STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Broadmeadow	500 South Broad Street Middletown, DE 19709

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to ensure residents were informed of psychotropic medication side effects and the associated risks versus benefits for two out of five residents (Resident (R) 58 and R5) reviewed for unnecessary medications of 31 sample residents. This failure had the potential for residents to be uninformed of potential outcomes related to psychotropic medications. Findings include: 1. Review of R58's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R58 was admitted on [DATE] with diagnoses which included bipolar disorder, major depressive disorder (MDD), and anxiety. Review of R58's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/23/25 and located under the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 14 out of 15, which indicated intact cognition. Review of the Order Summary Report located under the Orders tab of the EMR, active as of 01/29/26, revealed the following orders: -Buspirone HCL [hydrochloric acid] [antianxiety medication] oral tablet 15 MG [milligram]. Give one tablet by mouth two times a day for anxiety, dated 07/10/25. -Duloxetine HCL [antidepressant medication] oral capsule delayed release particles 60 MG. Give one capsule by mouth one time a day for MDD, dated 07/10/25. -Risperidone [antipsychotic medication] oral tablet three MG. Give one tablet by mouth at bedtime for delusional disorder, dated 07/10/25. Review of the EMR revealed no documentation of consent or risk versus benefit review with the resident or representative. During an interview on 01/29/26 at 1:09 PM, the resident stated she was told what medications she was on but not about potential effects related to the medications provided. During an interview on 01/29/26 at 8:05 AM, the Director of Nursing (DON) stated they did not have any documentation specific to the review of the potential effects of the psychotropic medications with the resident or representative. At 11:56 AM, she acknowledged that the required information was listed in the policy. 2. Review of R5's admission Record located under the Profile tab of the EMR revealed R5 was admitted on [DATE], and readmitted on [DATE], with diagnoses which included MDD and anxiety disorder. Review of R5's quarterly MDS with an ARD of 11/27/25 and located under the MDS tab of the EMR revealed a BIMS score of 15 out of 15, which indicated intact cognition. Review of the Order Summary Report located under the Orders tab of the EMR, active as of 01/29/26, revealed the following orders: -Buspirone HCL [antianxiety medication] oral tablet 10 MG. Give one tablet by mouth three times a day for anxiety, dated 08/25/25. -Duloxetine HCL [antidepressant medication] capsule delayed release particles 20 MG. Give one capsule by mouth one time a day for depression, dated 01/29/26. Review of the EMR revealed no documentation of consent or risk versus benefit review with the resident or representative. During an interview on 01/30/26 at 8:16 AM, the resident stated she did not remember having any discussion with staff about the medication effects. She stated she was unsure of what medication she was taking.During an interview on 01/30/26 at 9:38 AM, the DON stated there was no documentation of any staff conversation with R5 regarding risks versus benefits for the (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications. Review of the facility's policy titled, Psychoactive Medications, reviewed 01/13/26, revealed residents are educated on the benefits and the potential risks of the drugs and education is documented in the medical record.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to notify the correct emergency contact of a change in condition for one of one resident (Resident (R) 122) reviewed for change in condition out of a total of 31 sampled residents. This failure had the potential to delay timely notification of R122's representative regarding the resident's condition change.Findings include:Review of R122's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R122 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, severe, with other behavioral disturbance and chronic pain.Review of R122's annual Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 09/12/24, indicated R122 had a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated R122 was severely cognitively impaired. R122 was also coded as not having one or more unhealed pressure ulcers.Review of R122's Nursing Progress Notes located under the Progress Note tab in the EMR indicated on 11/03/24 at 2:20 PM, Charge nurse alerted writer that the resident [R122] was noted with a blister to right heel . Message left for [emergency contact #2]; awaiting return call.During a phone interview on 01/29/26 at 4:37 PM, Family Member (FM) 1 stated, I got a phone call from a nurse on 11/06/24 that [R122] had developed a wound to her buttocks and her heel. I asked the nurse when they first saw these wounds, and she stated that the right heel blister was noted on 11/03/24, and the nurse called [emergency contact #2]. I asked why I was not contacted since I was the first one to be contacted, and the nurse did not know.During an interview on 01/29/26 at 5:10 PM, Registered Nurse/Unit Manager (RN/UM) 1 stated, The nurse would contact the person listed as the first contact and then if they cannot get that person, the nurse would notify the second person on the list to be contacted. When asked if this would be documented, RN/UM1 stated, Yes, in the progress notes. The nurse would document who she notified of the change. If the nurse could not talk to the first contact on the list, then she would document that a message was left and then contact the second person on the list.During an interview on 01/30/26 at 2:36 PM, the Director of Nursing (DON) stated, For this resident it would be emergency contact number one [FM1], and if you were unable to get ahold of that person then you would contact emergency contact number two. The nurse is to document the phone call to the emergency contact. If the first emergency contact could not be contacted, then the nurse would call the second emergency contact and would document both phone calls. The DON confirmed that emergency contact number two was called for R122. A message was left for that person to call the facility back, but it should have been emergency contact number one contacted.Review of the facility's policy titled, Provider Notification of Resident Change in Medical Condition, dated 01/13/26, indicated . Staff will notify the provider and applicable POA [Power of attorney]/responsible parties of: . Significant change in condition in physical, mental, or psychosocial status .