency RN) training and competencies records indicated that the agency staff's first day in the facility 3/25/24. No completed nursing skills validation checklist could be located for E57. Review of E58's (Agency LPN) training and competencies records indicated that the agency staffs first day in the facility 6/24/24. No completed nursing skills validation checklist could be located for E58. 8/26/24 1:25 PM - During an interview, E48 (Staff Educator) stated that the staff were not retuning the skills checklist after their orientation period on the floor with their preceptors. E48 further confirmed that E56, E57 and E58 did not have the nursing skills validation checklist on their training files. The facility failed to ensure that the required nursing skills validation checklist was completed for 29 out of 29 nursing staff reviewed 8/26/24 2:33 PM - Findings were discussed with E1 (NHA). 8/27/24 2:52 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E10 (VPO).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32545 Based on observation, interview, review of clinical records and other documentation as indicated, it was determined that for one (R322) out of three residents reviewed for hospitalization s and three (R22, R33 and R95) out of nine residents reviewed for medication administration, the facility failed to ensure that residents were free of significant medication errors. On [DATE], R322 was administered R144's prescribed medications. As a result, R322 was emergently sent to the hospital requiring treatment and monitoring in the Intensive Care Unit (ICU). The facility's multiple failures involved in this incident had the potential to cause a serious adverse outcome or death to R322 with respect to receiving another resident's multiple blood pressure medications and diabetic medications. Due to the failures, an Immediate Jeopardy (IJ) was called on [DATE] at 2:08 PM. The IJ was abated on [DATE] at 11:59 PM. On [DATE], R95 was administered R48's prescribed medications. R95 remained in the facility and was monitored for adverse effects. For R22 and R33, the facility failed to ensure that each resident received their meals within 15 minutes of the administration of short acting insulin. Findings include: The facility's pharmacy policy and procedure entitled, #8.2 General Guidelines for Medication Administration, last revised ,d+[DATE], stated the following: . Medications are administered as prescribed in accordance with good nursing principles and practices . Procedures: . I. Preparation . 4. At a minimum, the 5 Rights - right resident, right drug, right dose, right route, and right time - should be applied to all medication administration and reviewed at three steps in the process of preparation: (1) when medication is selected, (2) when the dose is removed from the container, and (3) after the dose is prepared and the medication is put away . II. Administration . 4. When medications are administered by mobile cart taken to the resident's location ., medications are administered at the time they are prepared . 6. Medications are administered without unnecessary interruptions . 8. Residents are identified before medication is administered using one method of identification. Methods of identification may include but not limited to: a. Checking the photograph attached to the medical record. b. Calling the resident by name (except in residents with cognitive impairment). c. Having the resident verify his/her last name. d. If necessary, verifying resident identification with other facility personnel . 12. Medications are administered within 60 minutes of the scheduled administration time, except before, with, or after meal orders, which are administered based on mealtimes. Unless otherwise specified by a prescriber, routine medications are administered according to the established medication administration schedule for the facility . IV. Documentation (including electronic) 1. The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given . 1. Cross refer F726, example 2 Review of R144 and R322's clinical records revealed: For R144: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] - R144 was admitted to the facility in room XXXX. [DATE], [DATE] and [DATE] - Review of the [DATE] eMAR, E43 (RN) administered R144's medications scheduled at 8:00 AM. R144 was scheduled to receive the following 13 medications on [DATE] at 8:00 AM: - Losartan Potassium 100 mg, 1 tablet, for hypertension (high blood pressure); - Coreg 12.5 mg, 1 tablet, for hypertension; - Hydralazine 50 mg, 1 tablet, for hypertension; - Spironolactone 25 mg, 1 tablet, for hypertension; - Metformin 1000 mg, 1 tablet, for diabetes mellitis (high blood sugar); - Glipizide 5 mg, 1 tablet, for diabetes mellitis; - Aspirin 81 mg, 1 tablet, for CVA (stroke) and heart health; - Sucralfate 1 gm, 1 tablet before meals scheduled at 7:30 AM, for stomach ulcer; - Omeprazole 40 mg, 1 capsule, for gerd (stomach acid flows back into the esophagus); - Tylenol 325 mg, 3 tablets, for pain; - Miralax powder, 1 scoop mix in water or juice, for constipation; - Senna 8.6 mg, 2 tablets, for constipation; - Symproic 0.2 mg, 1 tablet, for constipation; - FiberCon 625 mg, 2 tablets, for constipation. For R322: [DATE] - R322 was admitted to the facility for short-term rehabilitation with diagnoses, including but not limited to, pneumonia, chronic respiratory failure, pulmonary fibrosis (lung disease when lung tissue becomes damaged and scarred), chronic obstructive pulmonary disease (chronic inflammatory lung disease) and dependent on supplemental oxygen. R322's room was YYYY, which was located on a different hallway from R144. [DATE] - Review of the [DATE] eMAR, E43 (RN) administered R322's medications scheduled at 8:00 AM. