STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kutz Rehabilitation and Nursing	704 River Road Wilmington, DE 19809

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, it was determined that for one (R23) out of thirty-five residents sampled, the facility failed to provide a special need for a larger bed. R23 rolled out of the bed on to the floor during incontinence care and was transported to the emergency room for evaluation and treatment. Findings include: Cross Refer F689, example 2 A review of R23's clinical record revealed: 8/24/23 - R23 was admitted to the facility with the following diagnoses including, but were not limited to, large body habitus, anxiety, compressed lower back nerves, muscle weakness, nerve pain and osteoporosis. 12/22/24 3:55 AM - A facility incident report documented R23 had a fall that a (CNA) did not assure positioning safety prior to attempting to provide care therefore contributing to the resident's fall onto floor. Resident taken to the ER (sic) for evaluation for complaints of pain returned in 24 hours with no acute findings. 12/22/24 - A facility statement for E40 documented, I was giving [R23] care this morning at 4AM she went to turn to her left side and continued forward out of the bed she had little to no room to actually move well from side to side when asked about a bigger bed for her I was told she was unable to get a bigger bed. 3/19/25 - Review of R23's quarterly MDS assessment for 12/4/24 and 3/5/25 revealed the resident was cognitively intact. 3/20/25 11:53 AM - Review of R23's ADL (activities of daily living) care plan interventions created on 9/23/23 documented . 1. Bed mobility the resident requires by (sic) x1 staff to turn and reposition in bed and as necessary. Further review of R23's care plan revealed an intervention created on 3/18/25 to turn and reposition: 2 person assist with all turns and repositioning for safety. The intervention was added to R23's care plan 3 months after the residents fall on 12/22/24. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/20/25 2:05 PM - During an interview, R23 was observed lying in a standard sized bed on her back with a fall mat on the right and left side of the bed. [R23] stated, I slipped out of the bed I was turning over and I fell out of the bed, the bed is not wide enough for me if I turn over, I am right here on the edge. R23 also stated, I'm afraid when I am being turned in the bed, I'm always on the edge of the bed no matter what, when I fell off the bed, I was right on the edge the aide could not grab me and then after that they put down mats, but I am still afraid of falling. 3/21/25 11:00 AM - During an interview, E2 (DON) stated, [R23] is not bariatric weight we moved her room to give her more space in her room. E2 also confirmed all residents in the building have enablers that are attached on their bed. When E2 was asked about approaches to assist with preventing another fall for R23, E2 stated, I think the CNA was educated on proper turning and repositioning and to be careful when providing care for R23 when in the bed. 3/21/25 1:10 PM - During an interview with E16 (DOR), it was revealed that the current therapy department arrived in October 2024 and that all the beds in the facility had enablers on them. E16, stated and confirmed, [R23] had enablers on the bed in October 2024. Additionally, E16 stated, she is in a standard bed and because she is a large lady it is a tight fit she is afraid when turning in the bed, and nursing said that she does not meet the classification for a larger bed. The facility failed to accommodate R23 a resident that would be more comfortable in a larger bed. 3/24/25 10:30 AM - Findings were reviewed and confirmed with E1 (CEO/LNHA) and E3 (SD). 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1, E2 (DON), E3 and nine department managers/representatives.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. A review of R19's clinical record revealed: 3/3/22 - R19 was admitted to the facility with diagnoses including a stroke which affected his right dominant side, cerebral palsy, and muscle weakness. 1/5/25 - R19's most recent quarterly MDS documented a BIMS' score of 10, which indicated a mild cognitive impairment, and R19 required substantial assistance with toileting. 1/15/25 - A facility's reported incident submitted to the Division documented, that R19 reported to E21 (LSW) at approximately 2:30 PM he asked E22 (CNA) to use the toilet. E22 entered his room and asked, What do you want? R19 stated that he needed to use the bathroom, and E22 replied, Its's too late, you should have asked to go to the bathroom at 2:00 PM. R19 described E22 as yelling at him and being Really mad. R19 also reported that after E23 assisted him onto the toilet, E22 returned and scolded him for attempting to wipe himself. 1/15/25 - During an interview, E23 (CNA) stated, I was coming to duty and I heard E22 talking to the resident [R19] very rudely. I saw that he (sic) very upset, I talked to him to calm him down. 3/13/25 - During an interview, R19 stated, I felt like I was being punished and yelled at by E22 when I asked If I could use the bathroom. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives. Based on interview, observation and record review, it was determined that for two (R19 and R82) out of fourteen residents reviewed for abuse/neglect, the facility failed to ensure that each resident remained free from abuse or neglect from staff. For R82, the facility failed to ensure the resident was free from neglect. For R19, the facility failed to ensure the resident was free from verbal and emotional abuse from a staff member. Findings include: A facility policy titled Resident Abuse Policies and Procedures, revised 12/2023, stated, The facility will prohibit, prevent and not tolerate residents to be subject to abuse, violence, neglect, mistreatment, or misappropriation of property by anyone, including: staff members, other residents, family members, resident representatives, friends, volunteers, consultants, visitors, or any other individuals . 1. Cross Refer F677, example 2 A review of R82's clinical record revealed: 12/9/24 - R82 was admitted to the facility with the following diagnoses left knee fracture, muscle weakness and osteoporosis. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/9/24 11:00 PM - A physician's order for R82 documented, immobilizer to left leg at all times do not bend left knee every shift. 12/16/24 - A review of R82's MDS five day admission assessment documented R82 was cognitively intact and required partial moderate assist for transfers. 12/23/24 2:40 PM - A facility reported incident documented, [R82] reported to E21 (LSW) that on 12/22/24 on 3-11 shift [R82] asked her assigned CNA to assist with transferring out of the bed. Further review of the incident report revealed the CNA told [R82] she could transfer herself and that R82 did not need the CNA's help. Additionally, on 12/31/24 the facility's follow up report documented [R82] reported to E21 (LSW) E38 (CNA) replied to R82's request for help stating, You don't need me, you can do it yourself, you don't need my help and that E38 was nasty when speaking to R82 which caused the resident distress. 3/20/25 12:30 PM - A review of a facility's discipline report titled Performance Conduct Title for E38 dated 10/27/23 documented . 1. Misconduct based on failure to assist a resident for the remainder of the shift and confirmed with video surveillance. In addition, on 12/27/24 E38's facility discipline documented . 2. Termination for misconduct allegation of abuse. 3/21/25 11:00 AM - During an interview E2 (DON) confirmed, review of the video footage of the shift in question revealed E38 did not provide the care that was documented in R82's record. Timeline of video camera footage E38 entered R82's room [ROOM NUMBER]:42:44 PM, E38 exiting at 3:42:59 15 seconds after entering R82's room, E38 entered R82's room [ROOM NUMBER]:15:12 PM E38 exited at 3:52:15 PM 2 minutes and 3 seconds after entering R82's room, E38 entered R82's room [ROOM NUMBER]:02:23 PM and exited at 5:02:46 PM 23 seconds after entering the room. E38 spent a total of 2 minutes and 41 seconds providing care to this resident in a 8 hour shift. [E38] documented in R82's chart for toileting times 3:40 PM, 5:41 PM, 7:30 PM, 8:00 PM, and 9:30 PM. [E38] documented repositioning [R82] at 2:56 PM, 4:41 PM, 6:22 PM, 8:22 PM and 10:00 PM. These times are not shown to have occurred on the video footage. R82 had a left knee fracture and required partial moderate assistance for toileting, bed mobility and transfers. Despite the documentation that E38 was in the room [ROOM NUMBER] minutes would not have been enough time to provide care for R82. 3/21/25 1:28 PM - An interview with E21 revealed [R82] was in a brace that immobilized her leg to extend out and she needed help with transfers. E21 stated, [E38] told [R82] she needed to transfer herself. E21 also stated, [R82] was very upset.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of the facility's Resident Abuse Policies and Procedures, last revised 12/2023, it was determined that the facility failed to develop a written policy and procedure that clearly addressed sections under Identification and Reporting. Findings include: Review of the facility's Resident Abuse Policies and Procedures included, but was not limited to, the following: POLICY . Any allegation of abuse, neglect, mistreatment, injury of unknown origin, suspected commission of a crime, misappropriation of resident property or financial exploitation will be thoroughly investigated and reported . While the facility policy under the separate section for Definitions listed the different types of abuse, neglect, exploitation of residents, the section for Identification lacked evidence that the facility addressed in the written procedures how staff can identify different types of abuse by resident outcomes, such as an unwitnessed injury that was suspicious or multiple injuries over time or unexplained changes in resident behaviors or activities. Under the section for Reporting, the facility failed to clearly delineate the reporting times for abuse, neglect, mistreatment under the Federal and State regulations, whichever is more stringent with the reporting timeframe. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interview, it was determined that for four (R5, R13, R19 and R65) out of fourteen residents reviewed for abuse, the facility failed to report the allegations of neglect/abuse and injury of unknown source to the State Agency within the required timeframe. Findings include: The facility's Resident Abuse Policies and Procedures . Identification- under Delaware State Law, any employee who has reasonable cause to believe that a resident has been abused, mistreated, neglected, or has been subject to misappropriation of funds MUST file a report immediately . If there is reasonable suspicion of a crime, and the events that cause the reasonable suspicion result in serious injury, the report must be made immediately after forming the suspicion as follows: Serious bodily injury- within 2 hours, All others- within 24 hours . Revised 12/2023 1. Review of R5's clinical record revealed: 1/17/18 - R5 was admitted to the facility with diagnosis including, but was not limited to, stroke with left-sided weakness. 11/27/24 - R5's MDS documented that R5 was not able to complete the BIMS cognitive assessment. 1/16/25 Approximately 9:30 AM - E18 (CNA) noted a mark on R5's face and reported it to E15 (LPN). 