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of 31 sampled residents (Resident (R) 28) was free from physical restraints when staff failed to identify a seatbelt worn on a motorized wheelchair as a physical restraint, restricting the resident's freedom of movement and access to their body. This failure created the potential for facility residents to receive inappropriate care and services, or a lack of, due to unidentified care needs and interventions from an unassessed lower extremity restraint. Findings include:Review of R28's Face Sheet, located in the Electronic Medical Record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included traumatic subarachnoid hemorrhage with loss of consciousness, lack of coordination, abnormal posture, hemiplegia unspecified affecting right dominant side, personal history of traumatic brain injury, aphasia following cerebral infarction, and contracture of right elbow, wrist, and hand. Review of R28's quarterly Minimum Data Set (MDS) Assessment, with an assessment reference date (ARD) of 11/04/25 and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of 13 out of 15, which indicated the resident was cognitively intact. The resident was documented to have functional limitation in range of motion for upper extremity on both sides and used a motorized wheelchair. R28 required substantial/maximum assistance for sitting to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfers. R28 did not use restraints.Review of R28's Comprehensive Care Plan, dated 09/14/22 and located in the EMR under the Care Plan tab, revealed R28 had an ADL (activities of daily living) self-care performance deficit related to right [side] hemiparesis. An identified intervention, revised 02/26/24, documented that R28 had a power chair (motorized wheelchair) with back cushion on her wheelchair to maximize safety, comfort, and independence in mobility throughout the facility. The care plan did not identify a seat belt intervention.Review of R28's Comprehensive Care Plan, and located under the Care Plan tab in the EMR failed to identify any problem or associated interventions that indicated the resident used a seat belt while seated in the motorized wheelchair, as observed throughout the survey.During an observation on 01/28/26 at 1:19 PM, R28 was observed in their room seated in their motorized wheelchair, with a seat belt on, with the buckle observed off to the right side of the lap. The resident was observed with a contracted right arm. R28 was asked if they were able to release the seat belt, and they stated yes. They then proceeded to lean to the left and attempted to manipulate the wheelchair controller.During an additional observation on 01/29/26 at 8:08 AM, R28 was observed in their room in their motorized wheelchair, with a seat belt on. During an additional observation on 01/30/26 at 7:55 AM, R28 was observed in their motorized wheelchair with a seat belt on, and with a visible right arm contracture. R28 was asked if the seat belt was comfortable. The resident leaned forward in their wheelchair and stated, No. The resident used their left hand to reach back and touch her lower left back. At 7:58 AM, Certified Nursing Assistant (CNA) 1 entered the resident room and observed R28 leaning forward. CNA1 said that residents with electric wheelchairs had seat belts. CNA1 said R28 did lean forward, so that the seat belt helped with safety. CNA1 stated that all electric wheelchairs had seat belts and then said that they placed the seat belt on R28 when they were put into the wheelchair in the morning and that it was on all day until bedtime, or if R28 had to go to the bathroom.During an interview on 01/30/26 at 8:13 AM, CNA2 said residents with electric wheelchairs had seat belts for their wheelchairs. CNA2 said the CNAs were trained during orientation, and the rehab staff would educate them if a resident was using a seat belt. CNA2 confirmed that they would put the seat belt on the resident when they put them into (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the wheelchair and only take it off when they were removed from the wheelchair, like toileting or going back to bed. CNA2 said they thought some of the residents could remove the belts themselves.During an interview on 01/30/26 at 8:25 AM, Registered Nurse/Unit Manager (RN/UM) 1 said that they were not sure what the seat belt process was at the facility but believed the rehabilitation department assessed for them and would then educate the CNAs on how to use them. RNUM1 then reviewed the EMR for R28 and confirmed that there was no order for R28 to use a wheelchair seat belt. RNUM1 again, upon review of the EMR, confirmed there was no care plan for a seat belt. RNUM1 said that the nurses could add interventions, but that care plans were reviewed with the interdisciplinary team.During an interview on 01/30/26 at 8:35 AM, MDS Coordinator (MDS) 1 said that they did not capture the seat belts in MDS because it was their understanding that the rehabilitation department would assess the residents, and that they would be capable of removing them. MDS1 confirmed they did not review these assessments. MDS1 said they would expect staff to check for positioning, that they were secure, and the residents could remove them. MDS1 confirmed these interventions should be identified in a care plan. During an interview on 01/30/26 at 8:58 AM, the Director of Rehab (DOR) stated that the facility tried not to use restraints. They said that during orientation they discussed gait belts, but they did not use seat belts. DOR said they were aware that most electric wheelchairs came with them, but the rehab department did not assess them to be used. DOR said that they assess residents quarterly to make sure the residents were positioned well and can get around safely, but since they did not use seat belts, they did not check them. DOR confirmed they were not aware that the CNAs were putting them on, and that it was probably a miscommunication. The DOR said she had been informed that R28 did not like the seat belt, and that she would have a tough time getting it off. They stated they would review the last time they reviewed R28's seat belt.During an additional interview on 01/30/26 at 10:04 AM, the DOR said that the last full assessment for R28's wheelchair was upon admission and provided the documentation. The DOR said that the assessment stated the resident could unlock the seat belt, and it would not be a restraint.Review of the facility provided document titled Physical Therapy and Plan of Treatment, dated 10/20/22, revealed that R28, .was able to unbuckle her seatbelt upon command but needs assistance w/buckling seatbelt.due to documented physical impairments and associated functional deficits, the patient is at risk for falls, injury to RLE (right lower extremity) during power chair mobility, further decline in function, increased dependency upon caregivers and compromised general health. This documentation revealed the facility was aware that the resident had a seat belt, and that it had been in use, but there was no indication in the EMR of any ongoing follow-up to its use or safety. During a follow-up interview on 01/30/26 at 10:15 AM, DOR provided the last wheelchair assessment from physical and occupation therapy.Review of the provided Occupational Therapy Discharge summary, dated [DATE], documented R28, .demonstrates MI (modified independent) and safety with wheelchair (sic) mobility with good demonstration of safety to reduce speed through doors and include.demonstrated an increase ROM (range of motion) for right shoulder flexion to 110* from 100*. Documentation review of the last wheelchair assessment for R28 revealed no documentation or assessment related to the identification of a seat belt on the wheelchair. This was the last documentation for wheelchair or seat belt assessment. During an interview on 01/30/26 at 1:08 PM, the Director of Nursing (DON) stated that they had been informed that wheelchairs should be assessed on admission and quarterly, going forward. They said that the seat belt should be a part of the care plan. She stated that if the seat belt is not being documented as a restraint in assessments, then it should not be on the electric wheelchair. The DON said there needed to be more training for staff regarding seat belt use.Review of the facility's policy titled, Restraint and Seclusion Policy, last reviewed (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	01/13/26 read, in pertinent part, .residents have the right to be free from any physical or chemical restraint/or seclusion imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.Physical Restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.In an extreme safety situation that compromises the safety of the resident or others, a provider's order may be obtained to restrain or seclude the resident until the situation has ceased or the resident has been transferred to an acute setting and the safety of the resident and others can be ensured.Documentation in the Electronic Medical Record must support the assessment for, evaluation of, and timeframe of use of a restraint or seclusion.