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 3:40 PM - A nurse's note by E44 (House Supervisor) documented, Patient was given medications that were prescribed for another resident. Patient was assessed; found to have an irregular pulse and low blood pressure. NP (Nurse Practitioner) and responsible party notify. Received order to send patient to ER (emergency room) for evaluation. [DATE] at 4:00 PM - A transfer to hospital summary note by E43 (RN) documented, Patient received medications scheduled for patient [R144] . Patient unremarkable in appearance, denies pain, symptoms, vitals ,d+[DATE] BP (blood pressure), HR (heart rate) 94, pulse ox 98% on baseline 4L (liters), skin warm, pink, no signs of distress, patient states 'I feel fine' 'I don't want to go to [name of hospital]'. Supervisor contacted, On-call MD (Medical Doctor) and RN contacted, ADON contacted, patient, [name of F3, family member] . contacted, EMS (Emergency Medical Services) summoned to take patient to [name] ER. [DATE] at 4:21 PM - The hospital record documented the following: . presents to the ED (emergency department) with hypoglycemia (low blood sugar) and hypotension (low blood pressure) after receiving the wrong medications at his rehab facility . EMS was activated. Upon EMS arrival, patient was found to be hypoglycemic in the 50s and oral glucose was given. Upon arrival here in the ED, patient was found to be hypotensive and hypoglycemic . likely secondary to the diabetic medications and antihypertensives he was given. Patient does not have a history of diabetes and is no longer on antihypertensives due to being hypotensive at baseline. Given that the patient was given glipizide (diabetic medication), he will most likely have persistent drops in his glucose. He will likely require repeated boluses (large doses) of D50 (dextrose sugar in water solution) and may still need to be started on a dextrose (sugar) drip. Ultimately, patient will require frequent glucose (sugar) checks and will need an ICU admission for management . [DATE] at 4:45 PM - Two days later, the facility reported the [DATE] incident to the State Agency as Resident [name of R322] . received another resident's medications . Resident became hypotensive and was transferred to hospital for evaluation. Investigation in progress. All licensed nurses to be educated on medication administration. The facility's investigation included the following statements: -E43's (RN) written statement included: . date of incident: [DATE]; time of incident: 14:00 (2:00 PM); I passed medications, realized error, alerted MD and Supervisor . Name(s) of staff member(s) involved: [name of E43 (RN)], E44 (House Supervisor) . Please identify any statements made by resident: 'I feel fine.' Identify all people you spoke with regarding the incident and describe what was said (ie staff, family of resident, etc.): on call Dr (doctor) . [name of E44], EMS, pt (patient), [title of F3, family member], [title of F4, family member]. Identify any documentation you completed related to the incident: Incident . Please provide any additional information: n/a (not applicable). Date the statement completed: (incorrect date). Time statement completed: 1101 (11:01 AM). (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-E45's (COTA) written statement (undated/untimed) included: . Around 12:30 PM this writer went to attempt to perform OT (occupational therapy) services with resident. [Title of F3] present. Resident stated 'no' and 'I don't want to' multiple times so this writer came back around 2:00 PM to attempt again. Upon returning to room, this writer was informed by resident's [title of F3] that at around 12:00 PM this day, patient was given another resident's dose of medication. The resident stated 'I feel fine.' At this time, nurse was on phone with family member [title of F4] and the charge nurse had come into room. Vitals were taken on resident by nurse and charge nurse made the decision to send the resident to the hospital. Resident continued to say 'I feel fine, I don't want to go to hospital.' This writer and resident's [title of F3] explained the situation in full to resident and he agreed to go. This writer assisted resident in putting on pants, socks, and shoes prior to ambulance getting to facility. This writer assisted resident in sitting up at the edge of the bed and when paramedics arrived, assisted in transfer to stretcher . Resident didn't say anymore, however [title of F3] was upset about incident . [DATE] (date initiated) - The facility's Performance Improvement Plan documented that E43 (RN) had a review of his job performance which indicated a need to improve on Medication Administration. This document was signed and dated . by both E43 (RN) and E3 (ADON). [DATE] - The facility's Employee Corrective Action documented, On [DATE] [name of E43, RN] administered Patient . medications to Patient . resulting in Patient . requiring hospitalization . [name of E43] is being suspended pending investigation. This document was signed and dated [DATE] by E43 (RN), E3 (ADON) and E1 (NHA). [DATE] at 4:38 PM - R322's hospital discharge summary documented, . Patient had blood pressure as low as ,d+[DATE] . Patient had point-of-care glucose of 50 requiring ampules (sealed glass vessel holding solution to be injected) of D50. In the emergency department patient was started on norepinephrine infusion (intravenous infusion to raise blood pressure in patients with severe, acute hypotension). The patient was admitted to the ICU for shock (critical medical condition) related to iatrogenic (illness caused by treatment) antihypertensive medication, hypoglycemia (low blood sugar) related to glipizide (diabetic medication) ingestion. He was treated supportively with vasopressors (medications that increase blood pressure in emergency situations), fluids, and stress dose steroids (medication that aids in preventing complications) for his hypotension and shock. For his hypoglycemia, he was given dextrose infusions and ampules as needed. He was also started on octreotride drip (infusion medication to inhibit insulin release from the pancreas) for his sulfonylurea overdose (prolonged low blood sugar). With these interventions, his sugars normalized, and he was weaned off vasopressors by the morning of ,d+[DATE]. Stress dose steroids have also been discontinued . Patient is now maintaining his blood pressure and blood sugar without supportive medications . [DATE] - The facility submitted the following five day follow-up investigation to the State Agency: -root cause analysis: . Failure to dual identify the resident prior to medication administration resulted in the error. The resident's picture was not available in PointClickCare (PCC/electronic medical record) at the time of the error. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085033	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/10/2024
