STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085037	A. Building B. Wing	07/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Atlantic Shores Rehabilitation & Health Center	231 South Washington Street Millsboro, DE 19966

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47142 Based on observations, interviews and record review, it was determined that for one (R36) out of three residents reviewed for dignity, the facility failed to promote dignity by not using a privacy bag for a urinary collection bag. Findings include: A review of the facility's policy titled Catheter Care last revised 4/2024, documented . 2. Privacy bags will be available and catheter drainage bags will be covered at all times while in use . Review of R36's clinical record revealed: 1/26/24 - R36 was admitted to the facility. 2/22/24 - A care plan documented that R36 has an indwelling catheter for neurogenic bladder. 4/3/24 - A physician's order for foley catheter to straight bag drainage for urinary retention. 7/9/24 - Observations of R36 lying in bed with the catheter collection bag was visible from the hallway and not in a privacy bag at 10:23 AM, 11:14 AM and 1:56 PM. 7/10/24 11:31 AM - An observation of R36's being pushed back to the room in a wheelchair where the catheter collection bag was not in a privacy bag and hooked onto the wheelchair. An interview with E15 stated she brought R36 back from the large therapy room located off R36's unit and located near the main facility entrance. E15 confirmed that the catheter collection bag did not have a privacy cover and immediately got a privacy bag and covered the catheter collection bag. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 46988 Based on interview and record review it was determined that for one (R143) out of thirty-three residents reviewed in the investigative sample, the facility failed to ensure care preferences were being honored. Findings include: Review of R143's clinical record revealed: 4/4/24 - R143 was admitted to the facility. 4/6/24 - An admission MDS revealed that R143 was not assessed for shower or bathing preferences. 4/10/24 - An admission recreation assessment revealed that for R143 it was very important to choose between a tub bath, shower, bed bath or sponge bath. 7/9/24 - R143 was readmitted from hospital. 7/9/24 12:31 PM - A physician's order revealed shower days were Wednesday and Saturday on the 3 -11 shift with skin check on Saturday and to document refusals every Wednesday and Saturday. 7/10/24 12:58 PM - An interview with R143 revealed that the facility did not give R143 a choice of shower day or time. R143 stated that she prefers showers in the morning. 7/17/24 11:00 AM - An interview with E12 (Activities Assistant Director) revealed that the initial recreation assessment is completed upon admission and is shared with the MDS coordinator and nursing to help establish what's important to the resident. 7/17/24 11:15 AM - An interview with E11 (LPN) revealed that shower schedule is based on room assignment. 7/17/24 11:20 AM - An interview with E10 (LPN UM) confirmed that shower scheduled is based on room assignment for day and time. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 47621 Based on record review and interview, it was determined that for one (R146) out of three residents reviewed for abuse, the facility failed to have written policies and procedures regarding the visitation rights of residents with cognitive impairments that do not have a legal decision maker. Findings include: Cross refer F602, F609 and F745. Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility with diagnoses, including but not limited to altered mental status. 4/2/24 2:59 PM - E5 (Social Work Director) documented in R146's EMR.[R146] scored 3/15 on her BIMS assessment which indicates that she has severe cognitive deficit . 4/5/24 - R146's admission MDS assessment documented a BIMS score of three, which reflected severe cognitive impairment. 5/29/24 - E46 (Psychologist) documented in R146's EMR, Her judgment and insight are impaired. At this time, patient is not capable of making her own healthcare decisions. 5/31/24 - The facility made a referral for capacity determination. 6/3/24 - E39 (MD) documented in a Physician Affidavit for Guardianship that R146 did not have capacity to function independently including: activities of daily living, pay her own bills, live alone, take medicine appropriately, give consent for medical procedures and resist scams. 6/3/24 10:06 AM - F4 (male friend) signed R146 out of the facility in the Leave of Absence log. R146 was signed back into the facility at 11:35 AM. 6/4/24- The facility petitioned the Court of Chancery to initiate R146's guardianship process. According to the Release of Responsibility for Leave of Absence log, R146 was signed out and left the faciity on a leave of absence with unrelated persons on 5/20/24, 5/25/24, 6/3/24, 6/21/24, 6/28/24 and 7/12/24. 7/10/24 3:20 PM - A review of R146's face sheet revealed that R146 listed as responsible party and F2 (R146's sister) listed as emergency contact #1 and F3 (R146's other sister) listed as emergency contact #2. The facility failed to ensure that R146, a resident with severe cognitive impairment, did not leave the facility without her family's consent. (continued on next page)

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F 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/12/24 3:13 PM - During an interview, E1 (NHA) stated, We don't have a policy or procedure for residents that have been deemed not to have capacity and don't have a legal guardian or POA (power of attorney). 7/15/24 12:29 PM - During an interview, E38 (NP) stated, There are no special orders that we place when a patient is deemed not to have capacity . 7/16/24 10:10 AM - During an interview, E5 (SW) stated, To my knowledge, there is no policy or precedent regarding when a resident is deemed not to have capacity. I am not aware of any restrictions regarding leaving the facility. I guess you would call her sister. I am not aware of a guardian ad litem. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47621 Based on record review and interview, it was determined that for one (R146) out of three residents reviewed for beneficiary notice, the facility failed to provide notification of service changes to R146's authorized representative. Findings include: Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility. 4/5/24 - R146's admission MDS assessment documented a BIMS score of three, which reflected severe cognitive impairment. 4/12/24 - R146 given a Notice of Medicare Non-Coverage (NOMNC) that advised that R146's effective date of last day of Medicare coverage was 4/17/24. The document was signed by E44 (Social Work) and E43 (Business Office manager) with the statement unable to sign BIM of 3 written in box beneath the statement Signing below means that you've received and understand this notice . 7/9/24 1:54 PM - During a telephone interview, F2 (R146's sister) stated that she was not informed about R146's last day of Medicare coverage and was not offered the opportunity to appeal. 7/10/24 3:20 PM - A review of R146's face sheet revealed that R146 listed as responsible party and F2 (R146's sister) listed as emergency contact #1 and F3 (R146's other sister) listed as emergency contact #2. The facility was unable to provide evidence of any attempt to reach either emergency contact for the purpose of receiving the NOMNC notification. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 46988 Based on observation and interview, it was determined that for one out of five resident units, the facility failed to provide a clean and homelike environment. Findings include: 7/9/24 10:13 AM - An observation in the 300 hallway of Ocean Gardens unit, revealed a broken handrail with jagged edges not covered. The baseboards in 400 hallway were dirty and dusty, and an area where a dark substance was spilled on wall with a stain. Subsequently the same observation occurred on 7/10/24 and 7/11/24. 7/12/23 1:00 PM - An interview with E13 (Maintenance Director) revealed that the facility has a plan to replace all handrails with new design. E13 stated he will cover the broken handrail for safety concerns for the current time until new rails are installed. E13 also stated that maintenance will clean the base boards and wall of the 400 hallway. 7/15/24 9:51 AM - An observation of a handrail in the 300 hallway of Ocean Gardens unit, revealed a broken handrail with jagged edges not covered. The baseboards in 400 hallway were dirty and dusty, and an area where a dark substance was spilled on wall with a stain. 7/15/24 2:17 PM - An interview with E13 confirmed the handrail should have been fixed over the weekend and it will get taken care of today. Also noted the walls and base boards will be cleaned today. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 47621 Based on record review and interview, it was determined that for one (R146) out of three residents reviewed for abuse, the facility failed to protect R146 from misappropriation of resident property/funds. Findings include: Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility. 