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to report an injury of unknown origin to the State Agency for one resident (Resident (R) 21) reviewed for injuries of unknown origin out of 31 sampled residents. The facility's failure to promptly report injuries of unknown origin limited regulatory oversight and had the potential to delay protective interventions. Findings include:Review of R21's admission Record, located under the admission tab of the electronic medical record (EMR) revealed R21 was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, dementia, and transient cerebral ischemic attack. Review of R21's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/14/25, revealed that R21 had a Brief Interview for Mental Status (BIMS) score of 7 of 15, indicating that R21's cognitive function was severely impaired. Review of R21's Care Plan, initiated on 12/04/25, located under the Care Plan tab revealed that R21 had fallen and was at an increased risk for experiencing additional falls related to deconditioning, hearing problems, poor safety awareness, impulsive, muscle weakness, unsafe transfer behavior, medications, and history of falls. Interventions included following facility post fall protocol, assess for injuries, monitoring vital signs, and notifying the physician. Review of R21's Care Plan, initiated on 12/12/25, located under the Care Plan tab revealed that R21 had impaired cognitive function related to dementia with an intervention in place that included, .to cue, reorient and supervise as needed.Review of the Nurse Practitioner's (NP), note dated 01/15/26, located under the Progress Notes tab in the EMR stated, [AGE] year-old female seen today for Right arm swelling, multiple falls, dementia. She is seen sitting up in a chair in the common area. Per staff they noticed swelling on her right forearm. Patient was unaware of it, denying pain. She has had multiple falls[.] No injuries noted at the time[.] Patient is a poor historian with advanced dementia. She was able to move her right arm, no grimacing, and no pain to area. Wrist, elbow and shoulder [have] full range of motion, positive pulses, [and] cap refill less than 3 seconds.Review of the facility provided form titled, Witness Written Summary, dated 01/14/26 at 8:30 AM, written and signed by physical therapy assistant (PTA)indicated, .during therapy session, resident was noted with increased edema on right forearm and resident was unable to explain what happened and quantify pain level due to cognition. Nursing was notified.Review of the facility provided form titled, Witness Written Summary, dated 01/14/26 at 11:29 AM, written and signed by Licensed Practical Nurse (LPN) 3 stated, .resident was noted with hematoma to right forearm and unable to recall what happened. Noted with signs of pain and resident was given pain medication per physician's order and the nurse practitioner was made aware.During an interview on 01/30/26 at 11:55 AM with the Administrator, she stated .for our state, an insignificant or non-serious injury of unknown source, that we do not have to report that to them. I report and the Director of Nursing (DON) does the investigation. She and I review the reports together.During an interview on 01/30/26 at 12:07 PM with the DON, she stated, .we determine if it needs to be reported. We interview the staff, the residents and then we determine if it meets the criteria for reporting. When asked if this incident was reported to the state, she stated, No, I don't have a copy of this being reported to the state.Review of the facility's policy titled, Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime, last review date of 01/09/26, on page four of five, stated, under the item, Investigation,. All alleged incidents involving abuse, neglect, mistreatment, misappropriation of resident property, exploitation, or reasonable suspicions of crime, including injuries of unknown source, shall be reported to the Administrator or designee immediately. The Administrator or designee shall investigate allegations and report to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate regulatory agencies and/or law enforcement.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and facility policy review, the facility failed to investigate an injury of unknown origin for one resident (Resident (R) 21) out of a total sample of 31 residents. The facility's failure to promptly investigate injuries of unknown origin had the potential to delay protective interventions for residents.Findings include:Review of R21's admission Record, located under the admission tab of the electronic medical record (EMR) revealed R21 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy, dementia, and transient cerebral ischemic attack. Review of R21's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/14/25, located under the MDS tab of the EMR revealed that R21 was assessed with a Brief Interview for Mental Status (BIMS) score of 7 of 15 indicating that R21's cognitive function was severely impaired. Review of R21's Care Plan, initiated on 12/04/25, located under the Care Plan tab revealed that R21 had fallen and was at an increased risk for experiencing additional falls related to deconditioning, hearing problems, poor safety awareness, impulsive, muscle weakness, unsafe transfer behavior, medications, and history of falls. Interventions included following facility post fall protocol, assessing injuries, monitoring vital signs, and notifying the physician. Review of R21's Care Plan, initiated on 12/12/25, located under the Care Plan tab revealed that R21 had impaired cognitive function related to dementia with an intervention in place that included, .to cue, reorient and supervise as needed.Review of the Nurse Practitioner's (NP) note, dated 01/15/26, located under the Progress Notes tab in the EMR stated, [AGE] year-old female seen today for Right arm swelling, multiple falls, [and]dementia. She is seen sitting up in a chair in the common area[.] Per staff they noticed swelling on her right forearm. Patient was unaware of it, denying pain. She has had multiple falls[.] No injuries noted at the time[.] Patient is a poor historian with advanced dementia. She was able to move her right arm, no grimacing, and no pain to area. Wrist, elbow and shoulder [have] full range of motion, positive pulses, [and] cap refill less than 3 seconds.Review of the paper form provided by the facility titled, Witness Written Summary, dated 01/14/26 at 8:30 AM, written and signed by physical therapy assistant (PTA) stated, .during therapy session, resident was noted with increased edema on right forearm and resident was unable to explain what happened and quantify pain level due to cognition. Nursing was notified.Review of the paper form provided by the facility titled, Witness Written Summary, dated 01/14/26 at 11:29 AM, written and signed by Licensed