NAME OF PROVIDER OR SUPPLIER Pike Creek Nursing & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5651 Limestone Road Wilmington, DE 19808	

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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 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-result of investigation: Staff member acknowledges medication error, stating 'I don't remember, in my head I thought I knew who the patient was. We don't bring the laptop in the room. I knew . who was in the room and who he was, but I had them confused, it turned out. On the MAR they were side by side, and I think I just read the first two letters . and got them confused . You stated his family was there, did you check with them on his name? No I didn't. To me, there was no question. I'd done that group of patients before. I just went too fast. I didn't check enough of my fail-safes. What fail-safes should you have checked? I could have verbally asked. To me, it was just a simple mistake on my part. At what point did you realize you had given the medications to the wrong resident? And how? I think it was about an hour from then, when I went to pass the medications to the second gentlemen (sic) and realized I had confused them before because the medications were different. All licensed nurses were reeducated on the rights of medication administration and medication competencies were performed. 100% audit was completed to confirm all residents have a picture in PCC or a bracelet ID (identification). Resident condition is unknown at this time as he did not return to the facility. -system changes: Resident's are to be issued name bracelets until photos are uploaded into PCC. Review of the facility's education after this incident by the Surveyor revealed that all licensed nurses were not educated nor competencies performed on medication administration. [DATE] at 11:58 AM - During an interview, E44 (House Supervisor) stated that she was completing a new admission on the second floor when E43 (RN) came up to ask her how to complete a medication occurrence. E44 stated that she explained the process and the nurse seemed very nonchalant (appearing relaxed and calm). E44 stated that she stopped working on the new admission because she thought she needed to follow-up on exactly what happened. E44 stated that when she arrived on the first floor, E43 was on the phone talking to the NP on-call and family. E44 stated that he [E43] told me at almost 2 PM. E44 stated that she reviewed the medications that were given which included 3 medications for blood pressure. E44 stated that she assessed the resident - blood pressure was low, heart rate irregular, resident has to go out. E44 stated that she called the doctor and received an order to send the resident out to the ER. [DATE] at 12:15 PM - On this date/time, the Surveyor placed a call and left a voicemail for E43 (RN) to return the call. As of [DATE] at 3:30 PM, no return call was received by the Surveyor. [DATE] at 9:44 AM - During an interview, E45 (COTA) stated that she entered the resident's room earlier on [DATE] and R322 declined therapy. E45 stated that when she went back to R322's room, she was present when the nurse, E43, came in and told the resident, with [F3, family member] present, that he gave him someone else's medications. The [title of F3] was upset and immediately called [title of F4] and [title of F4] was asking the nurse what medications were given. E45 stated that she was there when the charge nurse came in and said he was going to the ER. E45 stated that she assisted the resident with putting on his pants. While the facility documented the root cause analysis as R322's picture was not uploaded to PCC as an identifier, the facility failed to identify and address the following additional issues in their investigation: (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- identify the exact time E43 (RN) administered the wrong medications to R322. It was unclear in the facility's investigation exactly what time R322 was administered the wrong medications that were scheduled for 8:00 AM. Per E45's (COTA) written statement, [title of F3] told her that around 12 PM the resident was given another resident's dose of medications, four hours after the scheduled time. -failed to immediately suspend and/or remove E43 (RN) from administering medications to residents pending the facility's investigation. E43 continued to administer medications on [DATE] entire day shift, and on [DATE] morning day shift then was interviewed and suspended. E43 administered morning medications on [DATE] to R144. -failed to immediately report the significant medication error requiring emergent care to the State Agency within 8 hours, per State requirement. -failed to provide the Surveyor, as requested, with evidence of E43's (RN) education and medication competency before returning to work on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE]. -failed to perform an audit of the other resident's on E43's assignment on [DATE] for any medication errors, which included timeliness of administration, and document in the facility's investigation. [DATE] at approximately 11:30 AM - During a combined interview with E1 (NHA), E2 (DON), E3 (ADON) and E10 (VPO) to discuss R322's incident, the Surveyor asked about the education and competency of E43 (RN) as it was not included in the documentation provided. E3 (ADON) stated that it was included and immediately reviewed the red folder with the documentation that provided to the Surveyor. E3 (ADON) confirmed it was not there. No further documentation was provided to the Surveyor. The Surveyor also asked about E43's current status in the facility. E1 (NHA) stated that E43 resigned about two weeks ago. No reason provided. [DATE] at 9:40 AM - During a follow-up interview, E44 (House Supervisor) confirmed that she notified E36 (UM/on call nurse) and E3 (ADON) on [DATE] between 2 PM - 4 PM of the medication error and transfer to hospital. [DATE] at 12:12 PM - During an interview, F4 (R322's family member) stated that F3 (R322's family member) called me and told me that R322 received the wrong medications. F4 stated that [F3] left the facility to go get ice cream and came back and all hell broke loose. F4 stated that the nurse (E43, RN) reviewed all of the medications and what they were for over the phone and he said Oh we are going to monitor his vitals. He seemed calm and said - all well this happens. He was really rude. F4 said, He could have died . And he was a DNR (do not resuscitate) and if he died we would never have known. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 2:18 PM - During an interview, F3 (R322's family member) stated that she kept notes and reviewed them with the Surveyor. F3 stated she arrived at the facility at 10:40 AM and R322 was very alert. F3 stated that F3 stated that he had not been eating a lot. F3 stated that around 12:05 PM, the nurse [E43] brought him his meds and I asked the nurse what medications are being given. [E43] replied just the normal daily and Tylenol. F3 stated that the nurse confirmed that he didn't have narcotics and that he knew that [F4] did not want the resident to have any narcotics. At 12:15 PM, lunch was served and [R322] started to ignore me and did not want to eat. E45 (COTA) came in and [R322] was out of it as he didn't want to eat or do anything. At 12:20 PM, [R322] put his bed back. At 12:30 PM, I texted [another family member] that I think they gave him something because he was out of it. At 12:48 PM and 12:50 PM, [R322] kept taking off his nasal cannula off his nose. [R322] slept for little while and woke up at 1:45 PM and asked for ice cream. F3 said that I thought I would give him anything he would eat. F3 said she went to the grocery store at 1:45 PM and returned at 2:15 PM. The supervising nurse told me that they had given [R322] the wrong medications. I called [F4]. E45 (COTA) came back and I told her what happened. F3 stated that the supervising nurse checked vital signs, notified the doctor and called 911. The other nurse [E43] was on the phone with [F4] because [F4] wanted to know what medications were given. F3 stated that R322 ate some ice cream and said he was fine. F3 stated that the EMTs asked if the resident was a DNR and I knew he was a DNR. F3 stated that the nurse [E43] seemed very calm and it didn't seem like a big deal as he kept asking the resident, How are you buddy? [DATE] at 2:08 PM - During a meeting with facility management, the Survey Team notified E1 (NHA), E2 (DON) and E59 (incoming DON) of an Immediate Jeopardy for R322's significant medication error that occurred on [DATE]. [DATE] at 7:12 PM - E1 (NHA) submitted a signed, dated and timed written abatement plan to the State Agency. The facility's abatement included: -Licensed nurses will be assigned education Avoiding Common Medication Errors on Relias platform to complete in a proctored group setting at the Center or individually independently if not on schedule . Those completing it individually and independently will be educated once they are scheduled by a nurse manager on the specifics of the reasons/need for the education. Licensed nurses will complete this education and pass the final exam associated with it. Licensed nurses will complete a return demonstration of the education with a Nurse Manager utilizing a real-life medication administration for one resident. The nurse will be required to demonstrate review of the Rights of Medication Administration prior to administering the medication and passing the return-demonstration. -Administration team was notified of incident on [DATE] @ (at) 5:00 p.m. to be aware of the situation as leaders of the Facility. -Each resident's picture is uploaded into PCC unless refused, and those that refuse have all agreed to wear a wrist identification band. As of [DATE] all photos are up to date and complete for all residents admitted within the last 24 hours. -At time of education, Nurses will be educated on timely reporting of errors to supervisors and physicians . Date of abatement [DATE] @ 11:59 p.m. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] at 10:35 AM - During an interview, E36 (UM/on call nurse) stated that she was on the phone with E44 (House Supervisor) regarding another issue when she was told about R322's medication error. E36 stated that E44 was still upstairs and did not know the details about the med error yet. E36 stated that she found out later that day that R322 was sent to the hospital. E36 confirmed that she called E3 (ADON) on [DATE] regarding the medication error. [DATE] at 2:08 PM - During an interview, E2 (DON) stated that E34 (HR) was the Manager on Duty (MOD) on [DATE]. E2 confirmed that MOD's do not report any incidents to the State Agency, only the DON and ADON. E2 confirmed E3 (ADON) was back up as she was off that weekend. Based on record review of the facility's abatement plan which included nursing staff education, testing, signed attestation and observation of medication administration, follow-up interviews with nursing staff, review of new admissions records for pictures or identification bracelets and no further medication error incidents, the facility's IJ was abated on [DATE] at 11:59 PM. 2. Cross refer to F726, example 3 Review of R48 and R95's clinical records revealed: For R48: [DATE] - R48's census record documented her room and bed as XXX, B bed. [DATE] - R48's [DATE] eMAR revealed the following scheduled medications: - Ambien 5 MG, one tablet, for insomnia at 8 PM; - Tramadol 25 MG, one tablet, for pain at 8 PM; and - Xanax 0.5 MG, one tablet, for anxiety disorder at 9 PM. E55 (LPN) signed off the above medications as administered on the eMAR. In addition, E55 documented in the medication cart's controlled substance tracking book that the above three medications were signed out by E55 between 7:05 PM through 7:10 PM. For R95: [DATE] - R95's census record documented her room and bed as XXX, A bed. [DATE] - The quarterly MDS assessment documented that R95 had a BIMS of 7 (cognitive impairment). [DATE] at 8:00 PM - The facility's incident report documented, [Name of R95] received medications that were for her roommate: Tramadol 25 mg, Alprazolam 0.5 mg and Ambien 5 mg. Patient unable to give description. [DATE] at 9:37 PM - The facility reported the medication error to the State Agency and stated that New orders to monitor vitals and neuro checks. Nurse has been suspended pending investigation. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] (untimed) - A documented telephone interview between E2 (DON) and E55 (LPN) revealed: Tell me about when you were giving medications in room XXX at about 7:00 pm. I confirmed correct name and dosage to computer for the medications for [name of R48]. I took out the 3 meds, Tramadol, Ambien and Alprazolam. Why did you take only the 3 out and not her other scheduled medications? I was going to get the others, but I got sidetracked by the conversation at the nurse's station. Why didn't you also pull out the other scheduled 8:00 pm medications? I like to get the narcotics out and sign them out of the book. I usually get the narcotics then the other meds, but I walked away and when I came back I did not get the other meds out. My relief was there, and they were talking at the nurse's station, and I wanted to confirm with her (nurse relieving) that she was ready to report over, so I could start my documentation. I was up there for a while because I did not want to interrupt anyone's conversation. After I talked to her, I got the medications off the cart and I went into the room to the wrong patient, I got completely sidetracked. Was the nurse relieving you at the nurse's station? Yes, I was pretty sure it was, I wanted to confirm with her. There were other staff up there, I am not sure who everyone is (sic). I had a lot going on, the patient next door had some redness on her foot up to her thigh, her foot and ankle were swollen, I had a lot of stuff going on in my head. I went back to nursing cart, I already had the medication out in a cup, (Tramadol, Ambien, and Alprazolam) it was already prepared and I went to room XXX: (sic) I mistakenly went to the wrong bed, I realized when I went to chart, I gave the meds to A bed. [name of R95] How did you identify the patient when you went into the room? I looked at her and said I had her medications; I did not ask her name. Did you look at her picture in PCC? I looked at the picture and I was in the right room. When I went back from the nurse's station to get the medication off the cart I went to the wrong bed. Were you in the room prior to this time, did either of these residents get medication on the first med pass? Yes, I believe they got the medications that were due around 4:00 p.m. (review of the MAR determined that each resident did receive 4:00 pm medications that were signed out appropriately). 7:30 came and I started on the 8:00 o'clock meds. Did you identify those patients in the room? There was no distraction going on so I as (sic) able to focus. Do you remember how you identified the patients the first time you were in the (sic) there to give medications at 4:00 pm? Yes, I asked their names and I identified them by their picture. How did you ask them their name? I said, 'Hey [name of R95], or [name of R48]', before giving each of them their medications, they said yes that's me or they said yes. What time did you give the medications? It was about 7:30 when I gave the medication. It took about 20 minutes to give report then I went to do my documentation, then I realized I made a mistake, I told the nurse who took over, I got a hold of E60 (RN Supervisor) then E36 (UM/on call nurse) and then [name of E36] called [E2] (Director of Nursing). I came out of the room to give nurse, [name of E44], report at the cart, report and narcotic count were completed. Sat down at the computer to chart medication, I looked and saw the room number I realized it was XXXB bed's meds that I gave to XXXA. I immediately contacted nursing supervisor DON- nurse on call - and the NP. NP gave orders for vitals and neuro checks, and alert charting. [Title and name of R95's resident representative] was contacted 3x to no avail. A voicemail left with call back for contacting. Undated/untimed - A documented telephone interview between E2 (DON) and E44 (on-coming Nurse) revealed: I relieved the nurse for the patient. She realized her mistake and told me; the supervisor was told. We checked the patient, and she was fine. Everyone was notified. The patient was monitored when I was there, she was fine. [DATE] - The facility submitted a five day follow up to the State Agency, which included: - Root cause analysis: The nurse did not follow proper procedure for medication administration causing the medication error. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Result of Investigation: . the resident remained at the facility, vitals and neuro checks remained stable and there were no adverse outcomes in the patient's condition. The nurse had received the 10 rights of medication administration education during the new hire orientation which took place between [DATE] and [DATE]. The nurse remained suspended pending investigation. She will be returned to the facility after education, coaching/counseling and a medication pass observation has been completed . The other resident's medication administration records on the nurse's assignment were reviewed with no discrepancies noted, alert and oriented residents on the nurses' assignment were interviewed and asked if they had any issues with their medications given on ,d+[DATE] (PM) shift on [DATE] and there were no issues. [DATE] at 9:40 AM - During an interview, E44 (on-coming nurse) confirmed that she worked 7 PM to 11 PM on [DATE]. E44 stated that she relieved E55 (LPN) and was made aware of the medication error as E55 immediately self-reported and was upset about it. E44 stated that she was familiar with the resident and monitored R95 closely. E44 stated that the resident did not have a negative outcome. [DATE] at 12:35 PM - Observation of R95 in her room revealed that she was alert and was able to tell this Surveyor her name when asked. The facility failed to ensure R95 remained free of significant medication error. 