1/16/25 6:14 PM - E9 (RN) documented in R5's EMR progress notes, During AM care, CNA [E18] noticed a skin tear to mid forehead and notify (sic) nurse. Neuro check completed and within normal limits, MD made aware and treatment order in place, POA also made aware. 1/17/25 10:15 PM - E28 (RN/ADON) reported the incident of alleged injury of unknown source during care to the State Agency. The report of the alleged injury of unknown source was submitted thirty-five hours after this injury of during care was first noted. 3/13/25 2:20 PM - During an interview, R1 (R5's roommate) reported that on 1/16/25 in the early morning when the CNA [E42 (agency CNA)] was turning R5 to perform incontinence care with R5, R5's head struck the enabler bar on the bed. R5 then said, Well, do I have to wear a helmet to get changed? R1 stated that he did not see any other staff in the room until E18 (CNA) came in on day shift and noted the facial skin tear. 2. Review of R13's clinical record revealed: 9/15/22 - R13 was admitted to the facility with diagnoses including, but was not limited to, heart failure and dementia. 3/12/25 11:35 AM - Review of a facility grievance revealed that during a resident led meeting on 4/17/24, R13 reported that on 4/14/24 her CNA [E43 (agency CNA)] stated, You are not coming out of the bathroom until you brush your teeth. R13 explained that she preferred to eat her breakfast and then brush her teeth. Per R13, E43 blocked her from exiting the bathroom and would not listen. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/2/24 5:55 PM - E21 (LSW) reported the incident to the State Agency documenting that the incident of alleged mistreatment occurred on 4/14/24 at 9 AM. The report of the alleged mistreatment was submitted eighteen days after the alleged incident and fifteen days after the facility became aware of the allegation. 3. Review of R65's clinical record revealed: 10/6/23 - R65 was admitted to the facility, with diagnoses including, but were not limited to, heart failure and breast cancer. 3/12/25 11:40 AM - Review of a facility grievance revealed that during a resident led meeting on 4/17/24, R65 reported that on 4/12/24 another resident (R16) was throwing up so she (R65) went to the nurses' station to report it. R65 reported that there were four employees at the nurses' station and one stated that R16's assigned CNA was on dinner break and that the assigned CNA would check on R16 when she returned from her dinner break. 5/2/24 5:03 PM - E21 (LSW) reported the incident of alleged neglect to the State Agency. The report of the alleged neglect was submitted twenty days after the incident and fifteen days after the facility was aware of the allegation. 4. Review of R19's clinical record revealed: 1/15/25 - R19 reported to facility administration including E21 (LSW) that he alleged that E22 (CNA) verbally abused him during an interaction related to his request for assistance to use the toilet. 1/21/25 - The facility reported the incident of verbal abuse to the State Agency. The facility failed to report R19's allegation of verbal and emotional abuse to the State Agency in the required time of 2 hours. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, it was determined that for one (R26) out of fourteen residents reviewed for abuse, the facility failed to report their investigation results to the State Agency within 5 working days of the incident. Findings include: The facility's Resident Abuse Policies and Procedures: . Investigation . Within five days, a follow-up State Incident Report is completed indicating the results of the investigation and sent to the Division of Long Term Care Residents Protection electronically . Revised 12/2023 Review of R26's clinical record revealed: 9/3/20 - R26 was admitted to the facility with diagnoses including, but were not limited to, Parkinson's disease and dementia. 2/19/25 4:10 PM - E21 (LSW) reported an alleged incident of neglect to the State Agency. The report stated that on 2/18/25 at approximately 1 PM, R26 had to wait for an hour to be changed by her assigned CNA on 7-3 PM shift. F3 (R26's POA) reported this incident to the facility on 2/19/25 at 3:23 PM. The five day follow up report to the State Agency was due on 2/26/25. 3/14/25 1:54 PM - E21 filed the five day follow up report with the State Agency eighteen days late. 3/21/25 10:30 AM - E1 (CEO/LNHA) confirmed the incident was reported to the facility on 2/19/25 at 3:23 PM and the five day follow up was entered on the State Agency website on 3/14/25. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1, E2 (DON), E3 (SD/ICP) and nine department managers/representatives.

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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. Deficiency Text Not Available

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, it was determined that for two (R17 and R23) out of thirty-five residents sampled, the facility failed to develop and implement a comprehensive person-centered care plan for R17 that included specific directions for taking vital signs on a resident with a dialysis fistula. For R23, the facility failed to include bed enablers as an intervention on the care plan. Findings include: 1. Review of R17's clinical record revealed: 11/13/23 - R17 was admitted to the facility with diagnosis including, but was not limited to, end stage renal (kidney) disease with a dialysis fistula on his left arm. R17's most current orders included dialysis three times a week, on Mondays, Wednesdays, and Fridays, check vital signs pre- and post-dialysis on these days on both the day and evening shifts. And monthly vital signs on the first three days of each month during the evening shift. R17's most recent care plan included, Monitor vital signs as ordered. R17's dialysis care plan failed to include that the blood pressure should not be taken on the left arm to prevent injury to the fistula. 3/12/25 11:30 AM - Interview with E8 (LPN) stated that she knew to take the blood pressure on residents right arm due to it being in the orders, but there was no documentation of orders in the residents electronic chart. 2. Cross Refer F689, example 2 and F700, example 4 Review of R23's clinical record revealed: 8/24/23 - R23 was admitted to the facility with the following diagnoses including, but were not limited to, large body habitus, anxiety, compressed lower back nerves, muscle weakness, nerve pain and osteoporosis. 12/22/24 - R23 had a fall and was sent to the hospital for evaluation after the fall. 12/23/24 - Review of R23's care plan for an actual fall on 12/22/24 interventions documented . 1. Bed mobility evaluation and education on rolling/self-positioning in bed . 2. Continue interventions on at risk program. R23's care plan lacked evidence of the intervention bed enabler bars added for additional repositioning assistance. 12/31/24 - A review of a facility follow up incident report documented, Bed enabler bars added for additional repositioning assistance. 3/21/25 11:00 AM - During an interview, E2 (DON) stated, [R23's] care plan had not been revised to include enablers after the fall. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.

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F 0684 Level of Harm - 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** 3. A review of R11's clinical record revealed: 3/24/21 - R11 was admitted to the facility. 11/16/24 - R11 was admitted to hospice care. 3/12/25 - A review of the medications on the 2/26/25 hospice plan of care document in the electronic medical record (EMR) compared to the medications that the facility had profiled for R11 in the facility EMR revealed the following discrepancies: -Ativan 0.5 mg by mouth every four hours as needed for agitation that was ordered by hospice on 11/16/24 was on the hospice medication list but not on the current facility medication list. -Miralax 17 grams, 1 scoop daily by mouth for constipation, was ordered by the facility on 11/1/24 was on the facility medication profile, but not on the hospice list of medications. -Omeprazole 40 mg, 1 capsule daily for reflux, was ordered by hospice on 11/16/24 was on the hospice medication list, but not on the current facility medication list. 3/11/25 1:50 pm - During an interview, E17 (RN/UM) confirmed that the hospice medications on R11's 2/26/25 hospice plan of care did not match the current medications that the facility was administering to R11. 4. A review of R18's clinical record revealed: 2/1/23 - R18 was admitted to the facility. 1/4/24 - R18 was admitted to hospice care. 3/12/25 - A review of the medications on the 2/26/25 hospice plan of care document in the R18's chart compared to the medications that the facility had profiled in R18's EMR revealed the following discrepancies: -Sertaline 50 mg, give by mouth daily, was ordered by the facility on 2/2/23, but it was not on the 2/26/25 hospice plan of care medication list. Sertaline is a medication to help mood disorders. -Trazodone 50 mg, give 100 mg by mouth daily at bedtime, was ordered by the facility on 12/12/24, but the dosage was different, it was listed on the 2/26/25 medication list as Trazodone 150mg by mouth daily at bedtime. Trazodone treats sleeping problems and depression. 3/14/25 9:20 AM - During an interview, E2 (DON) confirmed that the hospice medications on the R18's 2/26/25 hospice plan of care did not match the current medications that the facility was administering to R18. 5. A review of R54's clinical record revealed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	12/16/24 - R54 was admitted to the facility, already under the care of hospice. 3/12/25 - A review of the medications on the hospice plan of care document in the R54's chart compared to the medications that the facility had profiled in R54's EMR revealed the following discrepancies: - Trazodone 50 mg ½ tab by mouth daily, ordered by the facility on 12/17/24, was not on the hospice medication list. 3/14/25 9:25 AM - During an interview, E2 (DON) confirmed that the hospice medications on R54's hospice plan of care in the chart did not match the current medications that the facility was administering to R54. The facility failed to ensure that the most recent hospice plan of care included the services furnished by the facility. The most recent hospice care plan medication list for R11, R18 and R54 did not match the medications that R11, R18 and R54 were receiving from the facility.The medication discrepancies between the facility and hospice medications as described above could lead to a delay in symptom treatment for R11, R18 and R54. The facility and the hospice medications should match so that the end-of-life care is seamless and without potential care delays. Based on record review and interview, it was determined that for seven (R7, R11, R18, R24, R54, R63, R80) out of fifteen residents reviewed for quality of care, the facility failed to provide the residents' care in accordance with the professional standards of practice. For R7, the facility failed to monitor R7's vital signs after noting a change in physical status on 10/16/24; failed to ensure the Provider ordered lab work to check R7's phenytoin levels and serum sodium orders were completed. The facility failed to identify and notify the Provider about the low heart rate, which resulted in a delay in care of R7 obtaining the appropriate level of care. The failure to monitor R7's phenytoin level resulted in in a harm as R7 was admitted to the hospital on [DATE] for lethargy and change in mental status with a critically high phenytoin level of 38.5 mg/L. For R63, the facility failed to monitor timely and accurately document the resident's vitals signs after an unwitnessed fall. For R11 and R54, the facility failed to ensure that each residents' most recent hospice plan of care included the services furnished by the facility. For R24, the facility failed to ensure the resident's skin discoloration was identified and assessed. Findings include: 1. Review of R7's clinical record revealed: Cross refer F580, F726, F755 and F760 Desmopressin: The major adverse effect of desmopressin for which to monitor is hyponatremia . Hyponatremia is an absolute contraindication to the administration of desmopressin . The National Library of Medicine, 2025. www.ncbi.nlm.nih.gov Phenytoin, a seizure disorder drug, has a narrow therapeutic range. Therapeutic range is defined as between 10-20 mg/L. Routine monitoring of serum phenytoin levels is not recommended. However, in clinical suspicion of drug toxicity, serum phenytoin levels should be measured. Clinical signs of phenytoin toxicity include: nystagmus, slurred speech, lethargy and confusion among other symptoms . National Library of Medicine, Phenytoin Toxicity 2022 [DATE]:15 (11): e253250. (continued on next page)