Practical Nurse (LPN) 3 stated, .resident was noted with hematoma to right forearm and unable to recall what happened. Noted with signs of pain and resident was given pain medication per physician's order and the nurse practitioner was made aware.During an interview on 01/30/26 at 11:55 AM, the Administrator stated For our state, an insignificant or non-serious injury of unknown source, that we do not have to report that to them. I report and the Director of Nursing (DON) does the investigation. She and I review the reports together.During an interview on 01/30/26 at 12:07 PM, the DON stated, We determine if it needs to be reported. We interview the staff, the residents and then we determine if it meets the criteria for reporting. When asked if this incident was reported to the state, she stated, No, I don't have a copy of this being reported to the state. No, this incident was not investigated.Review of the facility's policy titled, Abuse, Neglect, Mistreatment, Misappropriation, Exploitation, and Reasonable Suspicions of Crime, last review date of 01/09/26, on page four of five, stated, under the item, Investigation. All alleged incidents involving abuse, neglect, mistreatment, misappropriation of resident property, exploitation, or reasonable suspicions of crime, including injuries of unknown source, shall be reported to the Administrator or designee immediately. The Administrator or designee shall investigate allegations and report to appropriate regulatory agencies (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or law enforcement.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to ensure one of 31 sampled residents (Resident (R) 28) care plans were reviewed and revised to identify the regular use of a wheelchair seatbelt. This failure created the potential for facility residents to receive inappropriate care and services, or a lack of, due to unidentified care needs and interventions. Cross-reference to F604, Physical Restraints.Findings include:1. Review of R28's Face Sheet, located in the Electronic Medical Record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE]. The document indicated the resident's diagnoses included traumatic subarachnoid hemorrhage with loss of consciousness, lack of coordination, abnormal posture, hemiplegia unspecified affecting right dominant side, personal history of traumatic brain injury, aphasia following cerebral infarction, and contracture of right elbow, wrist, and hand.Review of R28's quarterly Minimum Data Set (MDS) Assessment, with an Assessment Reference Date (ARD) of 11/04/25 and located in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of 13 out of 15, which indicated the resident was cognitively intact. The MDS indicated R28 had functional limitations in range of motion for bilateral upper extremities and used a motorized wheelchair. R28 required substantial/maximum assistance for sitting to lying, lying to sitting on side of bed, sitting to stand, and chair/bed-to-chair transfers.Review of R28's Comprehensive Care Plan, dated 09/14/22 and located in the EMR under the Care Plan tab, revealed R28 had an ADL (activities of daily living) self-care performance deficit related to right [side] hemiparesis. An identified intervention, revised 02/26/24, documented that R28 had a power chair (motorized wheelchair) with back cushion on her wheelchair to maximize safety, comfort, and independence in mobility throughout the facility. The care plan did not identify a seat belt intervention.Further review of R28's Comprehensive Care Plan failed to identify any problem or associated interventions that indicated the resident used a seat belt while seated in the motorized wheelchair, as observed throughout the survey.During an observation on 01/28/26 at 1:19 PM, R28 was observed in their room seated in their motorized wheelchair, with a seat belt on.During an observation on 01/29/26 at 8:08 AM, R28 was observed in their room in their motorized wheelchair, with a seat belt on. During an observation on 01/30/26 at 7:55 AM, R28 was observed in their motorized wheelchair with a seat belt on.During an interview on 01/30/26 at 8:25 AM, Registered Nurse/Unit Manager (RN/UM) 1 reviewed the EMR for R28 and confirmed that there was no order for R28 to use a wheelchair seat belt. RNUM1 again, upon review of the EMR, confirmed there was no care plan for a seat belt. RNUM1 said that the nurses could add interventions, but that care plans were reviewed with the interdisciplinary team.During an interview on 01/30/26 at 8:35 AM, MDS Coordinator (MDS) 1 said that they did not capture the seat belts in MDS because it was their understanding that the rehabilitation department would assess the residents, and that they would be capable of removing them. MDS1 confirmed they did not review these assessments. MDS1 said they would expect staff to check for positioning, that they were secure, and the residents could remove them. MDS1 confirmed these interventions should be identified in a care plan. During an interview on 01/30/26 at 1:08 PM, the Director of Nursing (DON) stated that they had been informed that wheelchairs should be assessed on admission and quarterly, going forward. They said that the seat belt should be a part of the care plan. She stated that if the seat belt is not being documented as a restraint in assessments, then it should not be on the electric wheelchair. The DON said there needed to be more training for staff regarding seat belt use. During an additional interview on 01/30/26 at 5:09 PM, the DON stated that the facility did not have a policy specific to care plan (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revisions, just a comprehensive care plan policy.Review of the facility's policy titled, Care Planning, last reviewed 01/13/26 read, in pertinent part, .a comprehensive care plan is developed that incorporates resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practical, physical, mental, and psychosocial wellbeing.A comprehensive care plan must be prepared by an interdisciplinary team.Care plans should include: Services furnished to maintain highest practical well-being.The resident's goals for admission and desired outcomes.The resident's preferences.The comprehensive care plans should be reviewed and revised by the interdisciplinary team after each assessment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure residents who are unable to conduct activities of daily living (ADLs) receive the necessary services for one resident (Resident (R) 73) out of a total sample of 31 residents. R73 reported that she has not received help with oral care, and she was observed to have a buildup of debris on her teeth and gums. This failure had the potential to affect nutritional status, cause dental cavities, and gum diseaseFindings include:Review of R73's admission Record, located under the admission tab of the electronic medical record (EMR) revealed R73 was admitted to the facility on [DATE] with diagnoses that included dysphagia, cognitive communication deficit, bipolar disorder, and osteoarthritis. Review of R73's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 08/21/25, revealed R73 was assessed with a Brief Interview for Mental Status (BIMS) score of 12 of 15 indicating that R73 had moderately impaired cognition. The self-care functional abilities portion of the MDS for oral care revealed a score of 03 which indicated R73 required Partial/Moderate assistance, which is defined as the Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.During an interview on 01/28/26 at 11:08 AM, R73 stated she was not offered to