4/5/24 - R146's admission Minimum Data Set (MDS) assessment documented R146's BIMS score of three, which reflected severe cognitive impairment. 4/12/24 - A Notice of Medicare Non-Coverage (NOMNC) documented that R146's last day of Medicare coverage was 4/17/24. The document was signed by E44 (Social Worker) and E43 (Business Office manager) with the statement unable to sign BIM of 3 written in box beneath the statement Signing below means that you've received and understand this notice . 5/16/24 - According to a signed and dated statement, F2 (R146's sister) provided the facility with R146's identification, bank statement, other documents and R146's checkbook. F2 had E1 (NHA) and E5 (SW Director) sign the document listing all the documents and belongings that F2 handed over to the facility. 5/17/24 11:05 AM - E43 (Business Office manager) documented a note in R146's EMR that stated R146's checkbook and other documents were secured in the facility safe. 5/19/24 3:43 PM - E45 (RN) documented in R146's EMR that a family member called and requested that R146 should not sign anything without her family present. 5/23/24 - E1 (NHA) and E43 (Business Office manager) obtained R146's checkbook from the facility safe and assisted R146 to write two checks- Check #4483 to the facility in the amount of $6435 for April room/Board and another check as deposit for an assisted living facility that R146 was interested in transferring to. The facility failed to identify that R146 was not cognitively capable of understanding a financial transaction and failed to safeguard R146's property from inappropriate access. 5/29/24 - E46 (Psychologist) documented in R146's EMR, Her judgment and insight are impaired. At this time, pt is not capable of making her own healthcare decisions. 5/31/24 - E43 received an email from the facility Home Office stating that check #4483 was returned for insufficient funds. 5/31/24 - The facility made a referral for capacity determination. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/3/24 - E39 (MD) completed a Physician Affidavit for Guardianship which documented that R146 does not have capacity. 7/12/24 9:31 AM - During an interview, E44 (SWS) stated, When I was explaining about the insurance, she did not understand. She did not understand what she was signing so she did not sign. She would nod her head in agreement but she did not understand. 7/12/24 9:55 AM - During an interview, E43 stated, Only the NHA and I have access to the safe. The NHA and I took her checkbook to her to write the checks (to [assisted living facility] and to us). That is when we found out the money was gone because the checks bounced . I told the NHA and Social worker was to report it to APS (Adult Protective Services). The facility was unable to provide evidence that this allegation of missing resident funds was reported to the State agency. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interview, it was determined that for one (R130) out of ten residents reviewed for hospitalization , the facility failed to notify R130's family representative and the Ombudsman of R130's transfers to the hospital on 3/15/24 and 3/24/24. Findings include: 10/26/23 - R130 was admitted to the facility's locked dementia unit with diagnoses, including: dementia with agitation. 1/31/24 - R130's quarterly MDS documented a BIMS score as five, which reflected severe cognitive impairment. 3/15/24 - R130 was transferred to the hospital for three episodes of coffee-ground emesis and was diagnosed with a gastrointestinal bleed. R130 returned to the facility on [DATE]. 3/25/24 - R130 was transferred to the hospital for a syncopal episode. R130 returned to the facility on [DATE]. 7/17/24- Review of R130's EMR revealed F1 (R130's son) was listed as Emergency contact # 1 and R130 was listed as responsible party. 7/17/24 - Review of R130's Transfer Notices, dated 3/15/24 and 3/25/24, both revealed R130 listed as the responsible party to whom the notice was presented. In both instances, the facility failed to notify an appropriate resident representative of R130's transfers to the hospital. R130 had a documented and known severe cognitive impairment. 7/17/24 - Review of the March 2024, Ombudsman Admission/ Discharge Notice revealed that R130's name was not listed on the report at any point throughout the month of March 2024 as a transfer to an acute care hospital. Neither transfer (3/15/24 or 3/25/24) was listed on the Ombudsman notification for March 2024. The facility failed to provide the Office of the Ombudsman notification of R130's 3/15/24 and 3/25/24 transfers to an acute care hospital. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interview, it was determined that for one (R130) out of ten residents reviewed for hospitalization , the facility failed to notify the family representative of the bed-hold policy. Findings include: Review of R130's clinical record revealed: 10/26/23 - R130 was admitted to the facility's locked dementia unit with diagnoses including: dementia with agitation. 1/31/24 - R130's quarterly MDS documented a BIMS score of five, which reflected severe cognitive impairment. 3/15/24 - R130 was transferred to the hospital for three episodes of coffee-ground emesis (vomit) and was diagnosed with a gastrointestinal bleed. R130 returned to the facility on [DATE]. 3/25/24 - R130 was transferred to the hospital for a syncopal (fainting) episode. R130 returned to the facility on [DATE]. 7/17/24 - Review of R130's EMR revealed F1 (R130's son) was listed as Emergency contact # 1 and R130 was listed as responsible party. 7/17/24 - Review of R130's Bed-hold Policy Notices, dated 3/15/24 and 3/25/24, both revealed R130 listed as the responsible party to whom the notice was presented. The facility failed to notify an appropriate resident representative of the facility's bed-hold policy for R130's hospitalization s. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 40260 Based on record review and interview, it was determined that for three (R66 and R146) out of thirty-three residents reviewed in the investigative sample, the facility failed to ensure an accurate assessment. Findings include: 1 Review of R66's clinical record revealed: 5/10/18 - R66 was admitted to the facility. 2/17/24 - Section I of the annual MDS revealed the following: No natural teeth or tooth fragment(s) (edentulous): Yes. Obvious or likely cavity or broken natural teeth was not checked. 7/11/24 11:45 AM - In an interview, E20 (CNA) and E21 (CNA) revealed R66 does not complain of pain with eating and does not wear dentures. 7/11/24 11:50 AM - In an interview, it was revealed that R66 does not have dentures. The surveyor noted that R66 has teeth, but they are in disrepair. R66 stated that although dental exams are offered, R66 declines to attend. 7/12/24 3:35 PM - In an interview, E19 (MDS Coordinator) confirmed that the MDS reflected that resident is edentulous (lack of teeth). Surveyor advised that R66 has broken teeth and R66 confirmed she does not have dentures. 47621 2. Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility. 4/5/24 - R146's admission MDS assessment documented a BIMS score of three, which reflected severe cognitive impairment. 5/8/24 - E38 (NP) ordered a wander guard check placement every shift. 7/3/24 - R146's quarterly MDS documented that R146 did not have a wander/elopement alarm. 7/12/24 9:32 AM - During an interview, E42 (CNA) confirmed that R146 still had a wander guard alarm on her person. 7/12/24 3:42 PM - During an interview, E19 (RNAC) confirmed that R146's 7/3/24 quarterly MDS was modified yesterday to include that R146 did in fact have a wander guard alarm. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 46988 Based on interview and record review, it was determined that for three (R14, R37 and R98) out of three residents reviewed for PASARR, the facility failed to ensure that a referral for a PASARR screening was completed. Findings include: A review of the facility's policy titled Resident Assessment - Coordination with PASARR Program last revised 6/18/24, documented . 9. A resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. 1. Review of R14's clinical record revealed: 5/9/21 - R14 had a level I PASARR completed. 6/7/21 - R14 was admitted to the facility with the following diagnoses: major depressive disorder, adjustment disorder with depressed mood, and delusional disorder. 5/31/23 - R14 was diagnosed with the following diagnoses: unspecified dementia with agitation, violent behavior, and moderate major depressive disorder. 7/16/24 09:52 AM - An interview with E5 (SW Director) confirmed that R14 did not have a level II PASARR completed and one was needed. 40260 2. Review of R37's clinical record revealed: 11/4/18 - R37 was admitted to the facility. 11/5/18 - A level I PASARR was completed and revealed . this patient appears to have: Indicators of mental illness, mental retardation/related conditions, but meets physician's exemption criterion . 