48409 3. Review of R22's clinical records revealed: [DATE] - R22 was admitted to the facility with diagnoses including diabetes and heart disease. [DATE] - R22's care plans documented, The resident is at risk for complications and blood glucose due to diagnosis of diabetes .and insulin use. [DATE] - R22's quarterly MDS assessment documented a BIMS score of 15 (indicating sufficient judgement to manage every day events.) [DATE] - R22's Medication Administration Record (MAR) documented, Humalog Kwik Pen-injector 100 Unit/ML (fast acting insulin), inject per sliding scale before meals - if 0 - 100 = No insulin; 101 - 150 = 2 units insulin; 151 - 200 = 4 units insulin; 201 - 250 = 6 units insulin; 251 - 300 = 8 units insulin. Humalog Kwik Pen manufacturer ([NAME] Lilly and Company, [DATE]) instructions, Take (insulin) within 15 minutes before or right after a meal. [DATE] 7:30 AM - R22's MAR documented a blood glucose of 124 and received two (2) units of fast acting insulin. R22 was observed receiving a meal tray at 9:45 AM (2 hours and 30 minutes later.) [DATE] 11:30 AM - R22's MAR documented a blood glucose of 224 and received six (6) units of fast acting insulin. R22 was observed receiving a meal tray at 1:45 PM (2 hours and 45 minutes later.) (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE] 7:30 AM - R22's MAR documented a blood glucose of 295 and received 8 (eight) units of fast acting insulin. R22 was observed receiving a meal tray at 9:45 AM (2 hours and 30 minutes later.) During an interview, R22 stated, I usually get my insulin when they (nurses) check my blood sugar. [DATE] 10:00 AM - During an interview E42 (LPN) stated, I gave the residents their insulin when I checked their blood sugars. 4. Review of R33's clinical records revealed: [DATE] - R33 was admitted to the facility with diagnoses including diabetes and long -term use of insulin. [DATE] - R33's MAR documented, Humalog Kwik Pen 100 Unit/ML (fast acting insulin) inject as per sliding scale before meals: 101 - 150 = 2units; 151 - 200 = 4units; 201 - 250 = 6units; 251 - 300 = 8units; 301 - 350 = 10units; 351 - 400 = 12units [DATE] - R33's care plan documented, .At risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus with insulin use .administer insulin as ordered. [DATE] - R33's annual MDS assessment documented a BIMS score of 15 (indicating sufficient judgement to manage every day events.) [DATE] 7:30 AM - R33's MAR documented a blood glucose of 163. R33 received four (4) units of fasting acting insulin. R33 was observed receiving a meal tray at 9:45 AM (2 hours and 15 minutes later.) [DATE] 11:51 AM - R33's MAR d[TRUNCATED]

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32810 Based on observation and interview, it was determined that the facility failed to ensure that medications were stored and labeled properly in one out of three medication carts reviewed. Finding's include: The facility policy on storage of medications, last updated August 2020 indicated, .When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 12/4/24 - 2:35 PM - During a medication storage review of the second floor the following observed inside the Heritage II medication cart: - Four opened bottles of oral liquid medications with no open date labeled. - One opened bottle of powdered oral medication with no open date labeled. 12/4/24 - E3 (LPN) immediately confirmed the findings. 12/5/24 12:30 PM - Findings were reviewed with E1 (NHA), and E2 (DON) during the exit conference.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 32810 Based on observation and interview it was determined that for four (R21, R90, R119 and R172) randomly observed residents during dining observations, the facility failed to ensure food was served was palatable and at appetizing temperatures. Findings include: 1. Dining observation on 7/29/24 on the first floor unit right revealed: - 12:09 PM - Meal delivery cart containing lunch trays was delivered to the hallway. - 12:18 PM - R172's lunch tray taken to room was delivered to the bedside table by E39 (CNA) who then left the room with the residents breakfast tray and did not return. - 1:29 PM - R172 was repositioned in bed and offered assistance to eat lunch by E37 (CNA). The gravy on the mashed potatoes appeared firm and shiny. There was no visible steam. R172 began to feed himself with cueing, frowned and stopped eating after a few bites and shook head no. - 1:38 PM - E40 (DA) arrived to obtain food temperatures for R172's tray; crab cake 89.8 degrees, carrots mashed 91.3 degree's pot 93.1 degree's. During this time E37(CNA) confirmed that R172 meal was cold and stated, his ice cream is melted. During an interview on 7/29/24 at 1:54 PM, E38 (RN) confirmed that R172 should have received a replacement tray after 30 minutes and went to retrieve another meal for the resident. 7/29/24 - Review of the kitchen's food temperature log for the lunch served to R172 indicate initial cooking temperatures as: entree/crabcake 181 degrees. starch/mashed potatoes 183 degrees. vegetable/carrots 167 degrees. 46134 2. A review of R119's clinical record revealed: 12/29/22 - R119 was admitted to the facility. 8/1/24 9:10 AM - A random observation of R119's breakfast tray revealed that the tray did not include any packets of sugar. R119 stated that she likes to put sugar on her oatmeal and in her coffee. The finding was confirmed by E8 (CNA). 8/1/24 9:30 AM - A random observation of the facility second floor coffee cart revealed that the container that stored sugar did not have any sugar packets in it. The finding was confirmed by E8 (CNA). (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R119's food and drink were not palatable as evidenced by the facility not placing sugar packets on R119's 8/1/24 breakfast tray, or having sugar on the second floor coffee cart on 8/1/24 at the breakfast meal. 48409 3. Review of R21's clinical records revealed: 2/11/23 - R21 was admitted to the facility with diagnoses including heart disease and diabetes. 5/14/24 - R21's quarterly MDS documented a BIMS score of 14, indicating a cognitively intact status. R21's diet orders documented, Regular diet. 7/30/24 9:45 AM - R21 was observed receiving her breakfast tray. R21 stated, The food is horrible. See how cold it is? The surveyor asked R21 to check the plate to see if it was warm. R21 touched the plate and stated, It's cold. The meal ticket lacked documentation of the food that was served. 