brush her teeth in the mornings or in the evenings. During this interview, R73 was asked to open her mouth and R73's teeth and gums were observed with a buildup of white and brown debris. During an interview on 01/29/2026 at 10:26 AM, R73 did not have a toothbrush at the bedside and stated that she still had not received assistance to brush her teeth this morning or last night. During an interview on 01/29/26 at 2:17 PM, R125, assessed with a BIMS score of 15 of 15 on the quarterly MDS with an ARD of 12/16/25, stated, I brush my teeth on my own, but I have to ask for my toothbrush and toothpaste to be brought to me. It is inside my nightstand. If I don't remind them, they won't bring it to me.During an interview on 01/29/26 at 2:19 PM, R17, assessed with BIMS score of 15 of15 on the quarterly MDS with an ARD of 11/09/25, stated, I wheel myself to the bathroom to brush my teeth.During an interview on 01/29/26 at 2:20 PM, R33, assessed with a BIMS score of 15 of 15 on the quarterly MDS with an ARD of 11/11/25, stated, I wheel myself to the bathroom to brush my teeth.During an interview on 01/29/26 at 2:23 PM R66, assessed with a BIMS score of 15 of 15 on the annual MDS with an ARD of 01/17/26, stated, They have to be reminded to give me my toothpaste and toothbrush. If I don't ask for it, they won't bring it to me.During an interview on 01/30/2026 at 2:15 PM, R73 stated supplies to brush her teeth were not [NAME] to her last night or this morning and staff had not offered to assist her to brush her teeth. She stated, I still haven't brushed my teeth. I didn't ask for the supplies to be brought to me. R73 went on to say, You have to ask, if you don't, it will not be brought to you.During an interview on 01/30/26 at 11:00 AM, the Staff Development (SD) stated, The expectation is that staff should offer mouth care to residents and not have to be reminded by the residents that they need their mouth care supplies. This is all part of my orientation education upon hire for Certified Nursing Assistants (CNAs). During an interview on 01/30/26 at 12:20 PM, the Director of Nursing (DON) stated, The expectation is that the staff provide morning (AM) and evening (PM) care - personal hygiene, showers are scheduled on preferred day/time, including oral care. The CNA will take the outfit out of the closet, prepare the brief, water, washcloths, comb the resident's hair, shaving if necessary, grooming, brushing teeth or dentures, the CNA will set up toothpaste, toothbrush, and mouthwash, if any and perform the procedure if the resident is unable to perform the oral care themselves.During an interview on 01/30/26 at 3:00 PM, CNA4 stated, Oral care is part of morning (AM) care. When I come in for morning care, I let the residents know that I will help them get cleaned up from head to toe, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	basically.During an interview on 01/30/26 at 3:05 PM, CNA5 stated, Oral care is part of the morning care for residents. There are some residents that can't do the oral care on their own, and I make sure that I assist them.During an interview on 01/30/26 at 6:24 PM, CNA6 stated, Yes I usually work this unit. I usually work with R73 in the evenings. R73 is very chill, she is a heavy wetter so whenever I change her, I must change her sheets too. Sometimes she refuses to have her shirt changed or even her bed sheets changed. Sometimes I offer to have her brush her teeth in the evenings.Review of the educational presentation for CNAs, upon hire, titled, Oral Care, on page two of eight, revealed, Mouth care should be given in the morning, at bedtime and after meals and on page seven of eight, under the section titled, Personal Hygiene, revealed, this includes combing hair, brushing teeth, shaving, applying makeup, washing/drying of face and hands.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to assess and monitor comfort care (end of life) for one of three residents (Resident (R)122) reviewed for comfort care out of 31 total sampled residents and failed to follow physician orders for an ordered medication (Hyoscyamine Sulfate) for one of 31 residents. These failures had the potential for R122 not to receive the comfort care measures that she deserved at the end of life and not to receive physician ordered medication to control increased secretions which would cause R122 to have difficulty breathing.Findings include:Review of R122's undated Face Sheet, located under the Profile tab in the electronic medical record (EMR) indicated R122 was admitted to the facility on [DATE] with diagnoses of unspecified dementia, severe, with other behavioral disturbance, anxiety disorder, and chronic pain.Review of R122's annual Minimum Data Set (MDS), located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 09/12/24, indicated R122 had a Brief Interview for Mental Status (BIMS) score of two out of 15 which indicated R122 was severely cognitively impaired. Review of R122's Care Plan, located under the Care Plan tab in the EMR and dated 11/09/22 indicated R122 had a Focus of [R122] is on comfort care. Interventions were to . Assess for pain levels and contact physician for pain management with uncontrolled pain. Comfort Care: No hospitalization, No lab work, No tube feeding, No IV [intravenous] fluids, No weights, Yes liberalized diet and supplement, Yes antibiotics, Yes medication d/c [discontinue] per provider review.Review of the Progress Notes, located under the Progress Note tab in the EMR revealed a Provider Note dated 10/30/24 in which the Nurse Practitioner (NP) documented . slowly declining. There was no documentation that R122 was experiencing pain at that visit.Continued review of the Progress Notes, indicated from 10/31/24 through 11/07/24 the nursing progress notes did not reflect documentation of R122 having increased pain or shortness of breath (SOB).Review of R122's Medication Administration Record (MAR), dated November 2024 indicated from 11/01/24 through11/08/24 documentation reflected pain was assessed every shift using the Behavioral Pain Scale which indicated R122 had a pain level of 0 during this time.Further review of the Progress Notes, documentation indicated on 11/08/24, the NP (Nurse Practitioner) documented, . Nursing reported patient to have decreased oral intake. Patient lying in bed on room air without respiratory distress. displays no signs/symptoms of pain/discomfort. Plan: .Excessive secretions: None at this time. Ordered Hyoscyamine Sulfate [Levsin] sublingual 0.125 mg [milligram]. Give 1 [sic] tablet sublingually. Agitation/restlessness: None at this time. Ordered continue lorazepam 0.5 mg every 6 [sic] hours as needed. Pain/Shortness of breath: None at this time. Morphine Sulfate (Concentrate) 20 MG/ML [milligram per milliliter], 0.25 ml every 4 [sic] hours as needed.Review of the Nursing Progress Note, dated 11/08/24 at 4:29 PM located under the Progress Notes tab in the EMR indicated, Resident continues to decline and have poor intake. NP made aware.Review of the Administrative Note, dated 11/12/24 at 12:00 AM, located under the Progress Notes tab in the EMR revealed the nurse documented Morphine Sulfate (Concentrate) 20 MG/ML Give 0.25 ml by mouth every 4 [sic] hours as needed for Pain/SOB/Comfort. Resident was in distress and was given Morphine for comfort. The nurse did not complete a nurse note to document what distress R122 was having at this time.Review of the MAR for 11/12/24 at 12:00 AM, indicated R122's pain level was documented as a 4 out of 10 using the behavioral assessment but, the MAR did not provide documentation of how the pain