12/20/18 - A level 1.5 PASARR was completed and revealed The individual does have a documented serious mental illness (SMI) or a mental illness other than SMI but further review of level of impairment, recent treatment history, or other circumstances demonstrates a full level II is not required . 5/12/23 - Unspecified mood (affective) disorder and unspecified dementia, unspecified severity, without behavioral disturbance psychotic disturbance, mood disturbance and anxiety were added to R37's list of diagnoses. 7/11/24 2:28 PM - In an interview, E1 (NHA) confirmed that given the transition with social workers, there were issues with PASARR's not being completed. E1 stated this situation is being audited and this has been ongoing since May. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/11/24 - A request for a Level II PASARR was completed by E5 (SW Director). 7/16/24 - A Notice of a PASARR Level I Screen Outcome was received from Maximus confirming that a Level II Onsite PASARR was needed. 47142 3. Review of R98's clinical record revealed: 12/4/20 - R98 had a level I PASARR completed at the hospital with the indication of no level II needed and no suspected or confirmed PASARR conditions. 2/2/21 - R98 was admitted to the facility with diagnoses including cerebral infarction and altered mental status. 4/5/21 - R98 had a level I PASARR completed with the indication of no level II needed and no suspected or confirmed PASARR conditions. 2/2/23 - The electronic medical record documented a new diagnoses of unspecified mild dementia with psychotic disturbance and psychotic disorder with delusions were identified. 6/19/23 - The electronic medical record documented a new diagnoses of unspecified dementia with agitation and violent behavior were identified. 6/20/23 - R98 had psychiatry visits on 6/20/23, 7/5/23, 7/11/23, 1/10/24 and 3/6/24. 7/16/24 9:52 AM - During an interview E5 (SW Director) stated the psych nurse practitioner will screen residents weekly and notify him, the unit manager, or the DON if a resident has any behavioral changes. E5 stated once notified, they will initiate a PASARR review. E5 stated that the facility was without a psych nurse practitioner who had a definitive schedule for a long time and some residents got missed. 7/16/23 12:15 - E5 confirmed a Level II PASARR was not submitted for R98 and one should have been submitted for review. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46988 Based on interview and record review, it was determined that for four (R123, R143, R146 and R109) out of thirty-three residents in the investigative sample the facility failed to develop and implement a comprehensive resident centered care plan for an identified care area. Findings include: 1. Review of R123's clinical record revealed: 2/15/24 - R123 was admitted to the facility. 2/21/24 - An admission MDS assessment revealed that R123 was always continent of bowel and bladder. The MDS revealed that R123 was not indicated for a toileting program at this time. 5/21/24 - A quarterly MDS assessment revealed that R123 was frequently incontinent of bowel and bladder. The MDS revealed that R123 was not indicated for a toileting program at this time. 7/11/24 9:31 AM - A review of R123's care plan revealed the facility lacked evidence of an incontinence care plan. 7/15/24 10:29 AM - An interview with E27 (LPN UM) confirmed that R123 did not have a care plan for incontinence. 2. Review of 143's clinical record revealed: 4/4/24 - R143 was admitted to the facility. 4/6/24 - An admission MDS assessment revealed that R143 was occasionally incontinent of bowel and bladder. The MDS revealed that R143 was not indicated for a toileting program at this time. 7/11/24 9:42 AM - A review of R143's care plan revealed the facility lacked evidence of an incontinence care plan. 7/15/24 10:29 AM - An interview with E27 (LPN UM) confirmed that R143 did not have a care plan for incontinence. 47621 3. Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility. 4/5/24 - R146's admission MDS assessment documented a BIMS score of three, which reflected severe cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/15/24 9:45 AM - A review of R146's care plans revealed the facility lacked evidence of a cognitive impairment care plan with interventions. 7/15/24 1:35 PM - During an interview, E3 (QA/IP) confirmed the lack of care plan interventions with regard to R146's cognitive impairment. 4. Review of R109's clinical record revealed: 6/14/24 - R109 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation (Afib), deep vein thrombosis (DVT) and factor V Leiden heterozygous mutation, an inherited disorder that causes abnormal blood clots in legs or lungs. 7/11/24 10:45 AM - A review of R109's care plan revealed no evidence of a care plan or interventions regarding R109's need for anti-coagulation therapy due to the diagnoses of Afib and DVT. 7/15/24 1:35 PM - During an interview, E3 (QA/IP) confirmed the lack of care plan interventions with regard to R109's need for anti-coagulation therapy. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN), and E7 (ADON) at the exit conference.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40260 Based on record review and interview, it was determined that for six (R25, R37, R47, R66, R68, and R75) out of thirty-three sampled residents for care plan investigations, the facility failed to ensure that the required interdisciplinary team (IDT) memebers participated in the care plan meetings and for R66's care plan inaccurately includes dentures. Findings include: A facility policy entitled Comprehensive Care Plans (revised 4/24) states, The comprehensive care plan will be prepared by the interdisciplinary team, that includes, but is not limited to: a. The attending physician or non-physician practitioner designee involved in the resident's care, if the physician is unable to participate in the development of the care plan. B. A registered nurse with responsible for the resident. c. A nurse aide with responsibility for the resident. d. a member of the food and nutrition staff . The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 1. Review of R25's clinical record revealed: 9/21/23 - R25 was admitted to the facility. 9/25/23 - A baseline care plan was e-signed. 7/12/24 - E1 (NHA) provided a copy of a quarterly care plan meeting for 4/23/24 that lacked evidence of input from the Physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, and a food/nutrition services staff. Additionally, the facility lacked evidence that R25 had a quarterly care plan meeting in December, 2023. 2. Review of 37's clinical record revealed: 11/4/18 - R37 was admitted to the facility. 7/12/24 approximately 11:00 AM - E1 (NHA) provided a copy of a Comprehensive Resident Centered Care Plan Conference sheet for a quarterly meeting, which was undated. The facility lacked evidence that the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident and a member of food and nutrition services staff provided input. The surveyor also requested documentation for the three previous care plan meetings including the two quarterly meetings and the annual meeting, but the facility was not able to produce evidence that these meetings occurred. 3. Review of R66's clinical record revealed: 5/10/18 - R66 was admitted to the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/16/24 untimed - E1 (NHA) provided the surveyor with a Comprehensive Resident Centered Care Plan Conference Sheet for R66's annual care plan meeting on 8/28/23, which lacked evidence of input from the Physician, a nurse aide with responsibility for the resident, and a food/nutrition services staff. The facility lacked evidence that a quarterly care plan meeting was held in November, 2023, February, 2024 or May, 2024. Additionally, R66's care plan inaccurately reflected that R66 has an upper and lower dentures. 7/17/24 2:02 PM - In an interview, E14 (staff educator/acting UM) confirmed that R66's care plan inaccurately reflects that this resident had upper and lower dentures. E14 confirmed that resident has broken teeth but does not use dentures. 4. Review of R75's clinical record revealed: 10/9/18 - R75 was admitted to the facility. 7/15/24 approximately 9:45 AM - E1 (NHA) provided the surveyor with a Comprehensive Resident Centered Care Plan Conference Sheet for an annual care plan meeting on 10/26/23 that lacked evidence of from the Physician, a nurse aide with responsibility for the resident, and a food/nutrition services staff. The quarterly care plan meeting sheet also lacked evidence of input from these three IDT members. Additionally, the facility lacked evidence that R75 had a care plan meeting in August, 2023 or January, 2024. 46988 5. Review of R47's clinical record revealed: 5/27/16 - R47 was admitted to the facility with the following but not limited to diagnoses traumatic brain injury and tracheostomy status. 