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	085043	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	Temperature - may vary with the time of day and method used (axillary slightly lower) 98.6 F (37 C) is considered normal oral temperature, but range is 96.4 F (35.8C) to 99.1 F (37.3C). Pulse - Normal adult pulse (heart rate) is 60 to 80 beats/minute; regular in rhythm. Lippincott Manual of Nursing Practice 11th edition, 2019. 1/10/20 - R7 was admitted to the facility with diagnoses including but were not limited to, seizure disorder, diabetes insipidus and hypopituitarism. 11/16/23 - E4 (contracted MD) ordered in R7's EMR, Dilantin oral capsule 100 mg (phenytoin sodium extended)- give 100 mg by mouth three times a day for seizure disorder. 2023 - R7 had phenytoin levels drawn on 1/24/23, 4/11/23 and 8/3/23. 2/5/24 - E4 ordered in R7's EMR, CBC with diff, phenytoin free blood level, Vitamin D25-OH, total blood level. Fax results to Neurology . The facility failed to provide evidence that these labs were obtained. 8/24/24 - E4 ordered in R7's EMR, Phenytoin (anti-seizure medication) oral capsule 100 mg- give 1 capsule by mouth three times a day for seizures. 8/25/24 - E4 ordered in R7's EMR, Desmopressin Acetate oral tablet 0.1 mg- give 0.5 mg tablet by mouth in the morning for diabetes insipidus. 8/26/24 - The quarterly Minimum Data Set (MDS) documented R7's BIMS (basic Inventory of Mental Status) score as 15, which reflected normal cognition. 9/11/24 - E4 ordered in R7's EMR, BMP, TSH, free T4 one time for hyponatremia, hypothyroid. 9/19/24 12:52 PM - The facility laboratory reported R7's serum sodium level as 132 mmol/L. The normal serum sodium level is 135 to 145 mmol/L. 10/16/24 12:22 AM - E24 (RN/Shift supervisor) documented in R7's EMR progress note, Fall details: Date/Time of fall: 10/15/24 11:50 PM fall was not witnessed .Provider: [E4] Time notified 10/16/24 Notified of: fall . Resident found sitting on the floor legs facing the head board of the bed .Resident stated she was self transferring from wheelchair to the bed, when she fell. VS (vital signs) 154/66, p (pulse) 43, 97.6 T (temperature), 18 rr (respirations), bs (blood sugar) 89 . 10/16/24 1:13 AM - R7's heart rate was documented in the EMR as 43 bpm (beats per minute) (irregular-new onset) and temperature of 97.6 F (Fahrenheit). 10/16/24 3:36 AM - R7's heart rate was documented in the EMR as 43 bpm and temperature 97.7 F. The facility failed to identify that R7's heart rate was low and notify the provider of this change. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	10/16/24 6:45 AM - E10 (LPN) documented in R7's EMR progress note, Resident rang at 2350h (11:50 PM hour), employee went into the room and found the resident sitting on her buttocks on the floor . VS were obtained BP (blood pressure) 154/66, HR 43 SPO2 97%, . 10/16/24 10:45 PM - R7's heart rate was documented in the EMR as 41 bpm and temperature 97.2 F. There were no documented vital signs after 10/16/24 10:45 PM until 10/17/24 1:20 PM, which was thirty-six hours later, despite R7's heart rate being documented as bradycardic at 41 bpm. It should also be noted that the vital signs documented in the hospital transfer note did not include a temperature, respirations, and pulse oximetry. Additionally, the facility failed to monitor R7 with a full set of vital signs including temperature, pulse ox and blood pressure after R7 was documented as having a low heart rate. 10/17/24 1:20 PM - E17 (RN/UM) documented in R7's EMR progress note, resident had a sudden change in mental status. 148/43 BP, 44 HR and extremely lethargic. MD was called, new order to send to ED (emergency department) for evaluation . Resident left the facility at 1320 (1:20 PM) on a stretcher with 2 EMTS (emergency medical technicians) . R7 was transferred to the hospital thirty-six hours after being documented as bradycardic with a heart rate in the 40's. 10/17/24 to 10/28/24 - For eleven days, R7 was hospitalized for mental status change and visual changes. R7's hospital admission diagnoses included: hyponatremia (low serum sodium level) and phenytoin toxicity. R7 presented to the hospital on [DATE] with a phenytoin level of 38.5 mg/L (milligram/Liter) (normal phenytoin range is 10-20 mg/L) and a serum sodium level of 130 (normal sodium range is 135-145). 10/17/24 2:09 PM - C4 (hospital emergency room MD) documented in R7's ED Physician Record, .History of Present Illness: [AGE] year old female .Patient 's sister notes that the patient has been lethargic over the past 2 weeks . 10/17/24 2:18 PM - The hospital laboratory reported R7's serum sodium level as 130 mmol/L, with the normal range being 135 to 145 mmol/L. The facility's failure to monitor R7's vital signs and appropriately respond to her bradycardic heart rate resulted in a delay of obtaining the next level of care for R7. 10/18/24 2:46 AM - The hospital laboratory reported R7's phenytoin level as 38.5 mg/L, which is nearly double the therapeutic range. Review of R7's physician orders for 2024 to date revealed no other order for a phenytoin level until 10/31/24, which was after R7's eleven-day hospitalization from 10/17/24 to 10/28/24 during which R7 was discovered to have phenytoin toxicity. The facility's failure to monitor R7's phenytoin level resulted in R7 experiencing phenytoin toxicity. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	10/18/24 3:39 AM - C1 (hospital emergency room MD) documented in R7's hospital admission history and physical, Upon arrival to the ED (emergency department), vital were remarkable for hypothermia to 33.8 (degrees Celsius) and bradycardia to 42 . she did ultimately require 4 L nasal cannula, however does not require oxygen at home . The documented temperature of 33.8 C was the equivalent of 92.8 F. R7's most recent documented temperature prior to this hypothermic temperature obtained 10/18/24 3:39 AM in the hospital ED was on 10/16/24 at 10:45 PM. The facility failed to obtain a temperature as part of her vital signs when R7 was noted to have a mental status change on 10/17/24 at 1:20 PM. 10/24/24 12:23 PM - C1 (Hospital emergency room MD) documented in R7's discharge summary, . Hypothermia - Patient initially hypothermic with temp (temperature) 33.1 (91.6 F), thought to be secondary to phenytoin toxicity versus adrenal crisis. She (R7) was treated with Bair Hugger (a convective temperature management medical device used in hospitals to maintain a patient's core body temperature) and had symptomatic improvement. 3/24/25 3:54 PM - During a telephone interview, E4 (contracted MD) stated that she was not notified that R7's heart rate was in the 40's in October 2024. She stated that her practice's on-call coverage starts at 5 PM to 8 AM and that she does not typically receive a sign-out of any issues overnight so unless the staff told he or wrote in the doctor's book that R7 was bradycardic in the 40's, there would be no way for her to know. E4 did confirm that R7 was evaluated by a provider on 10/17/24 (the same day that R7 was transferred to the hospital) for nasal congestion but no vital signs were documented in that progress note. The constellation of failing to monitor vital signs, failing to identify and notify a provider about a low heart rate led to a significant time delay in obtaining the appropriate level of care that R7 required during this health crisis. The failure to monitor R7's serum phenytoin levels led to a critically phenytoin level that was diagnosed during R7's 10/17/24 hospitalization. 6. A review of R24's clinical record revealed: 6/27/18 - R24 was admitted to the facility with diagnoses including, but were not limited to paralysis of one side of the body due to a stroke, and blood clots. R24's current physician's orders included Aspirin 81mg, daily, and showers and skin checks on Tuesdays and Fridays on the 3-11 shifts. R24's current ADLs (activities of daily living) records revealed that her baths/showers on were scheduled on Mondays and Thursdays on the 7-3 shift. R24's current care plan documented, . At risk for bleeding related to use of aspirin . The interventions included, Monitor for any signs or symptoms of bleeding, as well as to notify the doctor with any concerns or changes. 3/3/25 - R24's clinical records lacked evidence that a skin check was completed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	3/6/25 11:05 AM - R24 was observed with purple and black discoloration on her left forearm, around the elbow area. 3/6/25 3:46 PM - R24's clinical records documented that a skin assessment was completed but failed to include the purple and black discoloration on the left forearm. 3/11/25 6:52 PM - R24's skin assessment was documented but failed to include the purple and black discoloration on the left forearm. 3/12/25 10:00 AM - During an interview, E2 (DON) stated that R24 had discoloration on the left elbow area, and it should be documented during bi-weekly skin assessments. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives. 2. The facility's policy entitled Fall Prevention Program, last reviewed/revised 2/2025, stated, . 9. In the event of a resident fall, the RN is to assess the resident and document the incident per the following instructions: a. An incident Report is to be completed . b. The 72 hour Fall Risk Assessment is to be completed in [name of electronic medical record system] . i. Document all assessments and actions . It should be noted that although the facility's policy stated that a 72 hour Fall Risk Assessment was to be completed in [electronic medical record system], the actual document nursing staff are currently using to monitor a resident after a fall on every shift for 72 hours was the Post Fall Evaluation (PFE). Review of R63's clinical record revealed: 9/19/24 - R63 was admitted to the facility with diagnoses that included, but were not limited to, dementia, aphasia and history of falls. 10/1/24 at 4:42 PM - A nurse's note documented, Late Entry: Resident found on the floor sitting on his bottom on top of his floor mat between his chair and his bed at 1600 [4 PM]. Resident was assessed no signs of bruises or trauma. There was no evidence of R63's initial vital signs and assessment was obtained and documented in the RN's initial assessment immediately after R63's unwitnessed fall during the evening shift of 10/1/24. 10/2/24 at 1:33 AM - A Post Fall Evaluation by E10 (LPN) documented the following vital signs (VS): - Temperature: [blank] . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- Blood Pressure: 125/72 Date: 10/3/2024 01:34 [1:34 AM] . - Pulse: 79 Date: 10/3/2024 01:34 . - Respiration: 20 Date: 10/3/2024 01:34 . - O2 sats: 98% Date: 10/3/2024 01:34 . - Pain Level: 0 Date: 9/29/2024 07:36 . 