level of four was determined at that time. There was no nursing note dated and timed for this administration of Morphine to indicate how the pain level of four was obtained using the behavioral assessment.Review of a Nurses Note, dated 11/12/24 at 11:51 AM, located under the Progress Notes tab in the EMR revealed the nurse documented, Resident with decreased responsiveness and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not able to take po [by mouth] food/fluids. Daughter at bedside and requesting PRN [as needed] Roxanol [Morphine Sulfate] be routine to help keep resident comfortable. NP made aware of above and assessed resident. New order to add Roxanol 5 [sic] mg SL [sublingual] every 4 [sic] hours along with PRN as previously ordered.Continued review of R122's MAR dated 11/12/24, revealed R122 was assessed every shift and on day shift for this date, R122 was experiencing a pain level of 4 but the MAR did not provide documentation of how the pain level of four was determined at that time. The EMR did not contain a nursing note dated and timed for this administration of Morphine to indicate how the pain level of four was obtained using the behavioral assessment.Review of the Progress Note, dated 11/14/24, located under the Progress Notes tab in the EMR revealed the NP made a visit with R122 and changed . Hyoscyamine Sulfate 0.125 mg every 4 [sic] hours routinely.Further review of the nursing progress notes for R122 from 11/12/24 through 11/21/24 did not reflect assessments of R122 and indicate if R122 was experiencing any declines. Review of the Nursing Note, dated 11/21/24 at 10:33 AM, located under the Progress Note tab in the EMR indicated, Resident seen by NP for increased secretions. New order: Increase Levsin 0.25 Q2h [sic] [every two hours] for increased secretions/end of life. Order updated in MAR.Review of the Administrative Note, dated 11/21/24 at 9:44 PM, located under the Progress Note tab in the EMR indicated the nurse documented Hyoscyamine Sulfate Oral Tablet 0.125 mg Give 1 [sic] tablet by mouth every 2 hours for increased secretions/end of life Resident not able to swallow.Review of the Nursing Progress Note, dated 11/22/14 at 3:27 AM, located under the Progress Note tab in the EMR indicated Resident stopped breathing at 0215.Review of the nursing notes from 1/21/24 at 9:44 PM through 11/22/24 at 3:27 AM, the nursing notes did not reflect an assessment of R122 or if there were any further signs of R122's of impending death.During an interview on 01/29/26 at 5:15 PM, Registered Nurse/Unit Manager (RN/UM)1 stated, [R122] was only alert to self. The nurse does a behavioral assessment for pain which comes up each shift and each time you administer pain medication. The behavioral assessment has certain different behaviors that you assess and depending on what you are seeing then you click on that behavior and at the end, the computer gives you a number pain level. RN/UM1 confirmed the only training/education she received was in nursing school and she stated she graduated from this in 2010. The RN/UM1 was asked what resources she as a supervisor used to make sure your staff deliver the most updated care to a resident on comfort care. RN/UM1 stated, I would follow the orders that the MD [medical doctor] or NP wrote for us to follow.During an interview on 01/29/26 at 5:30 PM, the Infection Preventionist/Staff Coordinator (IP/SC) stated, I have only been in this role for 29 days. I have not prepared for any additional education other than what staff gets on hire in orientation. We empower the staff to call the provider if they have any questions about unclear orders or if there is a problem with the order that has been given. For pain assessments, the nurse can assess particular behaviors if the resident is unable to verbalize pain and for alert residents the nurse can ask the resident to describe the level of pain they are experiencing. If the nurse is performing a behavioral pain assessment, the nurse goes through each behavior on the behavioral assessment and at the end the computer will add up the nurses' responses and a pain level will be documented as a number that correlates with the nurses' responses. The IP/SC was asked how the surveyor could review the responses that the nurse clicked on to get the pain level number and she stated, I don't believe that you can. The nurse should make a note as to her assessment of what she is seeing at the time the pain medication was given along with the pain level score. If the nurse notices a decline in the resident's condition, then that should be documented as well.During an interview on 01/30/26 at 2:53 PM, the Director of Nursing (DON) reviewed the nursing progress notes, under the evaluations and vital signs tab, and MAR from 11/01/26 through 11/07/26 and stated, I don't (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	see anything documented before the 8th of November that the resident was experiencing pain. I see where they discontinued the order for Levsin 0.125 mg for one tablet every two hours and put in an order for Levsin 0.125 mg Give two tablets every two hours but under the administrative times, the boxes have x's in them and no documentation of this order being given to [R122]. I can't explain why this happened. The nurses' chart by exception and only chart if there is a noted change in condition of the resident. Asked the DON when the medication changes were made for increased pain medication, increased secretions or the resident was unable to swallow, would these be changes in condition that would warrant alert charting. The DON stated, The nurse could have started the alert charting at that time. Anyone can initiate alert charting when it is needed. The nurses receive education on comfort care in the module on Advance Directives. We do not have a Comfort Care Policy, but we have a Palliate/Hospice Care Policy.During an interview on 01/30/26 at 7:46 AM, Licensed Practical Nurse (LPN)2 was asked about her assessment on the night shift on 11/21/24 and LPN2 stated, I didn't document in detail what she was doing. I should have documented exactly what I was seeing. She also stated, From what I saw in my documentation that I read last night she [R122] was restless and I gave her Morphine. I should have documented her restlessness instead of distress. I don't see any assessments charted. LPN2 was asked if assessments should have been completed for this resident? LPN2 replied Yes, we should have definitely charted assessments done on this resident. LPN2 stated ,[The RN/UM1] usually does that when she was asked who could initiate alert charting. Asked LPN2 if she initiated the alert charting during her shift on 11/21/24 due to the resident not being able to swallow on 11/21/24 at 9:44 PM. LPN2 stated, No, I didn't but I should have. LPN2 was asked if she had received any education on comfort care during her employment with the facility and LPN2 stated, No, what we have is usually on Relais that we do. I had some education on comfort care in nursing school and I graduated in 2006. LPN2 was asked if she assessed the resident on her shift and noted any changes in these assessments in the nursing progress notes. LPN2 stated, I probably went in there every two hours to check in on her, but I did not make any notes of this in her chart. I had some education on comfort care in nursing school and I charted this way. I have had patients pass away lately and it is more detailed than this. LPN2 was asked what should have been charted/documented and LPN2 stated, That I checked her vital signs, and notified the