5/29/16 - A review of a careplan for R47's impaired breathing mechanic's last updated 7/25/23 revealed that if R47's tracheostomy dislodges to complete the following interventions: 1. notify supervisor 2. call physician and 911 3. Assess respiratory status, if oxygen saturation is below ninety- two percent apply oxygen by ambu bag or by holding oxygen to the stoma site 4. liscense nurse may reattempt to resinsert trach as per policy. 6/1/16 - An admission MDS revealed that R47 required the following respiratory treatments oxygen, suctioning, and tracheostomy care. 5/22/24 - An annual MDS revealed that R47 required tracheostomy care. 7/15/24 10:29 AM- An interview with E27 (LPN UM) confirmed the care plan did not reflect the current needs related to R47's tracheostomy. The care plan did not reflect R47's current tracheostomy size or current emergency needs if tracheostomy dislodges. 6. Review of R68's clinical record revealed: 11/19/21 - R68 was admitted to the facility. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/16/23 - A care plan revealed that R68 is resistive and non-compliant with treatment and care related to dementia. The interventions included allow flexibility in ADL routine and if resists care to reapproach. 7/18/24 9:50 AM - An interview with E31 (RN UM) revealed R68 only refuses showers and the following interventions are used: to call daughter, change times, change staff, and change approach. E31 confirmed the current interventions are not reflected on the careplan. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 40260 Based on record review and interview, it was determined that for six (R25, R37, R47, R66, R68, and R75) out of thirty-three residents in the investigative sample the facility failed to ensure that the required interdisciplinary team (IDT) memebers participated in the care plan meetings and additionally, R66's care plan inaccurately included dentures. Findings include: State of Delaware Board of Nursing- RN (registered nurse), LPN (licensed practical nurse) and NA (nurses aide)/UAP (unlicensed assistive personnel) Duties 2024 .Admission Assessments - RN, Admission History Review -RN .Plan of Care: Initial- RN . Updated 4/10/24 1. Review of R160's clinical record revealed: 3/30/24 - R160 was admitted to the facility. 3/30/24 - E8 (LPN) completed the Prestige Admit/Readmit Screener. 4/3/24 - R160's baseline care plan was e-signed by E9 (LPN). An LPN, not an RN, as required by the Delaware State regulation for Board of Nursing Scope of practice, completed the admission assessment and baseline care plan for R160. 47621 2. Review of R109's clinical record revealed: 6/14/24 - R109 was admitted to the facility. 6/14/24 - E17 (LPN) completed the following admission assessments: Resident Basics/Medical History, Elopement Risk Assessment, Pain Assessment, Fall Assessment, Skin Integrity/ Braden Scale, Mobility/Lift/Side Rail assessment, Oral/Nutrition assessment, Respiratory/Smoking Evaluation, Bowel & Bladder Assessment and IV/Other. 3. Review of R144's clinical record revealed: 3/21/24 - R144 was admitted to the facility. 3/25/24 - Baseline care plan was generated by E9 (LPN). 4. Review of R148's clinical record revealed: 3/21/24 - R148 was admitted to the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/21/24 - E23 (LPN) completed the following assessments: Resident Basics/Medical History, Elopement Risk Assessment, Pain Assessment, Fall Assessment, Skin Integrity/ Braden Scale, Mobility/Lift/Side Rail Assessment, Oral/Nutrition Assessment, Respiratory/Smoking Evaluation, Bowel & Bladder Assessment and IV/Other. 3/25/24 - The baseline care plan was generated by E9 (LPN). 6/17/24 - R148 was readmitted to the facility. 6/17/24 - E18 (LPN) completed the follwoing assessments: Resident Basics/Medical History, Elopement Risk Assessment, Pain Assessment, Fall Assessment, Skin Integrity/ Braden Scale, Mobility/Lift/Side Rail Assessment, Oral/Nutrition Asessment, Respiratory/Smoking Evaluation, Bowel & Bladder Assessment and IV/Other. 5. Review of R157's clinical record revealed: 6/19/24 - R157 was admitted to the facility. 6/19/24 - E22 (LPN) completed the following assessments: Resident Basics/Medical History, Elopement Risk Assessment, Pain Assessment, Fall Assessment, Skin Integrity/ Braden Scale, Mobility/Lift/Side Rail Assessment, Oral/Nutrition Assessment, Respiratory/Smoking Evaluation, Bowel & Bladder Assessment and IV/Other. 6/20/24 - The baseline care plan was generated by E9 (LPN). 6. Review of R461's clinical record revealed: 6/19/24 - E24 (LPN) completed the following assessments: Resident Basics/Medical History, Elopement Risk Assessment, Pain Assessment, Fall Assessment, Skin Integrity/ Braden Scale, Mobility/Lift/Side Rail Assessment, Oral/Nutrition assessment, Respiratory/Smoking Evaluation, Bowel & Bladder Assessment and IV/Other. 7/17/24 9:19 AM - During an interview, E8 (LPN) stated that she has done admit/readmit screener on the electronic medical record (EMR) for newly admitted residents. The admit/readmit screener was defined as vitals, a skin check and a whole list of questions that we have to ask regarding things like fall and dentures and so on. When asked about the baseline care plan, E8 stated that the unit manager does the care plan. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (corporate RN) and E 7 (ADON) at the exit conference.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 47142 Based on observation, interview and record review, it was determined that for one (R128) out of seven residents reviewed for ADLs, the facility failed to provide mobility from bed to chair. Findings include: Cross refer F842. Review of R128's clinical record revealed: 8/11/23 - R128 was admitted to the facility with diagnoses including cerebral infarction and hemiplegia affecting the nondominant left side. 4/23/24 - A physician order documented that R128 was to be out of bed for a minimum of two hours every day and nursing to document and notify family of refusals every day shift. 5/16/24 - A quarterly MDS revealed that R128 had an impairment on one side for the upper extremities and no impairments for the lower extremities. R128 required substantial or maximal assistance for rolling left and right, sitting to lying, lying to sitting on the side of the bed and was dependent for transfer from bed to chair or chair to bed. R128's BIMs score was 13 out of 15 which indicated intact cognition. 7/9/24 - An interview with R128 stated, I stay in bed and they don't get me up. Observations of R128 laying in bed: 7/10/24 at 10:32 AM, 7/10/24 at 11:14 AM, 7/11/24 at 9:35 AM, 7/11/24 at 10:41 AM, 7/11/24 at 12:11 PM, 7/11/24 at 2:56 PM. 7/12/24 9:33 AM - During an interview R128 stated he did not get out of bed at any time on 7/11/24. 7/12/24 2:29 PM - During an interview, E25 (CNA) confirmed that R128 did not get out of bed on 7/11/24 and that R128 did not refuse. E25 stated, we did not ask if he wanted to get up. He usually tells us that he wants to be up. We did not ask, so he did not refuse. 7/12/24 2:31 PM - During an interview, E26 (LPN) stated, we have to document about him refusing in the [electronic] notes. There was no facility documentation of any refusals by R128 to get out of bed on 7/11/24. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47621 Based on record review and interview, it was determined that for one (R146) out of ten resident reviewed for hospitalization , the facility failed to ensure that R146's warfarin dosing was managed in accordance with the professional standards of practice. Findings include: The acceptable time frame to achieve anticoagulation with warfarin typically ranges from 5 to 7 days. However, it's important to note that the full therapeutic effect may take up to a week due to the long half-life of prothrombin (factor II), which is essential for converting fibrinogen to fibrin12. Warfarin inhibits the production of vitamin K-related factors, and its antithrombotic effect gradually becomes evident as prothrombin levels decrease. During this period, concurrent use of more rapidly acting anticoagulants, such as low-molecular-weight heparin (LMWH) or unfractionated heparin, is recommended. National Library of Medicine, Turkish Journal of Hematology 2016 Warfarin Dosing Guideline- .V. Warfarin dosing nonogram (in medicine, a pictorial representation of a complex mathematical formula) for Maintenance therapy (>1 week of warfarin therapy) of non-bleeding patient Goal INR 2-3 Dosing Adjustments INR <1.5 - Consider a one-time dose increase of 1.5-2 times daily maintenance dose -If adjustment to maintenance dose is needed, increase dose by 10-20% -Repeat INR in 1 week INR 1.5-1.7 -Consider a one-time dose increase of 1.5 times daily maintenance dose -If adjustment to maintenance dose needed, increase by 5-15% - Repeat INR in 2 weeks INR 1.8-1.9 -No dosage adjustment may be necessary if the last two INRs were in Range -Repeat INR within 8 weeks -Consider a one-time dose increase of 1.5 times daily maintenance dose -If adjustment to maintenance dose needed, increase dose by 5-10% -Repeat INR in 2 weeks (University of New Mexico Health System June 2020) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R109's clinical record revealed: 6/14/24 - R109 was admitted to the facility with diagnoses, including but not limited to, atrial fibrillation (Afib), deep vein thrombosis (DVT) and factor V Leiden heterozygous mutation, an inherited disorder that causes abnormal blood clots in legs or lungs. Due to the risk of blood clots, R109 was medically managed with warfarin for anti-coagulation therapy with the goal INR range of 2.0 to 3.0. (University of New Mexico Health System June 2020) 6/14/24 Friday - E39 (MD) documented in R109's EMR, Warfarin tablet 2 mg (milligram) - give 1 tablet by mouth in the evening every Sat, Sun and Warfarin tablet 2 mg- [NAME] 1.5 tablet (3 mg) by mouth in the evening every Mon, Tues, Wed, Thu, Fri. Total weekly warfarin dosage was 19 mg. 6/15/24 Saturday 11:12 AM - R109's INR was reported as 1.5, which was not at R109's therapeutic goal of 2. 