10/2/24 8:35 AM - A Post Fall Evaluation by E10 (LPN) documented the following VS: - Temperature: [blank] . - Blood Pressure: 125/72 Date: 10/3/2024 01:36 [1:36 AM] . - Pulse: 79 Date: 10/3/2024 01:36 . - Respiration: 20 Date: 10/3/2024 01:36 . - O2 sats: 98% Date: 10/3/2024 01:36 . - Pain Level: 0 Date: 9/29/2024 07:36 . It should be noted that E10 documented the same vitals signs on both 10/2/24 PFEs timed 1:33 AM and 8:35 AM. 10/2/24 8:37 PM - A Post Fall Evaluation by E10 (LPN) documented the following VS: - Temperature: 98 Date: 10/3/2024 01:38 [1:38 AM] . - Blood Pressure: 119/68 Date: 10/3/2024 01:38 . - Pulse: 73 Date: 10/3/2024 01:38 . - Respiration: 20 Date: 10/3/2024 01:38 . - O2 sats: 98% Date: 10/3/2024 01:38 . - Pain Level: 0 Date: 9/28/2024 07:36 [7:38 AM] . 10/3/24 1:40 AM - A Post Fall Evaluation by E10 (LPN) documented the following VS: - Temperature: 98 Date: 10/3/2024 01:41 [1:41 AM] . - Blood Pressure: 119/68 Date: 10/3/2024 01:38 [1:38 AM] . - Pulse: 73 Date: 10/3/2024 01:38 . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- Respiration: 20 Date: 10/3/2024 01:38 . - O2 sats: 98% Date: 10/3/2024 01:38 . - Pain Level: 0 Date: 9/28/2024 07:36 [7:38 AM] . It should be noted that E10 documented the same vitals signs on both 10/2/24 and 10/3/24 PFEs respectively timed 8:37 PM and 1:40 AM. The facility failed to ensure that vital signs were being accurately captured, monitored and documented every shift for 72 hours by nursing for R63, a dependent, non-verbal resident who had an unwitnessed fall on 10/1/24. 3/20/25 8:10 AM - During an interview, E9 (RN) explained the facility's procedure after a resident falls. When an incident report is started, a Fall Risk Assessment and Post-Fall Evaluation (PFE) forms are automatically triggered and are to be completed by a nurse. E9 stated that Charge Nurses are to complete PFEs every shift for nine (9) shifts [72 hours]. E9 explained that the PFE included entering vital signs, pain level, bruising, confusion, change of condition. E9 explained and showed the Surveyor that the PFE captured the date that it was opened, then the nurse has the ability to select box Finish Later or Complete. Complete button can only be selected if all the information was entered otherwise it remains shaded out and unable to be selected. When the PFE was completed and the nurse clicks the Complete button, then the nurse will check the box to sign, date and exit the form. The PFE form then locks. 3/21/25 at 12:21 PM - Finding was reviewed with E1 (CEO/LNHA) and E2 (DON). Surveyor reviewed the vital signs that were entered on R63's PFEs by E10 (LPN) that were timed on four back-to-back shifts: 10/1/24 - 10/2/24 night shift; 10/2/24 day shift; 10/2/24 evening shift; and 10/2/24 - 10/3/24 night shift. When asked if E10 (LPN) worked four 8-hour shifts back-to-back, E2 (DON) nodded her head no.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on record review and interview, it was determined that for one (R11) out of four residents sampled for range of motion, the facility failed to provide R11 with a right-hand palm guard that was ordered on 5/2/24. Findings include: A review of R11's clinical record revealed: 3/24/21 - R11 was admitted to the facility. 5/2/24 - An order was written in the EMR for R11 to have a right palm guard, to put the palm guard on after morning care, and to take the palm guard off before bedtime. 3/7/25 10:10 AM - During an observation, R11 was not wearing a right-hand palm guard. R11's right hand was contracted, with his fingers pressing into the palm of his hand. The following document review, observation and interviews occurred on 3/10/25: -A review of R11's care plan revealed that R11 was at risk for pain because of . and multiple contractures and decreased mobility. R11 had a diagnosis of a right hand contracture listed on the care plan. -9:30 AM - During an observation, R11 was not wearing a right-hand palm guard. R11's right hand was contracted with his fingers pressing into the palm of his hand. 3/10/25 9:35 AM - During an interview, E50 (CNA) stated that R11 had never worn a right-hand palm guard that she knew of. -A review of the medication and treatment administration record revealed that R11's palm guard did not show as a nursing task to be completed daily. -A review of the CNA Task List revealed that a right-hand palm guard application and removal was not a task for the CNA to do for R11. -10:00 AM - During an interview, E26 (LPN) confirmed that the application and removal of a right-hand palm guard for R11 was not present on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR) as a nursing task to complete. -11:30 AM - During an interview, E9 (RN) confirmed that the 5/2/24 order for a right-hand palm guard was present as an active order for R11, but the reason that the order was not showing on nursing tasks lists was because the 5/2/24 order was entered incorrectly into the EMR. The frequency for the palm guard application and removal was not entered as part of the order entry, which caused it to not show on any nursing task lists. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/14/25 9:20 AM - During an interview, E2 (DON) stated that the process to verify the accuracy of all new orders entered into the EMR is through a daily 24-hour chart check process. The 11-7 overnight nursing staff completes the chart check process and verifies the accuracy of any new order entered the EMR that day. After a review of R11's May 2024 TAR, E2 confirmed that a 24-hour chart check had been completed for R11 5/2/24 new orders. The facility's nursing staff failed to provide R11 with a right-hand palm guard as ordered from 5/2/24, for more than 10 months, or to be aware that there was an active order for R11 to have a right-hand palm guard. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and review of clinical records and other documentation as indicated, it was determined that for four (R63 and R23) out of eight residents reviewed for falls, the facility failed to ensure that each residents' plan of care was followed to prevent accidents. For R63, the facility improperly transferred the resident using one staff person stand and pivot when R63 required two staff persons and hoyer lift. As a result, R63 was harmed when the resident sustained a lower leg laceration requiring sutures in the emergency room. For R23, a dependent resident for bed mobility, rolled off the bed on to the floor during incontinence care. R23 was sent to the emergency room after the fall. Findings include: A facility policy titled Falls revised 3/2025 documented . 1. To institute individualized practices to minimize the resident's risk of falling and to maximize safety from fall; and to assess each resident of their fall risk on admission, and on a regular basis . 2. The fall risk assessment will categorize the risk for falling according to the following criterion: 1. Low - Risk - a fall risk evaluation score of less than 6. 2. High - Risk - a fall risk evaluation score of 6 or greater. 1. Review of R63's record revealed: 9/19/24 - R63 admitted to the facility with diagnoses including, but were not limited to, dementia, aphasia and history of falls. 10/21/24 - A physician's order documented, Hoyer lift transfer assist of two person. 12/5/24 - R63's Fall Risk Evaluation documented that the resident was a high fall risk. 1/3/25 at 11:05 AM - The facility's incident report documented that E20 (CNA) was assisting resident with transfer from bed to wheelchair where he obtained a laceration to right lower extremity. Resident unable to give description . R63's POA and E11 (contracted Physician) were notified. 1/3/25 at 11:49 AM - E20's written statement as part of the facility's investigation documented, . was transferring patient from bed to chair and leg was up against the leg rest connector . blood running down patient leg, along with a (sic) open area . Were you being assisted by anyone . no assistant (sic) from anyone . 1/3/25 at 1:19 PM - The hospital record documented, . suffered a laceration of . right leg while transferring from his bed into . wheelchair . Wound was thoroughly irrigated . and then repaired with . sutures and then Steri-Strips were placed over top of the area . The facility failed to report R63's 1/3/25 incident to the State Agency as required. In response to this incident, the facility did the following: - on 1/6/25, E3 (SD) provided E20 (CNA) one-on-one education and return demonstration for safe resident transfers. The skill competency was documented and signed by both E3 and E20. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3/24/25 10:34 AM - During an interview, E20 confirmed that she stood R63 up to transfer, his feet got twisted, leg was bleeding and he was sent to the emergency room. E20 stated that it was her first day shift and she asked another staff person how R63 transferred and was told stand and pivot transfer. When asked about her training, E20 confirmed that she had training on resident transfers during her orientation in April 2024 and had one-to-one education after R63's incident. 3/21/25 12:21 PM - Finding was reviewed with E1 (CEO) and E2 (DON). 3/25/25 at 1:08 PM - During an interview with E1 and E2 regarding the QAPI efforts in the facility, E1 stated that the facility currently has an ongoing initiative with a high fall risk committee reviewing falls every Monday. 2. R23's clinical record revealed: 8/24/23 - R23 was admitted to the facility with the following diagnoses including, but were not limited to, large habitus (body structure), compressed lower back nerves, muscle weakness, nerve pain, anxiety and osteoporosis. 9/23/23 - R23's care plan for ADL (activities of daily living) self-care performance deficit related to (sic) unspecified abnormalities of gait and mobility with interventions to include: 1. Bed mobility the resident requires (sic) x1 staff to turn and reposition in bed and as necessary. 12/3/24 - R23's quarterly MDS documented, R23 required substantial maximum assistance to roll from lying on back to left and right side and return to lying on back on the bed. 12/3/24 - R23's fall risk evaluation revealed a score of 7 and was a high risk for falls. 12/4/24 - R23's quarterly MDS assessment revealed the resident was cognitively intact. 12/22/24 - R23's fall risk evaluation revealed a score of 7 and was a high risk for falls. 12/22/24 3:55 AM - A facility incident report documented, CNA did not assure resident positioning safety prior to attempting to provide care therefore contributing to the resident's fall onto floor. [E40] CNA assigned to educational courses for resident safety. Resident taken to ER (sic) for evaluation for complaints of pain and returned to facility within 24 hours with no acute findings. Bed enablers applied for additional positioning assistance. 12/22/24 - A facility statement for E40 (CNA) documented, I was giving [R23] care this morning at 4 AM she went to turn to her left side and continued forward out of the bed she had little to no room to actually move well from side to side when asked about a bigger bed for her I was told she was unable to get a bigger bed. 3/5/25 - R23's quarterly MDS assessment revealed the resident was cognitively intact. 3/18/25 - R23's care plan created on 9/23/25 was updated with a new intervention to turn and reposition: two-person assist with all turns and repositioning for safety. (continued on next page)