7/31/24 9:30 AM - R21 was observed eating her breakfast. R21 stated, This food is cold. It is always cold. 7/31/24 1:00 PM - R21 was observed eating her lunch. R21 stated, I don't know what this is but looks like some kind of pasta. It is barely warm. 8/1/24 9:30 AM - R21 was observed eating her breakfast. R21 stated, This food is cold. I am tired of eating cold food every day. The surveyor asked R21 to touch the plate to check if it was warm, R21 touched the plate and stated, It is cold. 4. Review of R90's clinical revealed: 6/15/24 - R90 was admitted to the facility with diagnoses including heart disease and high blood pressure. 6/27/24 - R90's admission MDS assessment documented a BIMS of 15, indicating a cognitively intact mental status. R90's diet order documented, Heart Healthy Diet, Regular Texture. 7/29/24 10:50 AM - R90 was observed eating her breakfast. R90 stated, The food is cold almost all of the time. 7/30/24 1:30 PM - R90 was observed eating her lunch. R90 stated, This food is cold, I don't know what I am eating. The surveyor asked R90 to touch the food plate to check if it was warm. R90 touched the plate, and stated, It is cold. 7/31/24 1:07 PM - R90 was observed eating her lunch. R20 stated, I guess it's supposed to chicken parmesan. It would probably be good if it was warm. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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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. 46134 Based on record review and interview, it was determined that for one (R119) out of fifty-four residents sampled in the survey, the facility did not maintain accurate medical records. Findings include: A review of R119's medical record revealed: 12/29/22 - R119 was admitted to the facility with multiple diagnoses, including left sided paralysis, left sided weakness resulting from a stroke, and anxiety. 12/30/22 - A medication order for clonazepam 2 milligrams for anxiety was ordered for R119 by E6 (Nurse Practitioner). A review of the clonazepam package insert revealed that the medication can cause drowsiness and dizziness. A review of the electronic medical record (Emr) revealed a 12/30/22 admission care plan that indicated that R119 was a fall risk due to a history of falls, impaired balance/poor coordination, gait (walking) unsteadiness and left sided weakness. 3/25/24 3:07 PM - An Emr progress note documented that R119 had a fall without injury at 2:34 PM. 3/25/24 6:42 PM-An Emr progress note documented that R119 had a fall without injury at 6:30 PM. 3/26/24 12:46 AM - An Emr progress note documented that R119 had a fall without injury at 12:40 AM. R119 was sent to the hospital for evaluation. 8/6/24 - A review of Emr Post Fall Investigations reports for the above falls revealed the following: -3/25/24 2:34 PM - A post fall investigation was completed in the Emr by a facility nurse. The investigation report incorrectly documented under the medication section that R119 was taking a narcotic, R119 was not taking a narcotic. The report documented that R119 was not taking antianxiety medication, R119 was taking antianxiety medication. Additionally, under the section titled clinical considerations, the report did not document that R119 had Hemiplegia/Hemiparesis and weakness, which were relevant clinical factors related to falls. -3/25/24 6:30 PM - A Post Fall investigation document was completed in the Emr by a facility nurse. The Fall report incorrectly documented under the medication section that R119 was not taking antianxiety medication, R119 was taking antianxiety medication. Additionally, under the section titled clinical considerations, the report did not document that R119 had Hemiplegia/Hemiparesis and weakness, which were relevant clinical factors related to falls. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/26/24 12:40 AM - A Post Fall investigation document was completed in the Emr by a facility nurse. The Fall report incorrectly documented under the medication section that R119 was not taking antianxiety medication, R119 was taking antianxiety medication. Additionally, under the section titled clinical considerations, the report did not document that R119 had Hemiplegia/Hemiparesis and weakness, which were relevant clinical factors related to falls. R119 had three falls between 3/25/24 2:30 PM and 3/26/24 12:40 AM. The facility Post Fall Investigation reports that were completed by facility nurses after each fall did not accurately document the medications that R119 was taking, or the medical diagnoses that R119 had, in order to accurately investigate the reasons for R119's three falls within twelve hours. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 32545 Based on interview, review of the facility assessment and an identified deficient practice scoped as an Immediate Jeopardy during the survey, it was determined that the facility failed to conduct a quality assurance and performance improvement activity in response to R322's significant medication error and adverse event on 7/6/24. The facility failed to analyze the cause(s), implement preventive actions and mechanisms that included feedback and learning throughout the facility. Findings include: The facility's assessment, last updated 7/2024, revealed: . 3.5 Staff Training/ education and competencies All staff members have a competency checklist upon hire that is completed during orientation to provide adequate care for our residents . Topics . Date Presented . Medication and Treatment administration . Orientation & Annually, and as needed . Cross refer to F760, example 1 7/6/24 - Review of R322's clinical record and the facility's incident report documented that R322 was administered another resident's medications by E43 (RN) which resulted in R322 being emergently transferred to the hospital and admission to the Intensive Care Unit for treatment and monitoring. The facility lacked evidence that a quality assurance and performance improvement process was implemented immediately and followed-through with respect to R322's significant medication error and the failure to ensure E43 had a medication adminstration competency and skill set upon orientation. 8/26/24 at 12:50 PM - During an interview, E48 (Staff Educator) confirmed that she had no evidence of E43's medication administration competency and skill set. 9/10/24 at 2:10 PM - Finding was reviewed during exit conference with E1 (NHA).