0 to 3.0. The facility lacked evidence of any intervention for this below goal INR level. 6/18/24 Tuesday 12:06 PM - R109's INR was reported as 1.2, which was not R109's therapeutic goal of 2.0 to 3.0. 6/19/24 - E38 (NP) documented in R109's EMR, Warfarin tablet 2 mg- give 1.5 tablets (3 mg) by mouth in the evening every Mon, Tue, Wed, Thu, Fri, Sat, Sun. Total weekly warfarin dosage was 21 mg. This reflected an increase of 2 mg or 10 % of the total weekly warfarin dosage. 6/21/24 Friday 11:45 AM - R109's INR was reported as 1.3, which was below R109's therapeutic goal of 2.0 to 3.0. This was day 7 of anti-coagulation therapy in the facility and R109 did not reach the desired goal of INR 2.0 to 3.0. 6/21/24 - E38 (NP) documented in R109's EMR, Warfarin tablet 2 mg- give 2 tablets (4 mg) by mouth in the evening every Mon, Fri, Sun and give 1.5 tablets (3 mg) by mouth at bedtime every Tue, Wed, Thu, Sat. Total weekly warfarin dosage was 24 mg. This reflected an increase of 3 mg or 14.3 % of the total weekly warfarin dosage. 6/25/24 Tuesday 12:23 PM - R109's INR was reported as 1.7, which was still below R109's desired goal of 2. 0 to 3.0. 6/25/24 - E38 (NP) documented in R109's EMR, Warfarin tablet 2 mg- give 2 tablets (4 mg) by mouth in the evening every Mon, Tue, Wed, Fri, Sun and give 1.5 tablets (3 mg) by mouth at bedtime every Thu, Sat. Total weekly warfarin dosage was 26 mg. This reflected an increase of 2 mg or 7.7 % of the total weekly warfarin dosage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/26/24 - R109 was hospitalized for shortness of breath. During this hospitalization , R109 was treated with lovenox, an heparin injection, to help reach the desired anti-coagulation goal as R109's INR was not at goal upon admission to the hospital. 6/30/24 - R109 was readmitted to the facility. 6/30/24 - E38 (NP) documented in R109's EMR, Warfarin tablet 2 mg- give 2 tablets (4 mg) by mouth in the evening every Mon, Tue, Wed, Fri, Sun and give 1.5 tablets (3 mg) by mouth at bedtime every Thu, Sat. Total weekly warfarin dosage was 26 mg. 7/2/24 Tuesday 12:10 PM - R109's INR was reported as 1.2, which was not at R109's desired goal of 2.0 to 3.0. 7/3/24 Wednesday - E38 (NP) ordered in R109's EMR, Warfarin tablet 2 mg- give 2 tablets (4 mg) by mouth in the evening. Total weekly warfarin dosage was 28 mg. E45 (NP) also ordered, Warfarin tablet 1 mg- give 1 tablet (1 mg) by mouth at bedtime every Wed, Thu for 2 days for a total dose of 5 mg. With the additional 2mg of warfarin, the total weekly dosage was 30 mg. This one-time dose increase did not meet the professional standard guidelines of a one-time dose increase of 1.5-2 times daily maintenance dose. This reflected an increase of 4 mg or 15.4 % of the total weekly warfarin dosage. 7/9/24 12:08 PM - R109's INR was reported as 1.4, which was below R109's therapeutic goal of 2.0 to 3.0. 7/9/24 - E38 (NP) ordered in R109's EMR, Warfarin tablet 1 mg- give 1 tablet (1 mg) by mouth at bedtime every Tue, Wed, Thu. Give in addition to 2 mg tabs (total dose= 5 mg). Total weekly warfarin dosage was 31 mg. This reflected an increase of 3 mg or 10.7 % of the total weekly warfarin dosage. This was day 9 of anti-coagulation therapy in the facility after R109's re-admission to the hospital and R109's INR remained below therapeutic goal of 2.0 to 3.0. 7/12/24 12:33 PM - R109's INR was reported as 1.2, which did not meet R109's therapeutic goal of 2.0 to 3.0. 7/12/24 - E38 (NP) ordered in R109's EMR, Warfarin tablet 1 mg- give 1 tablet (1 mg) by mouth at bedtime. Give in addition to 2 mg tabs (total dose = 5 mg) and Warfarin tablet 2 mg- give 2 tablets by mouth at bedtime. Give in addition to 1 mg tab. Total dose =5mg). Total weekly warfarin dosage was 35 mg. This reflected an increase of 4 mg or 12.9 % of the total weekly warfarin dosage. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/15/24 12:34 PM - During an interview, E38 (NP) stated that he looked up the hospital records from the 6/26/24 admission and reviewed the Hematology consult note. I decided not to bridge with lovenox. There was conflicting documentation in the discharge summary regarding whether to bridge or not. I am following the INR and am increasing the dosage with each INR result. 7/16/24 - R109's INR was reported as 1.5, which was below R109's desired goal of 2.0 to 3.0. This was day 16 of anti-coagulation therapy in the facility after R109's re-admission to the hospital and R109's INR did not reach the therapeutic goal of 2.0 to 3.0. 7/16/24 - E38 (NP) ordered in R109's EMR, Warfarin tablet 2 mg- give 3 tablets (6 mg) by mouth at bedtime. Total weekly warfarin dosage was 42 mg. E45 (NP) also ordered, Warfarin tablet 2 mg- give 4 tablet (8 mg) by mouth at bedtime for 1 day. With the additional of the one-time 8mg dosage, the weekly warfarin dosage was 50 mg. This reflected an increase of 15 mg or 42.8 % of the total weekly warfarin dosage. 7/18/24 12:14 PM - During a telephone interview, E39 (MD) confirmed that R109's INR goal for anti-coagulation therapy was 2-3. With regard to the timeframe that it was taken to achieve this goal, E39 stated, It has taken too long. Of note, at the time of the survey team exit, the facility was still unable to provide evidence that R109 was therapeutically anti-coagulated with warfarin. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46988 Based on observation, interview and record review it was determined that for two (R123 and R143) out of three residents reviewed for bowel and bladder, the facility failed to respond to or provide services to restore bladder continence. Findings include: 1. Review of R123's clinical record revealed: 2/15/24 - R123 was admitted to the facility. 2/20/24 - A bowel and bladder initial assessment revealed that R123 was continent of bowel and bladder. 2/21/24 - An admission MDS assessments revealed that R123 was always continent of bowel and bladder and not indicated for a toileting program. April 2024 - A review of the April CNA task flow sheet revealed that R123 was incontinent of bladder sixty-five times out of ninety opportunities. 5/21/24 - A quarterly MDS assessment revealed that R123 was frequently incontinent of bladder and always incontinent of bowel and not indicated for a toileting program. May 2024 - A review of the May CNA task flow sheet revealed that R123 was incontinent of bladder seventy-two times out of ninety opportunities. June 2024 - A review of the June CNA task flow sheet revealed that R123 was incontinent of bladder eighty-[NAME] times out of ninety opportunities. July 2024 - A review of the July CNA task flow sheet revealed that R123 was incontinent of bladder twenty-nine times out of thirty-three opportunities. 7/15/24 12:53 PM - An interview with E40 (CNA) confirmed that R123 is usually incontinent and unable to recall if R123 was on a toileting program. E40 stated that R123 was on a different unit previously and was using a urinal. E40 stated she does not offer a urinal or commode to R123. 7/15/24 1:45 PM - An interview with E41 (COTA) confirmed that therapy assessed R123 for use of urinal and bedside commode. E41 confirmed that R123 is able to utilize both adaptive equipment safely. 7/16/24 12:19 PM - An interview with E14 (RN Staff Educator) revealed that the voiding diary gives them an idea of target times to assist the resident with incontinence. Nursing is able to initiate adaptive equipment such as a urinal but therapy has to initiate a commode. E14 confirmed that R123 is not currently using a urinal or commode. The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R123. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/16/24 1:20 PM - An interview with E3 (QA), E7 (ADON), and E2 (DON) revealed that R123 was offered a urinal trial starting on 7/15/24. 2. Review of R143's clinical record revealed: 4/4/24 - R143 was admitted to the facility. 4/6/24 - An admission MDS revealed that R143 is occasionally incontinent of bowel and bladder and is not indicated for a toileting program. April 2024 - A review of the April CNA task flow sheet revealed that R143 was incontinent of bladder fifty-nine out of one hundred and one opportunities. May 2024 - A review of the May CNA task flow sheet revealed that R143 was incontinent of bladder eighty-three out of one hundred and twenty-six opportunities. June 2024 - A review of the June CNA task flow sheet revealed that R143 was incontinent of bladder fifty-five out of ninety opportunities. July 2024 - A review of the July CNA task flow sheet revealed that R143 was incontinent of bladder twenty-eight out of thirty-eight opportunities. 