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	085043	A. Building B. Wing	03/26/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The intervention was added to R23's care plan at least three (3) months after the residents fall from the bed on 12/22/24. 3/20/25 2:05 PM - During an interview, R23 was observed lying in a standard sized bed on her back with a fall mat on the right and left side of the bed. R23 stated, I slipped out of the bed I was turning over and I fell out of the bed, the bed is not wide enough for me if I turn over, I am right here on the edge. R23 also stated. I'm afraid when I am being turned in the bed, I'm always on the edge of the bed no matter what, when I fell off the bed, I was right on the edge the aide could not grab me and then after that they put down mats, but I am still afraid of falling. 3/21/25 11:00 AM - During an interview E2 (DON) stated, [R23] is not bariatric weight we moved her room to give her more space in her room. E2 also confirmed all residents in the building have enablers that are attached on their bed. When E2 was asked about approaches to assist with preventing another fall for R23, E2 stated, I think the CNA was educated on proper turning and repositioning and to be careful when providing care for R23 when in the bed. 3/21/25 1:10 PM - During an interview with E16 (DOR), it was revealed that the current therapy department arrived in October 2024 and that all the beds in the facility had enablers on them. E16 stated and confirmed, [R23] had enablers on the bed in October 2024. Additionally, E16 stated, she is in a standard bed and because she is a large lady it is a tight fit she is afraid when turning in the bed, and nursing said that she does not meet the classification for a larger bed. The facility failed to ensure R23's safety when E40 asked R23 to turn in the bed during incontinence care and R23 rolled off the bed on to the floor. The resident was sent to the hospital emergency room after the fall. R23's ADL care plan intervention was not updated for 2 person staff assist for turn and reposition with all turns and repositioning for safety until 3/18/25. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 3. Review of R27's clinical record revealed: 4/12/21 - R27 was admitted to the facility. 3/7/25 9:00 AM - An observation revealed side rails (enablers) present on both sides of R27's bed. 3/10/25 9:30 AM - An observation revealed side rails (enablers) present on both sides of R27's bed. 3/12/25 - A review of R27's clinical records revealed the lack of the following documentation: -Bed rail use assessments, including appropriate alternatives to the bed rails/enablers, risk of entrapment in the bed rail/enabler, and the risks versus benefits of the use of bed rails/enablers. -Informed consent. 3/13/25 10:31 AM - During an interview, E16 (contracted DOR) stated that an effort to obtain assessments for the facility bed rails/enablers was in progress, but that there were no bed rail/enabler assessments that her department had completed for any resident at that point. 2. Review of R47's clinical record revealed: 2/3/21 - R47 was admitted to the facility with diagnoses that included, but were not limited to, hemiplegia and hemiparesis following a stroke affecting the right dominant side and a cognitive communication deficient. 1/9/25 - The annual MDS assessment documented that R47 had a functional limitation in range of motion on one side of upper extremity and both sides on lower extremities. 3/18/25 9:08 AM - Observation of R47 in bed with bilateral 1/4 enablers positioned up. 3/18/25 9:16 AM - During an interview, E16 (contracted DOR) confirmed that no bed rail assessment has been completed for R47 at this time. E16 also stated that her therapy company, which started providing services in November 2024, does not have access to the previous therapy provider records. 3/18/25 10:35 AM - During an interview, E34 (CNA) stated that R47 uses the bed enablers with only his good arm (left). E34 stated that R47 cannot use his right arm or right leg. E34 stated that when she rolls him over toward the window (on the right side), R47 was able to use the right enabler to hold onto with his left hand; however, when he rolls over on his left side, R47 cannot use his right hand to grab the left sided enabler although he tries to grab it with his left hand. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/18/25 10:43 AM - During an interview, E35 (LPN) was asked if she could provide the surveyor with R47's signed consent for the use of bed enablers. E35 reviewed R47's electronic clinical record and was unable to locate the signed consent. E35 stated that she would have to talk to therapy. The surveyor mentioned that the current therapy provider does not have access to the prior therapy company's documentation. E35 then said that she would have to elevate this request to someone higher that has access to the resident's therapy records. 3/21/25 11:30 AM - During a combined interview, finding was reviewed with E1 (CEO/LNHA) and E2 (DON). No further documentation was provided to the surveyor. The facility failed to ensure R47 was assessed for bilateral bed enablers and a signed consent was obtained before placing bilateral enablers on the resident's bed. Based on record review, observation and interview, it was determined that for four (R5, R23, R27, R47) out of four residents reviewed for bedrails, the facility failed to assess the residents prior to installing the bedrails/enablers and failed to obtain consent from the resident/POA/resident representative. Findings include: 1. Review of R5's clinical record revealed: 1/3/23 - R5 was admitted to the facility with diagnoses including, but was not limited to, stroke with left-sided weakness. 3/12/25 9:29 AM - The surveyor observed R5 lying in his bed, which had bilateral enablers at the head of the bed. 3/13/25 12:01 PM - The surveyor observed R5 lying in his bed, which had bilateral enablers. 3/20/25 4:10 PM- The surveyor requested evidence of therapy's assessment of R5 for the bedrail/enabler and a copy of the POA's consent for enablers. The facility was not able to produce evidence of R5's assessment by therapy for bedrails/enablers nor a copy of the consent from R5's POA for installing bedrails/enablers on his bed. 3/24/2511:24 AM - During an interview, E16 (contracted DOR) stated, We don't have a consent or assessment. 4. Review of R23's clinical record revealed: 8/24/23 - R23 was admitted to the facility with the following diagnoses including, but were not limited to, large body habitus, anxiety, compressed lower back nerves, muscle weakness, nerve pain and osteoporosis. 3/6/25 10:34 AM - An observation revealed bilateral enablers on R23's bed. 3/21/25 11:00 AM - During an interview E2 (DON) stated, We didn't know that a side rail assessment or consent was needed for a resident to have enablers on their bed. We are starting the process for the assessment for side rails and consent, therapy is now starting the evaluations for the enablers. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/21/25 1:10 PM - During an interview E16 (contracted DOR) stated, We are starting to do the enabler evaluations for the residents that are curently on therapy case load. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. Cross refer to F760, example 4 On 10/28/24 at 2:10 PM, the facility reported the following medication error incident to the State Agency: On Monday, October 7, 2024 nursing supervisor informed DON that medications had been found on a medication cart and left un-administered. Supervisor investigated and found that all medications had been documented as 'Administered'. Schedule review showed that LPN [name of E46] had been assigned to the residents whose medications were left un-administered . The incident occurred on 10/3/24 day shift and involved the following four residents: R4, R47, R52 and R84. 11/4/24 - The facility's 5-day follow-up investigation submitted to the State Agency reported: . the facility is able to SUBSTANTIATE . The facility discharged E46 (LPN) on 10/9/24 from working in the facility for progressive disciplines r/t [related to] medication administration resulting in termination. Review of E46's discipline record revealed previous medication administration occurrences: - 5/30/24 Medication Administration Error: E46 did not administer an anticonvulsant medication prescribed for an unidentified resident's seizure disorder as it was found in the medication cart still in the packaging. Medication was administered two hours after it was due. E46 received verbal coaching documented in E46's file on 6/4/24. - 9/18/24 Falsification of Medical Records: E46 documented administration of medication and assessments on an unidentified resident that was not in the building. E46 received a FINAL written coaching with a day off without pay and was documented in E46's file on 9/19/24. - 10/9/24 Falsification of Medical Records: On 10/3/24, E46 documented administration of medication for four residents which were later found in the medication cart during the next shift. E46 was terminated and documented in her file on 10/10/24. 3/21/24 10:26 AM - Surveyor requested evidence of E46's competency for medication administration since her hire date of 3/4/24. 3/26/25 2:00 PM - During an interview, E3 (SD/RN) confirmed that the facility did not have a medication administration competency for E46. The facility failed to ensure that E46 had a medication administration competency since her hire date of 3/4/24. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, record review and interview, it was determined that for five (R4, R47, R52, R68 and R84) out of fourteen residents reviewed for medications, one (R7) out of eight residents reviewed for falls, the facility failed to have competent nursing staff to meet the needs of the residents. For R7, the facility failed to ensure the licensed nurses had the specific competencies to recognize when R7 became bradycardic from 10/16/24 to 10/18/24. For R68, the facility failed to ensure the licensed nurse had the specific competencies to administer IVSS medication. For R4, R47, R52 and R84, the facility failed to ensure a nurse had a medication administration competency when each resident was not administered prescribed medications. Findings include: Facility's Orientation policy: It is the policy of this facility to develop, implement, and maintain an effective orientation process for all new staff ., consistent with their expected roles . 5. Checklists will be used to document training and competency evaluations during the orientation process . 11. All documentation to support completion of the orientation process shall be maintained in the employee's educational file. Date reviewed/revised 2/2025. 1. Cross refer F580, F684, F755 and F760 Review of R7's clinical record revealed: 1/10/20 - R7 was admitted to the facility with diagnoses including, but were not limited to, seizure disorder and hypopituitarism. 10/16/24 12:22 AM - E24 (RN/shift supervisor) documented in R7's EMR progress note, Fall details: Date/Time of fall: 10/15/24 11:50 PM fall was not witnesses . Provider: [E4] Time notified 10/16/24 Notified of: fall . Resident found sitting on the floor legs facing the head board of the bed . Resident stated she was self transferring from wheelchair to the bed, when she fell. VS (vital signs) 154/66, p (pulse) 43, 97.6 T (temperature), 18 rr (respiratory rate), bs (blood sugar) 89 . 10/16/24 1:13 AM - R7's heart rate was documented in the EMR as 43 bpm (beats per minute) (irregular-new onset). 10/16/24 3:36 AM - R7's heart rate was documented in the EMR as 43 bpm. 10/16/24 6:45 AM - E10 (LPN) documented in R7's EMR progress note, Resident rang at 2350h (11:50 PM), employee went into the room and found the resident sitting on her buttocks on the floor . VS were obtained BP (blood pressure) 154/66, HR 43 . 