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 32545 Based on interview and review of the facility's policy and procedure, it was determined that the facility failed to ensure mandatory effective communication training was completed for all direct care staff. Findings include: 3/8/21 - The facility's policy and procedure entitled LEP/Auxiliary Aid Services documented, In order to ensure effective communication with patients and their companions, the Center will provide appropriate auxilliary aids and services, where necessary, including, but not limited to, qualified sign language interpreters for patients and their companions who are deaf or have hearing loss, as well as aids and services to those who are vision impaired or have limited English proficiencies . 11. The Center will provide mandatory ADA (Americans with Disabilities Act) training for all employees and contract employees who are affiliated with the Center who might interact with patients and/or companions who have communication impairments. Training will also be included in new hire orientation and will be incorporated in the training library for all employees annually. 8/8/24 at 11:15 AM - During an interview, E48 (Staff Development) stated that she started working with the facility in April 2024. When the Surveyor asked for evidence of communication training for all direct care staff, E48 stated that was not part of the current facility orientation and mandatory annual training. E48 stated that she does not have any evidence that it was being done by the previous staff educator. The Surveyor and E48 reviewed that this includes staff education on alternative means of communication for residents that do not use the English language, for example using a qualified translation service, communication boards, etc. 8/12/24 at 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 40264 Based on interview and review of facility documentation, it was determined that for two (E57 and E58) out of five nursing staff reviewed, the facility failed to ensure that the required QAPI (Qualify Assurance And Performance Improvement) training was completed. Findings include: 8/26/24 1:00 PM - Review of the agency staff training records revealed a lack of evidence of QAPI training of the following agency staff: 3/25/24 - E57's first day in the facility assigned as Agency RN. 7/16/24 - E58' s first day in the facility assigned as Agency LPN. 8/26/24 1:30 PM - During an interview, E48 (Staff Educator) confirmed that E57 and E58 did not have records of the QAPI trainings on their files. 8/26/24 2:33 PM - Findings were discussed with E1 (NHA). 8/27/24 2:52 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E10 (VPO).

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide training in compliance and ethics. 40264 Based on interview and review of facility documentation, it was determined that for two (E57 and E58) out of five nursing staff reviewed, the facility failed to ensure that the required training on Compliance and Ethics Program was completed. Findings include: 8/26/24 1:00 PM - Review of the employee training records revealed a lack of evidence of Compliance and Ethics Program training of the following staff: 3/25/24 - E57's first day in the facility assigned as Agency RN. 7/16/24 - E58' s first day in the facility assigned as Agency LPN. 8/26/24 1:31 PM - During an interview, E48 (Staff Educator) confirmed that E57 and E58 did not have records of the Compliance and Ethics Program trainings on their files. 8/26/24 2:33 PM - Findings were discussed with E1 (NHA). 8/27/24 2:52 PM - Findings were reviewed with E1 (NHA), E2 (DON) and E10 (VPO).

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 47114 Based on interview and review of facility documentation, it was determined that for three (E14, E26 and E27) out of five sampled CNA's (Certified Nursing Assistants) reviewed the facility failed to ensure that these employees had the mandatory twelve hours of annual in-service training. Findings include: 8/7/24 11:00 AM - Review of the staff training hours documentation revealed the following: 1. E14 (CNA) with a hire date of 9/1/22 had zero hours of annual in-service training and was confirmed by E34 (HR). 2. E26 (CNA) with a hire date of 3/4/08 had 11.25 hours of training and was confirmed by E34. 3. E27 (CNA) with a hire date of 7/22/08 had zero hours of annual in-service training and was confirmed by E34. 8/12/24 1:34 PM - Findings were confirmed with E2 (DON), E3 (ADON). The facility lacked evidence that these employees completed the mandatory twelve hours of annual in-service training. 8/12/24 2:15 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (ADON), E10 (VPO) and a State of DE Ombudsman (via telephone).

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide behavior health training consistent with the requirements and as determined by a facility assessment. 40264 Based on interview and review of facility documentation, it was determined that for five (E43, E55, E56, E57 and E58) out of five nursing staff reviewed, the facility failed to ensure that the required Behavioral Health training was completed. Findings include: 8/26/24 1:00 PM - Review of the employee training records revealed a lack of evidence of Behavioral Health training of the following staff: 6/4/24 - E43's first day in the facility hired for the Registered Nurse (RN) position. 6/24/24 - E55's first day in the facility hired for the Licensed Practical Nurse (LPN) position. 7/8/24 - E56's first day in the facility hired for the LPN position. 3/25/24 - E57's first day in the facility assigned as Agency RN. 7/16/24 - E58' s first day in the facility assigned as Agency LPN. 8/26/24 1:30 PM - During an interview, E48 (Staff Educator) confirmed that E43, E55, E56, E57 and E58 did not have records of the Behavioral Health trainings on their files. 8/26/24 2:33 PM - Findings were discussed with E1 (NHA). 8/27/24 2:52 AM - Findings were reviewed with E1 (NHA), E2 (DON) and E10 (VPO).