7/5/24 - A voiding diary was completed for R143 from 7/3/24 to 7/5/24. The facility lacked evidence of implementing a plan to restore continence for R143. 7/17/24 10:25 AM - An interview with E20 (CNA) revealed that [R143] is independent and will notify staff if she is incontinent. [R143] is able to clean herself up and I (E20) dont normally have to assist her. The facility lacked evidence of responding to decreased continence and failed to provide evidence of services to restore continence for R143. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 46988 Based on observation, record review and interview, it was determined that for two (R47 and R121) out of two residents reviewed for respiratory care, the facility failed to provide respiratory care consistent with professional standards of practice. Findings include: 1. Review of R47's clinical record revealed: 5/27/16 - R47 was admitted to the facility with diagnoses including traumatic brain injury and tracheostomy status. 7/7/22 - A physician's order was written for R47 Emergency Trach Supply list - Items are to be kept in a bag together at bedside/head of bed at all times 1. The same size trach 2. next size smaller trach 3. Ambu bag and mask 3. Sterile lubricant (2 packets) 4. Suction Machine with tubing 5. Suction Catheter 6. Oxygen tank/full 7. sterile gloves 8. Trach Ties *check for expiration dates and replace prn *. 5/22/24 - An annual MDS revealed that R47 required tracheostomy care. 7/15/24 9:15 AM - A review of the R47's physician's orders lacked evidence of current tracheostomy size and brand of use. 7/15/24 10:29 AM - An interview with E27 (LPN UM) revealed that all tracheostomy orders would be located in the EMR under orders. E27 confirmed R47's size and type of trach was not indiciated in EMR. E27 stated R46 is a size 6 based on the emergency equipment. 7/15/24 10:40 AM - A physician's order for R47 revealed that tracheostomy size #4 shiley was the current tracheostomy size and brand. 7/15/24 2:50 PM - An interview with E32 (RN) stated she was unsure of R47's trach size prior to today. 7/16/24 9:58 AM - An observation of a size #6 and size #4 replacement tracheostomy to be hanging at bed side with emergency equipment. 7/17/24 9:30 AM - An interview with E28 (NP) confirmed R47 should be a shiley #4 trach and that the facility does not have the proper equipment at this time to accommodate a smaller size as the emergency order states. 44706 2. Review of R121's clinical record revealed: 10/27/23 - R121 was admitted to the facility with a diagnosis of acute respiratory failure with hypoxia (deficiency in amount of oxygen reaching body tissues). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/10/23 - A physicians' order documented continuous oxygen at 2 liters/minute via nasal cannula (tube placed into nostrils to deliver oxygen). Change, date and initial tubing weekly and change humidifier bottle weekly and PRN, every night shift on Saturday. 7/9/24 11:10 AM - During an observation, the oxygen tubing was not labeled with date and initials, this was confirmed with E30 (LPN).

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. 46988 Based on interview and record review, it was determined that for one (R47) out of two residents reviewed for respiratory care, the facility failed to ensure that the Physician's orders included trach size, type, and accurate emergency orders. Findings include: Review of R47's clincal record revealed: 5/27/16 - R43 was admitted to the facility. 7/7/22 - A physician's order was written for R47 Emergency Trach Supply list - Items are to be kept in a bag together at bedside/head of bed at all times 1. The same size trach 2. next size smaller trach 3. Ambu bag and mask 3. Sterile lubricant (2 packets) 4. Suction Machine with tubing 5. Suction Catheter 6. Oxygen tank/full 7. sterile gloves 8. Trach Ties *check for expiration dates and replace prn *. 7/15/24 9:15 AM - A review of the R47's physician's orders lacked evidence of current tracheostomy size and brand of use. 7/15/24 10:29 AM - An interview with E27 (LPN UM) revealed that all tracheostomy orders would be located in EMR under orders. E27 confirmed R47's size and type of trach was not indiciated in EMR. 7/15/24 10:40 AM - A physician's order for R47 revealed that tracheostomy size #4 shiley is current tracheostomy size and brand. 7/17/24 11:50 AM - An interview with E28 (NP) confirmed that the emergency order instructions were not accurate for R47's plan of care. The facility failed to have a current order for R47's tracheostomy that included type and size and failed to have accurate emergency order's, 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0726 Level of Harm - Minimal harm or potential for actual harm 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. 46988 Based on interview and review of the clinical record, it was determined that for one (R47) out of two residents reviewed for respiratory care, the facility failed to have nursing staff with the appropriate competencies and skill sets to provide nursing and related services to a resident with a tracheostomy. Findings include: Review of R47's clinical record revealed: 5/27/16 - R47 was admitted to the facility with the following but not limited to diagnoses traumatic brain injury and tracheostomy status. 5/22/24 - An annual MDS revealed that R47 required tracheostomy care. 7/15/24 02:58 PM - An interview with E32 (RN) stated she was unsure of R47's trach size prior to today. 7/17/24 10:30 AM - An interview with E36 (Agency LPN) revealed in an emergency you would insert the smaller size trach if it comes out. 7/17/24 10:45 AM - An interview with E37 (Agency LPN) revealed that E37 was unable to articulate what to do in an emergency with a tracheostomy resident. E37 stated I would call the supervisor for help. 7/17/24 12:30 PM - A review of tracheostomy care competency checklists provided by E14 (Staff Educator RN) revealed that the facility lacked evidence of verifying compentcies with all agency nurses and lacked evidence of all staff being verified for emergency tracheostomy procedures. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. 47621 Based on record review and interview, it was determined that for one (R146) out of three residents reviewed for abuse, it was determined that the facility failed to provide medically related social services to R146, who was cognitively impaired and did not have a legal decision maker. Findings include: Cross refer F582, F602 and F609. Review of R146's clinical record revealed: 3/30/24 - R146 was admitted to the facility with diagnoses, including but not limited to altered mental status. 4/1/24 3:09 PM - R146 signed the facility's Admission Agreement, which included an authorization form to release financial data. The clauses that identified R146's legal representative and responsible party were left blank in this signed document. The facility's Admission Agreement included information regarding resident's rights, payment obligations, grievance process, advanced directive and other services provided by the facility. 4/2/24 2:59 PM - E5 (Social Work Director) documented in R146's EMR.Her sister [F2] was invited to the meeting (care plan meeting) .SW (social work) was unable to get in contact with her sister .The plan is to have [R146] move in with one of her sisters .[R146] scored 3/15 on her BIMS assessment which indicates that she has severe cognitive deficit . 4/5/24 - R146's admission Minimum Data Set (MDS) assessment documented a BIMS score of three, which reflected severe cognitive impairment. 4/9/24 9AM - E6 (SW) documented in R146's EMR Update delivered to family and CM (case management) in phone call. The facility failed to identify that R146 with a BIMS of 3, did not have the cognitive ability to be her own responsible party and was unable to provide evidence of any intervention on behalf of R146 to address the need for a responsible party with R146's two known sisters. 4/12/24 - R146 was given a Notice of Medicare Non-Coverage (NOMNC) that advised that R146's effective date of last day of Medicare coverage was 4/17/24. The document was signed by E44 (Social Worker) and E43 (Business Office manager) with the statement unable to sign BIM of 3 written in box beneath the statement Signing below means that you've received and understand this notice . (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/15/24 10:58 AM - E5 (SW director) documented in R146's EMR, .[R146] received a NOMNC letter with a last cover date of 4/17/24. [R146]'s original discharge plan was to return home alone or to live with one of her sisters. [R146] does not feel like she can live on her own. It was reported to the social services department that she can no longer live with her sister .SW (social work) will work with [R146] and her family to assist with getting her transferred to another facility. 