10/16/24 10:45 PM - R7's heart rate is documented in the EMR as 41 bpm. 10/17/24 1:58 PM - C4 (hospital emergency room MD) documented in R7's heart rate as 42. R7 was documented in her EMR as having a low heart rate in the 40's from 10/15/24 at 11:50 PM until 10/16/24 at 10:45 PM, which was almost 24 hours in duration. R7 was found to be bradycardic with a heart rate of 42 upon arrival to the hospital emergency room on [DATE] at 1:58 PM. Review of R7's EMR progress notes revealed no mention of R7's low heart rate other than documentation of the number by any of staff that cared for R7 from 10/15/24 night shift until 10/17/24 dayshift when R7 was sent to the hospital for a change in mental status. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/21/25 10:10 AM - Review of E10 (LPN)'s skills checkoff for vital signs revealed that E10, who was hired on 1/22/24 and cared for R7 on 10/16/24 night shift, was signed off by her preceptor [E28 (ADON)] on each skill. However, the form was not signed or dated as completed by the assessor, nor was a final score documented. Additionally, E10 did not fill in the five test questions at the bottom of the checkoff sheet. Question four was pertinent to this situation as it asked 4. The appropriate pulse range for an adult is: _____ to _____ beats per minute. For E24, who worked as the RN supervisor on night shift on 10/16/24, the facility was not able to produce any skills checkoff list for this employee. 3/21/25 3:45 PM - During an interview, E3 (SD/ICP) stated that E24 was hired prior to her and therefore, she does not have copies of her skills checkoff lists. The facility was unable to provide evidence that these two nurses had the specific competency to recognize that R7's heart rate was too low and needed to be intervened upon. 2. Cross refer F760, example 1 and F940 Review of R68's clinical record revealed: 12/5/24 - R68 was admitted to the facility with diagnoses including, but were not limited to, Parkinson's disease, diabetes and osteomyelitis of the vertebrae and sacral region. 1/14/25 - E4 (contracted MD) ordered in R68's EMR, Piperacillin Sod- Tazobactam (Zosyn) solution 4.5 gm - Give 4.5 gm intravenously every 6 hours for wound infection. As a result of this order, February 2025 Medication Administration Record (MAR) scheduled R68 to receive this antibiotic at 12 midnight, 6:00 AM, 12:00 PM and 6:00 PM. 2/11/25 approximately 3 PM - During change of shift report, E14 (LPN) reported to E29 (LPN) that she [E14] gave IVSS (intravenous soluset solution) Zosyn at both 8:30 AM and 1:19 PM. E29 alerted [E30] RN supervisor of the incorrect timed medication error. Review of R68's February 2025 MAR revealed E14 signed out the 1:19 PM Zosyn dose at the 1200 time slot but did not document the 8:30 AM dose on the MAR. Further review revealed E29 documented appropriately holding the 6 PM Zosyn dose as was instructed by E4 when she was alerted to this medication error. 3/17/25 1:34 PM - During an interview, E14 (LPN), who was a new nurse and was hired on 7/23/24, stated, I was pulled to the 400 unit. It was the first time that I worked there. I had never given an IVSS antibiotic before . I was not trained about IV (intravenous) antibiotics during orientation because we did not have anyone in the building with IV antibiotics . The facility was not able to provide evidence of E14's skills checkoff with regard to medication administration: intravenous. 3/21/25 3:45 PM - During an interview, E3 (SD/ICP) confirmed that that the facility did not have a skills checkoff for Medication Administration: Intravenous for E14. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility failed to ensure E14 had the specific competencies to administer medications to R68.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 2. Review of R7's clinical record revealed: Cross refer F580, F684, F726 and F760 1/10/20 - R7 was admitted to the facility with diagnoses including, but were not limited to, seizure disorder, diabetes insipidus, central blindness and hypopituitarism. 10/28/24 Monday - R7 readmitted to the facility after a hospitalization. 10/28/24 - E4 (contracted MD) ordered in R7's EMR, Cortef (hydrocortisone) oral tablet 10 mg - give 1 tablet by mouth one time a day for hypopituitarism. 10/29/24 9:56 AM - E7 (LPN) documented in R7's EMR, Cortef oral tablet 10 mg . for hypopituitarism . Medication n/a (not available). 10/29/24 1:21 PM - E7 (LPN) documented in R7's EMR, Cortef oral tablet 5 mg . for hypopituitarism . Medication n/a (not available). 10/30/24 9:10 AM - E26 (LPN) documented in R7's EMR, Cortef oral tablet 10 mg . for hypopituitarism . awaiting arrival. 10/30/24 2:20 PM - E26 (LPN) documented in R7's EMR, Cortef oral tablet 5 mg . for hypopituitarism . awaiting arrival. 10/31/24 10:48 AM - E7 (LPN) documented in R7's EMR, Cortef oral tablet 10 mg . for hypopituitarism . awaiting pharmacy delivery. 10/31/24 2:04 PM - E7 (LPN) documented in R7's EMR, Cortef oral tablet 5 mg . for hypopituitarism . awaiting pharmacy delivery. 10/31/24 11:03 AM - R7's facility lab results reported serum sodium level as 153 mmol/L (normal range 135-145 mmol/L). 11/1/24 8:17 AM - E27 (RN) documented in R7's EMR, Cortef oral tablet 10 mg . for hypopituitarism . not available in passport machine. 11/1/24 2:45 PM - E27 (RN) documented in R7's EMR, Cortef oral tablet 5 mg . for hypopituitarism . N/A (not available) waiting for pharmacy delivery. R7 missed nine doses of her ordered Cortef (hydrocortisone). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11/1/24 Friday 2:53 PM - E27 (RN/ADON) documented in R7's EMR as a communication with physician, Situation: Medication (hydrocortisone) unavailable per pharmacy, uncovered by insurance. Background: Sodium level high as result. Per Endocrinology, should be sent to emergency department for assessment and treatment. Assessment (RN)/ Appearance (LPN): Lethargy presented as longer response on questions. Recommendations: Physician [E4] to send e-script for hydrocortisone to commercial pharmacy [name of pharmacy] for family to self-pay/private pay and bring in to (sic) facility. Per physician, consulted and confirmed with endocrinology, this will avoid emergency room visit. Endo (endocrinology) also requesting to increase fluid intake by 500 ml and obtain urine for a specific gravity to potentially adjust medication. 11/1/24 2:57 PM - E27 documented in R7's EMR communication with family, Family notified of need for medication (Hydrocortisone) and that resident has not received this medication due to pharmacy not making the medication delivery. Per pharmacy, the medication is not covered by insurance any longer. Family requested to have prescription sent to commercial pharmacy for self-pay/private pay by family who will supply to the facility. 11/1/24 4:49 PM - E27 documented in R7's EMR, Resident father delivered bottle of 45 hydrocortisone tabs at 10 mg with direction to take 1.5 tabs twice daily. Counted and verified by [E27]. Bottle has two refills. Orders placed in PCC (point click care). 3/21/25 11:41 AM - During a telephone interview, E19 (contracted consultant pharmacist) stated, I don't have anything to do with supplying the medications. 3/24/25 10:15 AM - During an interview, E26 (LPN) stated, the pharmacy was not sending the medication. 3/24/25 11:46 AM - During a telephone interview, C2 (contracted pharmacy pharmacist director) stated, Cortef is a pretty common drug and the pharmacy should have it on hand. C2 stated that R7's Cortef order was ordered and only profiled on 10/28/24 as the medication required a prior authorization. 3/24/25 3:54 PM - During a telephone interview, E4 (contracted MD) stated that due to the hydrocortisone not being available, she reached out and spoke with R7's endocrinologist (C3) who informed her that if R7 did not receive the medication by 11/1 afternoon, she should be sent to the hospital emergency room for care. 3/25/25 10:54 AM - During a telephone interview, E19 (contracted consultant pharmacist) stated that he was unaware that R7's Cortef was not available from 10/28/24 to 11/2/24. He stated that the facility does not tell him if there are issues with obtaining medications due to prior authorizations being required. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives. Based on record review and interview, it was determined that for two (R41 and R7) out of fourteen residents reviewed for pharmacy services, the facility failed to provide pharmaceutical services to meet the needs of each resident. Findings include: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's policy and procedure for Unavailable Medications: . 4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable: a. Determine the reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. B. Notify the physician of the inability to obtain the mediation upon notification or awareness that the medication is unavailable . c. Notify the Nurse Supervisor/Unit manager of delay, so they can escalate the issue. Date revised: 3/2025 1. Review of R41's clinical record revealed: 10/21/23 - R41 was admitted to the facility with multiple diagnoses including human immunodeficiency virus (HIV) disease and chronic obstructive pulmonary disease (COPD). The following medications were ordered on 10/21/23: -Dovato Oral Tablet 50-300 mg, give one tablet daily for antiviral. -Formoterol Fumarate Inhalation Nebulization Solution 20mcg/2ml, inhale 2 ml orally two times a day for COPD. 3/25/25 -The following chart documents were reviewed for the medications Dovato and Formoterol: Dovato: Review of Medication Administration Record (MAR) for January 2025, February 2025 and March 2025 revealed that the antiviral medication Dovato was not administered to R41 on the following dates: 1/13/25, 1/14/25, 2/15/25, 2/16/25, 2/18/25, 2/19/25, 3/24/25 and 3/25/25. The MAR for the Dovato administration for dates above had the charting code 9 listed in each date. Review of the chart coding section of the MAR revealed that 9 meant: Other/See Progress Notes. Review of progress notes for several of the missed doses of Dovato medication revealed the following: 1/14/25 9:56 AM - Orders Administration Note: .Medication not available, awaiting pharmacy delivery. 2/16/25 10:49 AM - Called pharmacy regarding Dovota (sic). Per pharmacy, Dovota (sic) needs to be ordered from their supplier and should be available tomorrow. Md and primary nurse made aware. 2/17/25 3:42 PM - Dovato is out of stock at pharmacy. This writer spoke with the pharmacy today. They will try and get medication through there (sic) backup pharmacy. 2/19/24 2:44 PM - Call out to pharmacy, med is on back order not sure when it will be ordered. MD made aware. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/25/25 9:18 AM - Spoke with pharmacy, medicatipon (sic) is on order and will be sent out as soon as they receive medication. Formoterol: Medication Administration Record (MAR) for February 2025 and March 2025 revealed that Formoterol was not administered to R41 on the following dates and times: 2/6/25 AM, 2/23/25 AM, 2/26/25 AM, 3/17/25 PM thru 3/22/25 AM. -Progress notes for several of the missed doses of Formoterol medication revealed the following: 2/23/25 6:08 AM - Medication has not arrived. Pharmacy called multiple times and no answer. Message left for on call but no answer 3/17/25 3:17 - Formotorol not available from pharmacy or back up 3/25/25 10:15 AM - During an interview, E9 (RN) confirmed the dates and times of the missed doses of Dovato and Formpterol. The facility failed to ensure resident medications were available.