supervisor, checked for lung sounds, heart rate, and temperature. I see that I should document everything even if they are not on alert charting. I cannot believe that I charted this way and left important information out that should have been charted.Review of staff education for Comfort Care provided during training on Advance Directives . Comfort Care stated, Residents on hospice, palliative care and comfort care should have orders for pain medication. Morphine is often ordered for end of life as a pain regimen and to help with shortness of breath/air hunger.Review of the facility's policy titled, Alert Charting, dated 01/09/26 indicated, . Whenever a significant change occurs in a resident's condition, the resident may be placed on alert charting. Residents placed on alert charting are assessed by the nurse each shift and assessment data entered into nursing notes. Nursing judgement determines when a resident is placed on and removed from alert charting notes. Document objective data related to the resident's condition. presence or absence of pain, and response or lack of response to treatment.The facility did not have a comfort care policy to direct the nursing care of the resident receiving this service while in the facility.Review of the online training module titled, Advance Directives, under the section Comfort Measures indicated, Residents on hospice, palliative, and comfort care should have orders for pain medication. Morphine is often ordered to end of life care as a pain regimen and to help with shortness of breath/air hunger.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and policy review, the facility failed to administer oxygen in accordance with physician orders for one of one resident (Resident (R) 4) reviewed for oxygen therapy out of a total of 31 residents sampled. This failure had the potential to cause R4 to retain carbon dioxide and increased the risk of oxygen toxicity.Findings Include:Review of R4's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R4 was admitted to the facility on [DATE] with the diagnosis of chronic obstructive pulmonary disease (COPD).Review of R4's quarterly Minimum Data Set (MDS) located under the MDS tab in the EMR, with an Assessment Reference Date (ARD) of 01/01/26 indicated R4 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated R4 was cognitively intact. R4 was also coded as receiving oxygen therapy while a resident in the facility. Review of R4's Care Plan located under the Care Plan tab in the EMR and dated 07/22/24 indicated a Focus which stated, [R4] has altered respiratory status/difficulty breathing r/t [related to] Chronic [sic] respiratory failure, COPD, CHF [congested heart failure], Sleep Apnea [sic]. The intervention indicated, Oxygen as ordered.Review of R4's Physician Orders located under the Orders tab in the EMR indicated an order dated 06/30/25 for Oxygen at 4 LPM [liters per minute] via [by] NC [nasal cannula] . During observations on 01/27/26 at 12:45 PM, 01/28/26 at 11:25 AM, and 01/30/26 at 10:40 AM, R4 was lying in bed with the oxygen concentrator approximately two feet from the left side of the bed, administering oxygen at 4.5 LPM via nasal cannula.On 10/30/26 at 10:43 AM, Registered Nurse/Unit Manager (RN/UM) 1 accompanied the surveyor to R4's room. RN/UM1 confirmed the oxygen was being administered at 4.5 LPM via nasal cannula. RN/UM1 reviewed the Physician Orders in the surveyor's laptop and confirmed the order for R4's oxygen administration was to be at 4 LPM instead of 4.5 LPM. RN/UM1 adjusted the oxygen concentrator to administer oxygen to R4 at 4 LPM. When asked if R4 was able to get out of bed to adjust the oxygen concentrator on her own, RN/UM1 stated, No. She [R4] cannot.During an interview on 01/30/26 at 2:36 PM, the Director of Nursing (DON) confirmed the orders for R4's oxygen were for 4 LPM.Review of the facility's policy titled, Nasal Oxygen Administration, dated 01/13/26, indicated, . Read and note the physician's written order for nasal oxygen with stated flow rate in liters per minute.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observation, interview, and document review, the facility failed to ensure the Facility Assessment included an accurate and comprehensive review of the facility's resident population, including an identified population of residents receiving Comfort Care. The failure to update the Facility Assessment to accurately reflect resident needs for this specific resident population receiving care and services meant the facility assessment plan had potentially missed critical care needs specific and unique to this population. This failure had the potential to affect the care provided to the facility population and the training required for both direct and indirect care staff. These failures had the potential to impact all 108 residents in the facility related to safety, pain, person-centered environment, psycho-social services, and the number of adverse events or other resident complications. Cross reference: F684 Quality of Care. Findings include:Review of the Facility Assessment 2025-2026, dated 10/08/25 through 10/29/25, revealed it did not include any indication or recognition of an identified resident population that received Comfort Care within the facility. Facility provided documentation revealed 10 residents received Comfort Care at the facility, making up approximately 9.3% of the current facility population. Only two residents were identified with Hospice services, making up approximately 1.9% of the current facility population. The Comfort Care population was not identified in the current Facility Assessment. The current Facility Assessment identified residents on Hospice and Palliative Care services only. During staff interviews, noted below and cross-referenced with F684, the facility did not identify unique and distinctive characteristics and care need differences between residents receiving Comfort Care and Palliative Care. During an interview on 01/30/26 at 1:40 PM, the Administrator stated that they had provided the most current Facility Assessment for review.During an interview on 01/30/26 at 5:09 PM, the Director of Nursing (DON) provided an Order Listing Report, which she stated revealed the current list of residents receiving Comfort Care. The resident list identified 10 current residents, each documented with Palliative Care-Form on File. The DON said that this was the current list of residents on Comfort Care and that the facility used the term Palliative interchangeably with Comfort Care.During a follow-up interview on 01/30/26 at 6:05 PM, the Administrator confirmed that the facility had been using the terms Palliative and Comfort Care interchangeably. She said that they used a Comfort Care/Palliative Care Assessment in the nursing home setting and it was used like a wish list advanced directive, documenting preferences related to their care. The Administrator stated they were aware that they used the terminology Palliative in the Facility Assessment, and not Comfort Care. She stated that she had been told they were the same thing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085050	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cadia Rehabilitation Broadmeadow	500 South Broad Street Middletown, DE 19709