4/17/24 - R146 was cut from Medicare insurance coverage and deemed private pay at the rate of $495 per day, as stated in the Admission Agreement, for her stay at the facility. 4/18/24 4:04 PM - E5 (SW Director) documented in R146's EMR, .[R146] was scheduled for discharge today to her sister, [F3]. SW spoke with both of [R146]'s sisters. [F3], she states that her daughter called this morning and left a message on the admission director's voicemail stating that the resident cannot come and live with her. [F3] also wants to be removed from the electronic medical record as a point of contact for [R146]. SW spoke with the resident's other sister, [F2]. She states that she did not know that the resident could not go home with her other sister. [F3] said that she is home with COVID. F3 will revisit the resident coming home to live with her once she is systematic (sic). SW updated the IDT (interdisciplinary team) that [R146] will not be discharged today. The facility continued to fail to identify a responsible party for R146 and failed to initiate a referral to the medical staff for a capacity determination. 5/19/24 3:43 PM - E45 (RN) documented in R146's EMR that a family member called and requested that R146 should not sign anything without her family present. According to the Release of Responsibility for Leave of Absence log, R146 was signed out and left the faciity on a leave of absence with unrelated persons on 5/20/24, 5/25/24, 6/3/24, 6/21/24, 6/28/24 and 7/12/24. The facility failed to verify that the persons had authorization to take R146 out of the building. 5/14/24 1:52 PM - E5 documented in R146's EMR,[R146]'s sister called and stated that she wanted referred (sic) to [assisted living] facility program. SW spoke with [R146] and she agreed with a referral to be sent to [assisted living facility]. SW completed the referral and now awaiting a response from [assisted living facility] to see if they will accept [R146]. 5/24/24 9:48 AM- E5 (SW) documented in R146's EMR, [R146] visited [assisted living facility] on Monday with her sister. [R146] had been referred to [assisted living facility] for possible placement. [R146] had been accepted by [assisted living facility]. [R146] provided a deposit for [assisted living facility]. There are other documents that need to be filled out by her sister and the n here. There is no set discharge date for [R146] at this time. IDT team has been made aware. 5/28/24 1:15 PM - E44 (SW) documented in R146's EMR, SW added new contact in PCC (Point Click Care) w/permission of [R146]. Her male friend [F4] xxx-xxx-xxxx. 5/29/24 - E46 (Psychologist) documented in R146's EMR, Her judgment and insight are impaired. At this time, pt is not capable of making her own healthcare decisions. 5/31/24 - The facility made a referral for capacity determination. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This capacity referral was made fifty-six (56) days after the initial BIMS assessment that documented R146 having a severe cognitive impairment. 6/3/24 - E39 (MD) documented in a Physician Affidavit for Guardianship that R146 did not have capacity to function independently including: activities of daily living, pay her own bills, live alone, take medicine appropriately, give consent for medical procedures and resist scams. 6/3/24 10:06 AM - F4 (male friend) signs R146 out of the facility in the Leave of Absence log. R146 was signed back into the facility at 11:35 AM. 6/4/24- The facility petitioned the Court of Chancery to initiate R146's guardianship process. This petition was initiated one (1) day after R146 was deemed not to have capacity and sixty (60) days after R146 was documented to have a severe cognitive impairment and lacked family/community support. 7/9/24 1:54 PM - During a telephone interview, F2 (R146's sister) stated that she was not informed about R146's last day of Medicare coverage nor was she offered the opportunity to appeal. F2 also confirmed that she was not asked about allowing R146 to go out the facility with unrelated persons. 7/9/24 - The Court of Chancery filed paperwork that appointed C3 (Esquire) as attorney ad litem of R146, a person with an alleged disability and stated the hearing for guardianship would be on August 15, 2024. 7/10/24 10:24 AM - E5 (SW) documented in R146's EMR, [R146]'s care plan meeting was rescheduled until July 23rd at her request. IDT team was made aware of her meeting being rescheduled. 7/10/24 3:20 PM - A review of R146's face sheet revealed that R146 listed as responsible party and F2 (R146's sister) listed as emergency contact #1 and F3 (R146's other sister) listed as emergency contact #2. Ninety-six (96) days after R146 was documented as having severe cognitive impairment and thirty-seven (37) days after R146 was deemed not to have capacity, R146's face sheet continued to document that R146 was her own responsible party. 7/12/24 9:31 AM - During an interview, E44 (SWS) stated, When I was explaining about the insurance, she did not understand. She did not understand what she was signing so she did not sign. She would nod her head in agreement, but she did not understand. 7/12/24 10:54 AM - During an interview, F5 (CSA, female friend), I don't have a contract with [R146]. I just really like her and am keeping touch because I like her. I have taken [R146] to Dairy Queen, my grandson's birthday party, out for lunch. She has met my daughter. I have never taken her to the bank. She does not have any money. I heard [F4] and [F3] were trying to get POA (power of attorney). 7/12/24 11:03 AM - During an interview, E1 (NHA) stated, We were trying to get a Medicaid application together. When we got the bounced check, that was when we became aware that there was a problem. That was in May sometime. No, I did not report it to APS. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/12/24 1:07 PM - When shown a copy of the facility Release of Responsibility for Leave of Absence log, F5 (CSA, female friend) stated, Yes, that is my chicken scratch (pointing to the dates of 5/20, 5/25, 6/21, 6/28, & 7/12 on the release log). F5 then stated that the signature on 6/3 was F4 (male friend). I remember seeing them here on 6/3; it's my birthday. 7/12/24 3:13 PM - During an interview, E1 (NHA) stated, We don't have a policy or procedure for residents that have been deemed not to have capacity and don't have a legal guardian or POA (power of attorney). 7/15/24 10:15 AM - During a telephone interview, F2 (R146's sister) reported that R146's roommate F7 alleged that F4 came to the facility and had R146 call the bank to have another debit card mailed to R146's apartment and F4 was the person who picked up R146's mail. 7/15/24 11 AM - The surveyor informed the facility of the allegation against F4 who was listed on R146's face sheet as friend. 7/15/24 12:29 PM - During an interview, E38 (NP) stated, There are no special orders that we place when a patient is deemed not to have capacity. We were not aware that [R146] had been financially exploited. 7/15/24 5:30 PM- After inquiry by the surveyor, E2 (DON) filed a complaint with the [local] police regarding R146's returned check #4483 from 5/23/24 for insufficient funds. 7/16/24 10:10 AM - During an interview, E5 (SW) stated, To my knowledge, there is no policy or precedent regarding when a resident is deemed not to have capacity. I am not aware of any restrictions regarding leaving the facility. I guess you would call her sister. I am not aware of a guardian ad litem. 7/16/24 11:42 AM - During an interview, E1 (NHA) stated, The facility petitioned for guardianship on 6/4/24. The referral for capacity was made on 5/31/24. [R14]'s need for a capacity determination was discussed and decided at morning meeting so there are no notes from an IDT meeting about it. If [R146} wants to leave the facility with friends, we allow her to go. 7/18/24 - F4 (male friend) remained listed on R146's face sheet as a friend. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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	085037	A. Building B. Wing	07/18/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38302 Based on observation and interview it was determined that the facility failed to ensure food was stored, prepared, and served in a manner that prevents food borne illness to the residents. Findings include: 7/9/24 11:05 AM - Observation of nourishment refrigerator located at the nurse's station number two (2) revealed a carton of Nutritional Shake that was undated. The instructions on the carton indicate that once opened, any remaining product should be discarded after four (4) days. 7/9/24 11:06 AM - The food storage shelves in the walk-in refrigerator were covered in numerous areas of rust, the floor of the walk-in was wet, and there was some small areas of ice build up in the walk-in freezer. 