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4.Review of R41's clinical record revealed: Cross refer F755, example 1 10/21/23 - R41 was admitted to the facility with multiple diagnoses, including human immunodeficiency virus (HIV) disease and chronic obstructive pulmonary disease (COPD). R41's medication orders included the following: -Dovato Oral Tablet 50-300 mg, give one tablet daily for antiviral. -Formoterol Fumarate Inhalation Nebulization Solution 20mcg/2ml, inhale 2 ml orally two times a day for COPD. 3/25/25 - A review of the Medication Administration Record (MAR) revealed that Dovato and Formoterol medications were not administered on the following dates: Dovato 1/13/25, 1/14/25, 2/15/25, 2/16/25, 2/18/25, 2/19/25, 3/24/25, and 3/25/25. Formoterol 2/6/25 AM, 2/23/25 AM, 2/26/25 AM, 3/17/25 PM thru 3/22/25 AM. 3/25/25 10:15 AM - During an interview, E9 (RN) confirmed the missing doses of medication of Dovato and Formoterol. 3/26/25 11:45 AM - Finding was reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives. Based on record review and interview, it was determined that for four (R7, R17, R41 and R68) out of fourteen residents reviewed for medications, the facility failed to ensure the residents were free from significant medication errors. For R68, the facility failed to prevent R68 from receiving three doses of Zosyn in six hours on 2/11/25. For R7, the facility failed to obtain R7's cortef (a critical med) from 10/28/24 to 11/2/24. For R17, the facility failed to have available R17's sevelamer medication causing R17 to miss twenty-seven out of seventy-two opportunities for this medication administration from 3/10/25 to 3/25/25. For R41, the facility failed to have the resident's Dovato and Formoterol medications available. Findings include: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's Medication Administration Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physicians and in accordance with professional standards of practice, in a manner to prevent contamination or infection . 10. Ensure that the six rights of medication administration are followed: a. right resident, b. right drug, c. right dosage, d. right route, e. right time, f. right documentation. 11. Review MAR (Medication Administration Record) to identify medication to be administered . Date reviewed/revised 12/2024. 1. Review of R68's clinical record revealed: Zosyn is an antibiotic combination of piperacillin and tazobactam, which are penicillin class antibiotics that are used to fight infections caused by bacteria. www.drugs.com/zosyn.html January 2025 12/5/24 - R68 was admitted to the facility with diagnoses including, but were not limited to, Parkinson's disease, diabetes and osteomyelitis of the vertebrae and sacral region. 1/14/25 - E4 (contracted MD) ordered in R68's EMR, Piperacillin Sod- Tazobactam (Zosyn) solution 4.5 gm - Give 4.5 gm intravenously every 6 hours for wound infection. As a result of this order, February 2025 Medication Administration Record (MAR) scheduled R68 to receive this antibiotic at 12 midnight, 6:00 AM, 12:00 PM and 6:00 PM. 2/11/25 approximately 3 PM - During change of shift report, E14 (LPN) reported to E29 (LPN) that she [E14] gave IVSS (intravenous soluset solution) Zosyn at both 8:30 AM and 1:19 PM. E29 alerted [E30] RN supervisor of the incorrect timed medication error. Review of R68's February 2025 MAR revealed E14 signed out the 1:19 PM Zosyn dose at the 1200 time slot but did not document the 8:30 AM dose on the MAR. Further review revealed E29 documented appropriately holding the 6 PM Zosyn dose as was instructed by E4 when she was alerted to this medication error. On 2/11/25, R68 received three doses of IVSS Zosyn between 6 AM and 1:19 PM, when R68 should have only received two doses during this time period. The third dose was given on the night shift at aprroximately 5:30 AM, prior to E14 (LPN) assuming care fo R68. 3/17/25 1:34 PM - During an interview, E14 (LPN), who was a new nurse and was hired on 7/23/24, stated, I was pulled to the 400 unit. It was the first time that I worked there. I had never given an IVSS antibiotic before. I asked a nurse to help me at 9 AM and we hung the med [Zosyn] and ran it. Then I did it alone at the 12 noon dose We did not check the MAR for the 9 AM dose . 2. Review of R7's clinical record revealed: Cross refer F580, F684, F711, F726 and F755 1/10/20 - R7 was admitted to the facility with diagnoses including, but were not limited to, seizure disorder, diabetes insipidus and hypopituitarism. 10/28/24 - E4 (contracted MD) ordered in R7's EMR, Cortef oral tablet 10 mg (hydrocortisone)- give 1 tablet by mouth one time a day for hypopituitarism and Cortef oral tablet 5 mg (hydrocortisone)- give 1 tablet by mouth one time a day for hypopituitarism. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R7's October 2024 MAR revealed E7 (LPN) documented on 10/29/24 and 10/31/24 at both the 9 AM 10 mg Cortef and the 12 PM 5 mg Cortef doses 9, which per the MAR legend means other/See progress notes. E26 (LPN) documented on 10/20/24 at both the 9 AM 10 mg Cortef and the 12 PM 5 mg Cortef doses 9, which per the MAR legend means other/See progress notes. 10/29/24 9:56 AM - E7 (LPN) documented in R7's EMR, Cortef oral tablet 10 mg . for hypopituitarism . Medication n/a (not available). 10/29/24 1:21 PM - E7 (LPN) documented in R7's EMR, Cortef oral tablet 5 mg . for hypopituitarism . Medication n/a (not available). 10/30/24 9:10 AM - E26 (LPN) documented in R7's EMR, Cortef oral tablet 10 mg . for hypopituitarism . awaiting arrival. 10/30/24 2:20 PM - E26 (LPN) documented in R7's EMR, Cortef oral tablet 5 mg . for hypopituitarism . awaiting arrival. 10/31/24 10:48 AM - E7 (LPN) documented in R7's EMR, Cortef oral tablet 10 mg . for hypopituitarism . awaiting pharmacy delivery. 10/31/24 2:04 PM - E7 (LPN) documented in R7's EMR, Cortef oral tablet 5 mg . for hypopituitarism . awaiting pharmacy delivery. Review of R7's November 2024 MAR revealed E27 (RN) documented on 11/1/24 at both the 9 AM 10 mg Cortef and the 12 PM 5 mg Cortef doses 9, which per the MAR legend means other/See progress notes. 11/1/24 8:17 AM - E27 (RN) documented in R7's EMR, Cortef oral tablet 10 mg . for hypopituitarism . not available in passport machine. 11/1/24 2:45 PM - E27 (RN) documented in R7's EMR, Cortef oral tablet 5 mg . for hypopituitarism . N/A (not available) waiting for pharmacy delivery. R7 missed nine doses of her ordered Cortef (hydrocortisone). 3/24/25 10:45 AM - During an interview, E26 stated, The pharmacy was not sending the med [Cortef]. 3/24/25 11:46 AM - During a telephone interview, C2 (contracted pharmacist) stated, The electronic transfer of R7's Cortef was on 10/28/24. It is a pretty common drug and the pharmacy should have it on hand. C2 stated that R7's Cortef was ordered and only profiled on 10/28/24 as the medication required a prior authorization. 3/24/25 1:38 PM - During a telephone interview, F1(R7's family member) stated, The doctor [E4] called in a prescription to [local pharmacy]. [F2, R7's family member] went to [local pharmacy] and paid out of pocket for the medication . No, we were not reimbursed . 3/24/25 2:30 PM - During a telephone interview, C3 (local [pharmacy] pharmacist) stated, According to our records, they [F2] paid cash so they would not need a prior authorization. The script (prescription) was filled on 11/29/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Review of R17's clinical record revealed: 1/23/20 - R17 was admitted to the facility with diagnoses including, but was not limited to, end stage renal disease with dependence on renal dialysis. 12/27/23 - R17 was ordered in his EMR, Sevelamer Carbonate oral packet 2.4 gm- give 1 packet via PEG (percutaneous endoscopic gastrostomy) tube with meals for ESRD (end stage renal disease). 3/10/25 12:58 PM - E8 (LPN) documented in R17's EMR progress notes, Spoke with pharmacy, medication [sevelamer] will be sent out on next run. Made MD aware. NNO (no new orders). 3/10/25 1:01 PM - E31 (LPN) documented in R17's EMR progress notes, Sevelamer carbonate oral packet . not available. 3/11/25 7:12 PM - E32 (LPN) documented in R17's EMR progress notes, Sevelamer carbonate oral packet 2. 5 gm, not available, on order from pharmacy. 3/14/25 11:44 AM - E9 (RN) documented in R17's EMR progress notes, Message left for the nurse at the Nephrology office in reference to the pharmacy needing prior [NAME] (sic) in order for him [R17] to continue to receive his sevelamer Carbonate oral packet 2.4 gm. Awaiting return call. 3/14/25 6:21 PM - E32 documented in R17's EMR progress notes, Sevelamer ., not available from pharmacy . 3/15/25 6:03 PM - E31 documented in R17's EMR progress notes, Sevelamer . not available. 3/16/25 6:48 PM - E31 documented in R17's EMR progress notes, Sevelamer . not available. 3/17/25 4:37 PM - E32 documented in R17's EMR progress notes, Sevelamer . on order from pharmacy . 3/18/25 5:42 PM - E32 documented in R17's EMR progress notes, Sevelamer . not available from pharmacy . 3/19/25 11PM - E33 (LPN) documented in R17's EMR progress notes, Sevelamer . call out to pharmacy regarding med availability, med is being reordered this evening and will be out on next available run per [pharmacy staff] from pharmacy. 3/20/25 8:57 AM and 11:29 AM - E8 documented in R17's EMR progress notes, Sevelamer . Medication on back order per pharmacy. MD made aware. NNO (no new orders) for a (sic) interchangeable medication. 3/20/25 6:15 PM - E32 documented in R17's EMR progress notes, Sevelamer . not available from pharmacy. Pharmacy called . 3/21/25 6:06 PM - E32 documented in R17's EMR progress notes, Sevelamer . on back order from pharmacy . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/24/25 9:24 AM - E9 (RN) documented in R17's EMR progress notes, Call nephrology in references to Sevelamer not covered through his [R17} insurance. Therefore, the medication is not delivered to us. Message left for the second time with Nephrology and awaiting return call. 3/24/25 3:24 PM - E9 documented in R17's EMR progress notes, Spoke with nurse from Dialysis in reference to Sevelamer not been (sic) covered by his [R17's} insurance and prior auth needs to be send (sic) to pharmacy in order for prescription to be filled. [E11 (contracted MD)] made aware. The facility failed to notify the dialysis center that R17 was not receiving his ordered Sevelamer prior to 3/24/25. 3/24/25 6:43 PM - E31 documented in R17's EMR progress notes, Sevelamer . not available. 3/25/25 9:16 AM - E8 documented in R17's EMR progress notes, Sevelamer . Spoke with pharmacy, medication is on order and will be sent out as soon as they receive medication. 3/25/25 11:15 AM - Review of R17's March 2025 MAR revealed that R17 missed thirty-two of the seventy-three scheduled dosages of Sevelamer for the month of March 2025.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, it was determined that for one out of three medication carts observed, the facility failed to adhere to proper labeling and storage practices for insulin pens as per regulatory standards and best practices. Findings Include: [DATE] 12:00 PM - Upon observation of insulin administration for R61, the surveyor observed that the insulin aspart pen was open and used, but there was no indication of an open date on the medication. The absence of an open date on the insulin pen created a risk of using expired medication, which could compromise resident safety and treatment efficacy. [DATE] 12:01 PM - Interview with E8 (LPN) confirmed that no open date was labeled on the pen. [DATE] 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, it was determined that for two (R27 and R42) out of eight residents reviewed for falls, the facility failed to ensure that each resident had a complete and accurate medical record. Findings include: 1. Review of R27's clinical record revealed: 4/12/21 - R27 was admitted to the facility with multiple diagnoses, including a history of falls, history of a fracture, osteoporosis and arthritis. 