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the medical record was complete and accurate for one resident (Resident (R) 48) out of 31 total sampled residents. The facility failed to ensure current Physician Orders reflected an active order for R48's Comfort Care Program. This failure had the potential for residents to have unmet care needs. Findings include:Review of R48's admission Record, located under the admission tab of the electronic medical record (EMR) revealed R48 was admitted to the facility on [DATE] with diagnoses that included heart failure, peripheral vascular disease, cerebral infarction with right-sided weakness, history of falls, and chronic obstructive pulmonary disease. Review of R48's Clinical Profile, in the EMR, revealed that R48 had Special Instructions: COMFORT CARE: NO further hospitalization, NO IV fluids, NO discontinuation of medication, NO weights, YES lab work, YES supplements, YES antibiotics.Review of R48's Order Summary, located under the Orders tab in the EMR revealed that the order, COMFORT CARE: NO further hospitalization, NO IV fluids, NO discontinuation of medication, NO weights, YES lab work, YES supplements, YES antibiotics were discontinued on 02/27/25 and 05/29/25. During an interview on 01/30/26 at 9:36 AM, Licensed Practical Nurse (LPN) 4 stated, R48 is able to make her needs known. When she is up to it, she wheels herself around the building. When asked to describe what Comfort Care was, she stated, Comfort care is just one level down palliative care, we make them comfortable, pain free, I believe by the time the patient is on comfort care, I'm trying to find the words to say, they are just trying to be comfortable, no more invasive or aggressive procedure, if with infection such as a Urinary Tract Infection (UTI) it can still be treated. LPN4 was asked how she would know if a resident was on the Comfort Care Program? LPN4 stated, The Unit manager will let us know that the resident was placed on comfort care. For example, I would verify the order with RN/UM2 that she [the resident] was on comfort care. When asked to check for a Comfort Care physician order in the EMR for R48, she stated, There is supposed to be an active order for comfort care for R48. I am checking just to be sure because it might be somewhere else. I might be missing it; I'm looking through, but I don't see it. Not that I can't see. It's just not there.During an interview on 01/30/26 at 9:57 AM, RN/UM2 was asked if there should be an active physician order in R48's list of Physicians' orders and RN/UM2 stated, Do you mean in the orders? Yes, it should be listed in the active orders. RN/UM2 was asked to show where the active physicians' order for Comfort Care was located in the EMR, and she confirmed that there was no active physician order listed.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, document review, and review of McGeer's criteria, the facility failed to have an Antibiotic Stewardship Program consistent with current standards of practice for the prescribing of an antibiotic for one of five residents (Resident (R) 71) reviewed for antibiotic stewardship out of a total sample of 31 residents. This failure had the potential to result in the unnecessary use of antibiotics, increasing the risk of antibiotic resistance and adverse medication-related side effects for residents. Findings include:Review of R71's undated Face Sheet located under the Profile tab in the electronic medical record (EMR) indicated R71 was admitted to the facility on [DATE] with the diagnosis of Parkinson's Disease.Review of R71's Nursing Progress Notes located under the Progress Note tab in the EMR indicated on 05/25/25 at 12:10 PM the nurse documented, Resident was not feeling well. O2 [Oxygen saturation] 89-90% [percent] on room air. 96% on 2L [liters] of oxygen; right upper lobe congested; [name of NP] notified and order for albuterol nebulizer Q6H [every six hours] prn [as needed] and stat chest x-ray.Review of R71's chest x-ray results dated 05/25/25 and provided by the facility indicated the reason for this test was Wheezing. The findings were . Bilateral lower lobes infiltrates. Right pleural effusion . Review of R71's Physician Orders located under the Orders tab in the EMR indicated an order dated 05/25/25 for Amoxicillin-Clavulanate Potassium (antibiotic medication) 875-125 milligram give one tablet by mouth twice a day for bilateral lobe infiltrates for seven days.Review of R71's Medication Administration Record (MAR) dated May and June 2025, indicated R71 completed the course of the antibiotic that was prescribed on 05/25/25.Review of R71's Potential Infection Evaluation provided by the facility and dated 05/27/25 indicated documentation as follows: -Temperature 97.8 degrees Fahrenheit on 05/25/25-Most Recent O2 sats (saturation) 89% on 05/25/25- . Lower Tract Infection-Does the resident have a fever? . No fever . -Does the resident have chronic obstructive pulmonary disease (COPD)? Yes . -Is the resident over 65? Yes . -Does the resident have a new or increased cough with purulent sputum production? . No [Does not MEET criteria for LRI] . Nursing home protocol criteria are . NOT MET, The resident does not need an immediate prescription for an antibiotic, but may need additional observation . Review of R71's Provider Progress Notes located under the Progress Note tab in the EMR and dated for 05/27/25 indicated, . Plan . Pneumonia, acute - CXR [chest x-ray] showed bilateral lower lobe infiltrates. Pt. [patient] was started on Augmentin for pneumonia on 5/25 . Monitor clinically . Review of the EMR revealed R71 had no lab work completed prior to the start of the antibiotic, had no documented fever, and had no change in function or mental status.Review of the facility's Infection Control Surveillance Log dated January through December 2025 and provided by the facility indicated the logs had missing documentation to reflect the signs and symptoms the resident was experiencing, organism that was present on the culture results if one was obtained, and if the McGeer's criteria were met. During an interview on 01/30/26 at 5:00 PM, the Infection Preventionist/Staff Coordinator (IP/SC) confirmed that R71 did not meet criteria for use of an antibiotic according to the Potential Infection Evaluation form used the facility, since she had no cough. The IP/SC stated that was a form used by the prior IP, and she had not realized it did not coincide with McGeer's criteria, which the facility used.During an interview on 01/30/26 at 5:00 PM, the Director of Nursing was asked her expectations for residents receiving antibiotics and the DON stated, The symptoms that the resident is having meets McGeer's criteria for the use of the antibiotics prescribed.Review of the McGeer's Criteria located at www.nursinghomehelp.org/educational/infection-control-guidelines indicated the following for Revised McGeer Criteria for Infection Control Surveillance Checklist for Pneumonia: Must fulfill 1, 2, and 31. Chest X-ray with pneumonia or a new infiltrate2. At least one of the following (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	criteria-New or increased cough-New or increased sputum production-O2 sat < [less than] 94% on room air, or > [greater than] 3% decrease from baseline O2 sat-New or changed lung exam abnormalities -Pleuritic chest pain-Respiratory rate >/= [greater than or equal] 25 beats/ [per] minute3. At least one of the following criteria -Fever-Leukocytosis-Acute mental changes-Acute functional declineReview of the facility policy Antibiotic Stewardship dated 01/13/26 indicated, It is the policy of [name of facility] to establish an antimicrobial stewardship program that promotes the appropriate use of antibiotics and includes a system of monitoring to improve resident outcomes and reduce antibiotic resistance . utilize McGeer's Criteria for assessing residents and appropriate diagnostic testing .