7/9/24 11:27 AM - During a tour of the kitchen, the surveyor observed E48 (Dining Services Director) and E49 (Assistant Dining Services Director) test the sanitizer level of the solution in two red sanitizing buckets. When E49 tested the sanitizing solution in the bucket from the prep area, the test strip from that bucket indicated that the level of chemical concentration was not at a sufficient level to provide proper sanitization. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 47142 Based on record review and interview, it was determined that for one (R128) out of thirty-three (33) residents in the investigative sample, the facility failed to ensure the clinical record contained accurate documentation. Findings include: Cross refer F676. Review of R128's clinical record revealed: 8/11/23 - R128 was admitted to the facility. 4/23/24 - R128's physicians orders documented R128 to be out of bed for a minimum of two hours every day and nursing to document and notify family of refusals every day shift. 5/16/24 - A quarterly MDS revealed that R128 was dependent for transfer from bed to chair or chair to bed. R128's BIMs score was 13 out of 15 which indicated intact cognition. 7/10/24 at 10:32 AM - 7/11/24 at 2:56 PM - Multiple observations of R128 laying in bed. 7/12/24 9:33 AM - During an interview R128 stated he did not get out of bed at any time on 7/11/24. A review of the treatment administration record (TAR) revealed a checkmark with E8 (LPN)'s initials for the treatment order that states, Resident to be out of bed for a minimum of 2 hours every day - Nursing to document and notify Sister . of refusals every day shift. 7/12/24 2:29 PM - During an interview, E25 (CNA) confirmed that R128 was not out of bed on 7/11/24 and they did not offer to get R128 out of bed. 7/12/24 2:31 PM - During an interview E26 (LPN) stated, we have to document about him refusing in the [electronic] notes. 7/17/24 9:19 AM - During an interview E8 confirmed that the checkmark on the treatment administration record for 7/11/24 means that the task was completed and R128 got out of bed. There was a lack of facility documentation of any refusals by R128 to get out of bed on 7/11/24. The facility documented that R128 was out of bed when he was never out of bed on 7/11/24. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0867 Level of Harm - Potential for minimal harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 46988 Based on review of facility documentation, review of cited deficiencies from the facility's annual survey of 7/14/23 and staff interview, it was determined that the facility's Quality Assurance and Performance Improvement (QAPI) program failed to correct previously cited deficiencies. Findings include: 7/11/24 - A review of the facilities undated policy titled, Medication Regimen Review, lacked information regarding the time frames for a pharmacist response, urgent and non-urgent medication recommendations, or a time frame for a facility response to recommendations. 7/11/24 - A review of the 2567 from Annual and Complaint survey dated 7/14/23 revealed a previous deficiency cited for the facilities MRR policy and lack of time frames for response times. 7/12/24 9:48 AM - An interview with E1 (NHA) confirmed the MRR policy provided was current. The facility failed to update the MRR policy per the Plan of Correction dated 9/6/23 which indicated the facility would revise and update policy. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46988 Based on observations, interviews and record review, it was determined that for three (3) (R36, R47 and R461) out of thirty-three (33) reviewed in the investigative sample, the facility failed to ensure a urinary catheter bag was kept off the floor and to ensure staff utilized enhanced barrier precautions (EBP). Findings include: 2023 - A facility policy titled, Enhanced Barrier Precautions- It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). Enhanced barrier precautions refers to the use of gown and gloves for use (sic) during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices) . Policy Explanation and Compliance Guidelines: 7. High-contact resident care activities include: . g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes 1. Review of R47's clinical record revealed: 5/27/16 - R47 was admitted to the facility with diagnoses including: traumatic brain injury and tracheostomy status. 5/22/24 - An annual MDS revealed that R47 required tracheostomy care. 5/5/23 - A careplan for R47 revealed enhanced barrier precautions related to presence of tracheostomy last revised on 3/19/24. 7/16/24 1:55 PM - An interview with E3 (QA and IP) confirmed that supplies for enhanced barrier precautions should be stored in plastic containers in the room and extra supplies are stored in the units linen closets. 7/16/24 2:58 PM - An observation of tracheostomy care completed by E8 (LPN Agency) lacked use of enhanced barrier precautions. E8 failed to utilize a gown or face shield during tracheostomy care with R47. R47's room lacked necessary supplies needed for enhanced barrier precautions. 47621 2. Review of R461's clinical record revealed: 6/13/24 12:18 PM - E33 (MD) documented the successful placement of right upper extremity PICC (peripherally inserted central catheter) line. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/13/24 - R461 was admitted to the facility. 6/13/24 - E34 (NP) ordered Assess PICC line site RUE (right upper extremity) area for any signs of infection and notify MD (medical doctor) every shift in R461's EMR. 6/13/24 - E39 (MD) ordered Enhanced Barrier precautions: related to PICC line and staph infection 1. Gown. 2. Mask 3. Face shield (if splattering expected to occur) 4. Gloves very shift in R461's EMR. 7/2/24 - E28 (NP) ordered piperacillin sod- tazobactam Intravenous solution 4.5 gm - give 4.5 grams IV four times a day related to infection in R461's EMR. 7/15/24 2:09 PM - During medication administration, E35 (LPN) was observed administering R461's 2 PM Piperacillin IVSS dose wearing only gloves, E35 did not have a yellow gown on. 47142 3. Review of R36's clinical record revealed: 1/26/24 - R36 was admitted to the facility. 2/22/24 - A care plan documented that R36 has an indwelling catheter for neurogenic bladder. 4/3/24 - A physician's order for a foley catheter to straight bag drainage for urinary retention. 7/9/24 - Observations of R36's catheter collection bag lying flat on the floor without a privacy bag while R36 was resting in bed at 10:23 AM and 11:14 AM. 7/10/24 11:31 AM - An observation of R36's catheter collection bag was hooked on the wheelchair and the bottom of the collection bag was dragging along the floor while R36 was being pushed in the wheelchair by E15 (COTA). The catheter collection bag did not have a privacy bag cover. An interview with E15 stated she brought R36 back from the large therapy room located off R36's unit and located near the main facility entrance. E15 immediately got a privacy bag, covered the catheter collection bag and hung it off the floor. 7/12/24 9:44 AM - An observation of R36's catheter collection bag was in a privacy bag but touching the floor. E16 (UM) confirmed the catheter collection bag was touching the floor and stated the privacy bag straps are attached to the bed and it is difficult to keep the catheter collection bag off the floor. E16 then manipulated the privacy bag straps and was able to raise the catheter collection bag off the floor. 7/12/24 12:32 PM - An observation of R36's catheter collection bag lying flat on the floor without the privacy bag straps tied to the bed to keep it raised off the floor. An interview with E16 confirmed the catheter collection bag was on the floor. E16 stated she had the collection bag off the floor, the hooks came off the collection bag earlier and she would try something else. 7/12/24 3:05 PM - An interview with E16 revealed that the collection bag was corrected and they used the hooks on the collection bag to attach to the bed frame. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/16/24 12:47 PM - An interview with E3 (QA/IP) revealed that the privacy bags are being evaluated for functionality and they may order different bags. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA) , E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 38302 Based on observation and interview, it was determined that the facility failed to maintain a safe and sanitary environment for staff. Findings include: 7/9/24 12:17 PM - Several pipes in the ceiling area of the clean laundry room were dripping onto the floor and into a trash can that had been placed under a portion of the leaking area. All of the leaking pipes had numerous areas of black staining, which appeared fuzzy in some sections. Three wet and stained towels were on the floor under the areas of the leaks. 7/9/24 1:46 PM - During an interview, E50 (Laundry Staff) confirmed the dripping and standing water and stated that the water had been dripping from the pipes and pooling on the floor for several months. 7/18/24 1:05 PM - Findings were reviewed with E1 (NHA), E2 (DON), E3 (QA/IP), E4 (Corporate RN) and E7 (ADON) at the exit conference.