7/3/24 - A MDS assessment completed for R27 documented that she was frequently incontinent of bowel and bladder. 7/11/24 10:30 AM - R27 had a fall out or bed as she was being provided personal hygiene. 7/12/24 - A post fall risk assessment was completed for R27 which documented that she had 1-2 predisposing diseases that could contribute to a fall. R27 actually had three (3) predisposing disease (arthritis, osteoporosis and previous fractures) that would contribute to her increased fall risk. 8/9/24 - R27 experienced a fall while she was being showered. A post fall risk assessment was completed for R27 that documented the following: -R27 did not have any falls in the last three months. R27 had a fall on 7/11/24. -R27 was chairbound and continent. - R27 had 1-2 predisposing diseases that could contribute to a fall. R27 actually had three (3) predisposing diseases (arthritis, osteoporosis and previous fractures) that would contribute to her increased fall risk. 3/24/25 - During an interview, E9 (RN) confirmed that R27 had the following: -For the 7/12/24 and the 8/9/24 fall risk assessments, that R27 had three (3) diseases that could predispose her to a fall, instead of the two (2) predisposing diseases that the fall risk assessments listed. - The 8/9/24 fall risk assessment should have captured that R27 had a fall that had occurred within the last three months, and that R27 was frequently incontinent. R27's 7/12/24 and 8/9/24 fall risk assessments did not correctly capture all of the risk factors that placed R27 at an increased risk for falls. 2. Review of R42's clinical record revealed: 7/27/24 4:07 PM - A nurse's note documented that R42 was found on her bedroom floor. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/14/24 3:27 AM - A nurse's note documented that R42 was found at 2:30 AM on her bedroom floor mat and was sent to the emergency room for evaluation. 9/14/24 - The Fall Risk Evaluation documented that R42 had no falls in the past three (3) months. The facility failed to accurately complete R42's Fall Risk Assessment with respect to two previous falls. 3/21/25 9:09 AM - During an interview, finding was reviewed E2 (DON). No further information was provided to the Surveyor. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2, E3 (SD/ICP) and nine department managers/representatives.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview, record review and identified deficiencies during the survey, it was determined that the facility's QAPI program failed to effectively address ongoing issues that impact quality of care with respect to staff to resident abuse, repeated medication errors by nursing staff and the continued lack of availability of medications from the pharmacy for multiple residents. Findings include: 3/25/25 1:08 PM - During a combined interview with E1 (CEO/LNHA) and E2 (DON), E1 stated that the QAPI Committee discusses all medication errors in their meetings. E1 mentioned that the 10/3/24 medication error incident involving four residents was reviewed and staff nurses were educated in November 2024. The Surveyor reviewed that there were additional medication errors on 1/3/25 and 2/11/25. E2 stated that the facility provided education in November 2024, December 2024 and again in February 2025. Also Supervisors started doing medication pass audits after the 2/11/25 incident. The Surveyor was informed that the facility has not had a consistent Staff Development nurse and they have not been able to conduct a skills fair for staff. While the medication errors by nursing are routinely discussed during the QAPI meetings and staff education was provided, the facility's QAPI Committee documentation lacked evidence of measurable goals, what systemic changes were implemented and monitoring the performance to ensure the changes were successful and sustained. Medication audits provided and reviewed by the Surveyor were done on 2/5/25 and 2/11/25. No additional information was provided. An additional concern identified during the survey was about the lack of availability of medications for some residents, E1 stated that this was discussed in the last QAPI meeting in March 2025 (during the survey) where the pharmacy representative was present. Surveyor asked about how do you get information about residents' medications not being available? E2 stated that they [Management] are notified by nursing staff when they bring it to their attention. E1 and E2 confirmed that there have been issues with the current pharmacy since October 2024. Surveyor was told that since October 2024, it would improve at times, but for the past month there have been issues with obtaining residents' medications. With respect to the two incidents of staff to resident abuse on 12/22/24 and 1/15/25 and both identified in the current survey as deficiencies, E1 confirmed that there was no current PIP (performance improvement plan) for abuse. E1 stated that the QAPI Committee discusses abuse at each meeting. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1, E2, E3 (SD/ICP) and nine department managers/representatives.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085043	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kutz Rehabilitation and Nursing	704 River Road Wilmington, DE 19809

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that one (R78) out of ten residents reviewed for Infection Control, the facility failed to order and maintain Enhanced Barrier Precautions (EBP) for R78 when he had an indwelling catheter from [DATE] to [DATE]. Findings include: Facility's Enhanced Barrier Precaution policy - . refer to infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and gloves use during high contact resident care activities . 2. Initiation of Enhanced Barrier Precautions: . b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds And /or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO . 4. High-contact resident care activities include: . g. Device care or use: central lines urinary catheters . [DATE] - R78 was admitted to the facility with diagnoses including, but were not limited to, emphysema, neurogenic bladder and obstructive uropathy. [DATE] - E4 (contracted MD) ordered in R78's EMR, Foley catheter care every shift. Flush foley catheter with 60 ml (milliliter) of sterile water Q (every) shift for Infection prevention. [DATE] - E4 reordered in R78's EMR , Flush foley catheter with 60 ml of sterile water Q shift for Infection prevention. This order meant that during each shift, the nursing staff (nurses and CNAs) would have high-contact with R78 as they worked with his urinary catheter and flushed it with 60 mls of sterile water. [DATE] - The Centers for Medicare and Medicaid Services (CMS)'s Enhanced Barrier Precautions in Nursing Homes recommendations become effective as part of the F880 Infection Prevention and Control regulation. [DATE] - E4 reordered in R78's EMR, Foley catheter care every shift. [DATE] 2:20 PM - While reviewing R78's order recap for his entire stay at [facility], the Surveyor noted there was no order for EBP. The facility was not able to provide evidence that R78 was placed on EBP at any point during his admission. [DATE] 12:34 PM - During an interview, E15 (LPN) stated, [R78] did have a foley catheter while he resided here. I don't recall him being on any type of precautions. [DATE] 4:16 PM - During an interview, E3 (SD/ICP) stated, We did not start EBP until [DATE] in this facility. [DATE] - R78 died on hospice care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 and nine department managers/representatives.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, it was determined that for one (R17) out of thirty-five (35) sampled residents reviewed, the facility failed to ensure that R17 had functioning call bell systems to request staff assistance. Findings include: Review of R17's clinical record revealed: 11/13/23 - R17 was admitted to the facility with diagnosis including, but was not limited to, end stage renal (kidney) disease. 11/13/23 - R17's admitting MDS score was 00 for ADL's, meaning he was completely dependent for care by the facility. 3/6/25 10:05 AM - The surveyor observed that R17 did not have a call bell available in his room. 3/7/25 12:00 PM - The surveyor observed that R17 did not have a call bell available in his room. 3/10/25 1:40 PM - The surveyor observed that R17 did not have a call bell available in his room. The facility failed to provide R17 a call bell in three out of three observations. 3/10/25 1:44 PM - During an interview, E13 (CNA) stated that R17 previously had a touch call bell, but it was removed because it was not functioning properly. 3/10/25 3:18 PM - During an interview, E1 (CEO/LNHA) stated that a maintenance request for a new call bell was submitted after the Surveyor brought the lack of a call bell to her attention. 3/10/25 3:37 PM - The Maintenance staff installed a new touch call bell in R17's room. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 (SD/ICP) and nine department managers/representatives.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to implement and maintain an effective training program for new LPN staff regarding intravenous medication administration prior to being assigned to independently provide this service to R68 on 2/11/25. Findings include: Cross refer F726, example 2 and F760, example 1 Review of R68's clinical record revealed: 3/17/25 1:34 PM - During an interview, E14 (LPN), who was a new nurse and was hired on 7/23/24, stated, [On 2/11/25] I was pulled to the 400 unit. It was the first time that I worked there. I had never given an IVSS antibiotic before . I was not trained about IV (intravenous) antibiotics during orientation because we did not have anyone in the building with IV antibiotics . 3/20/25 1:45 PM - Review of the Facility Assessment (dated [DATE]) revealed that administration of IV medication (page 12 of the Facility Assessment) occurs in only 0.5% of their admissions/stays, which is very low relative to the benchmark. The Facility Assessment (page 26) also documented that the Staff training/Competencies/Skills in the area of IV medication was insufficient and an Action Plan was in place. It should be noted that this IVSS medication error occurred seven months after the Facility Assessment had concluded that the staff skills with regard to IV medication was lacking and an Action Plan had been put into place. 3/21/25 10:10 AM - The facility provided copies of the new orientee skills checkoff packet, which contained a skills checkoff for Medication Administration: Intravenous. 3/21/25 3:45 PM - During an interview, E3 (SD/ICP) confirmed that that the facility did not have a skills checkoff for Medication Administration: Intravenous for E14. The facility was unable to provide evidence of a training process for new staff to learn the skills necessary to care for a resident that requires IVSS medication administration when there are no residents in house with this need. The facility did not provide any information regarding the Action Plan for IV Medication that was referenced in the Facility Assessment. 3/26/25 11:45 AM - Findings were reviewed during the exit conference with E1 (CEO/LNHA), E2 (DON), E3 and nine department managers/representatives.